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Nursing: a Profession in Process

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AN ABSTRACT OF THE THESIS of Mary Elizabeth Dilling Rambousek for the
Master of Science in Teaching in Sociology presented February 25, 1972.

Title: Nursing: A Profession in Process

APPROVED BY MEMBERS OF THE THESIS COMMITTEE:

~~Joseph B. Vong~~ Chairman

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James E. Weiss

The general concern of this thesis is with the professional status of nurses in the United States. Specifically, the focus is on the progression of nursing along the occupation continuum toward professionalism. The perspective of this study was adopted from Elliot A. Krause's discussion of, "A Historical Perspective," in his The Sociology of Professions. Krause maintains that an analysis of the past key periods of the history of an occupation can provide a basis for predicting what it will become in the future. The acceleration of change in all aspects of society, and particularly in the role of the nurse in the medical process, and her progression toward professionalism, prompted the study.

It is accepted that nursing is an occupation, but there is no general concensus about its professional status. By following the progression of nursing from its earliest period when it emerged from a home-based art into an organized occupation with a specialized science, this study

points out and analyzes the steps nursing made in its professionalization process. The criteria of a profession are used as the basis upon which the degree of progress is judged.

The process of professionalization of nursing is shown to be very complex, fraught with many obstacles imposed by many factors. There are reasons to debate whether the occupation of nursing has yet reached the status of a profession, or if such achievement is even possible. The study also shows the direction nursing appears to be taking into the future, and the alternatives it can take. The study points out the importance of the professional versus the non-professional status, and the implications failure to attain professional status may have on nursing.

The characteristics of nursing are presented in a broad macroscopic overview. Microscopic vignettes could be found which would refute any of the blanket statements made about nursing, but no attempt is made in this study to cover the miniscule exceptions.

Data for the study were obtained from the literature dealing with the history, definitions and concepts of labor, professions, sociology, and nursing, as well as periodical professional publications.

TO THE OFFICE OF GRADUATE STUDIES:

The members of the Committee approve the thesis of
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February 25, 1972

NURSING: A PROFESSION IN PROCESS

by

MARY ELIZABETH DILLING RAMBOUSEK

A thesis submitted in partial fulfillment of the
requirements for the degree of

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M.E.D.R.

CHAPTER I

Introduction

One of the major historical changes occurring in human societies is the importance of work in man's life. Ever since the first man was reported to have received the order to "go forth and earn his bread by the sweat of his brow," work has been a centrality of an individual's life, rivaled only by sleep as a routine activity. Once an activity of survival, work has become not only a necessity, but a determinant of social prestige. Work - occupations and professions - is one of the main mediators between the individual and society.

Part of the importance of work is related to the economic rewards derived from it, but a large portion is attached to the importance accorded by society to the types of work performed. Frequently, this factor assumes paramount importance. The division of labor early layered the different types of work into a hierarchy of importance, but a special deference was reserved for a select few occupations. These were generally considered the major professions of religion, law, medicine, and the military. History records a rise and fall in them as to order of importance, but throughout most of it, they maintained their major status among occupations. The military profession experienced the greatest number of peak and depression periods, depending upon the political position of a society at a given time, or the rise of new professions such as economics and politics. Now, as an occupation, it is seldom considered a profession¹. The other three, however, have survived until the present day. As late as 1711, Addison² referred to the "three great professions of divinity, law, and physic," (Carr-Saunders and Wilson: 1933).

Present day authorities and writers still use theology, law, and medicine as examples of typical professions, although they usually reverse their order of importance.

As distinct groups of workers began to form organizations, new professions arose. The pace, slow at first, picked up during the period of the Industrial Revolution, then literally bounded ahead with the advent of the Atomic Age. As the term profession, came under the analytical scrutiny of the social scientists, in the twentieth century, and received definitions which included loftier attributes, the importance of profession rose to the point where it was desired for its implications of status. Virtually all self-conscious groups practicing a definite technique founded upon a specialized training now apply it to themselves at some time or another, either to flatter themselves or to try to persuade others of their importance and to be accepted as professions.

The result of the rather loose application of the label of professionalism to any and all groups, is a division of thought in regard to the appropriateness of its application to any given occupation. Rather tight lines are drawn between those already in the established professions and the members of the aspiring occupations. There is a recurrent idea among students of occupations that the labor force as a whole is in one way or another becoming professionalized (Wilensky: 1964)³.

Many occupations are engaged in heroic struggles for professional identification. Probably in no occupation is this more true than in nursing. Nursing is seeking a place for itself in an increasingly specialized world. Behind this search for identity are drives for prestige, disparities between ideology and the actual job experiences of nurses,

and competing expectations for role performance. The confusion is reflected in a series of contrasting career themes; ambiguous roles amidst an abundance of job descriptions and regulations; high morale and a favorable view of the status of nursing within the profession, but dissatisfaction with conditions of employment; and commitment to the field of nursing together with transitory investment in the career (Corwin: 1963:187).

In the preface of his book, The Nursing Profession (1966), Fred Davis explains that in all of his studies of nurses, and in reading the essays of the authors who contributed to the book, he was struck by the proliferation of paradoxes that characterizes contemporary nursing. Because Davis has so concisely pinpointed the most acute factors apparently blocking the professionalization of nursing, and echoes clearly, the frustrations faced by nurse leaders today, his paradoxes are cited verbatim:

--It is a paradox that despite the considerable responsibility assumed by professional nurses for the treatment and care of patients, their organizational role in hospitals and elsewhere is so lacking in the autonomy and authority characteristically associated with professional status.

--It is a paradox that, at any one time, a third of those qualified to practice as professional nurses (that is, R.N.'s) choose not to.

--It is a paradox that, in popular parlance, the same, unmodified nouns "nurse" and "nursing" should be applied so indiscriminately to a wide variety of health care activities, carried on in different settings under different institutional auspices, and to an occupation that includes some of the least-educated members to the most educated (such as persons with advanced degrees who serve as consultants to federal, state, and municipal health agencies).

--It is a paradox that, whereas other occupations in

America accorded the prestigious title of profession have long since established the bachelor's degree as a minimum prerequisite for practice, professional nursing continues, despite historic and bitterly fought battles, to rely overwhelmingly on the services of persons who have not received a college education.

--It is a paradox that, although great material technological, and organizational strides have been made in recent decades in the health sciences--all of which would seem to favor parallel advances in the art of patient care--a growing chorus of complaints, both from the public at large and from informed critics of health affairs, has arisen about the quality of nursing that is being dispensed (Davis: 1966:vii-viii).

NURSING - OCCUPATION OR PROFESSION

In the immediate post World War II period, almost three and a half centuries after Addison, an instructor in a school of nursing faced her class of eager "probies" and asked, "Is nursing a profession?" Emphasizing her own reply with a slow shake of her head, she went on. "No! The only professions are medicine, law, and the ministry."⁴

Graduates from that class of nursing students, and from hundreds of other classes across the country, went out into the world of nursing marked by similar indoctrination. Some nurses still adhere to it today; they are joined by the non-nurses who take sides to support the two contentions. Nursing is only an occupation; nursing is a profession. Some take a neutral course and concede that nursing is a semi-profession (Etzioni: 1969:xiv)⁵.

So disturbed was the administrative head of one national nursing association about the indiscriminate use of the term "professional nurse," that she always referred to the nurse who is professional in the generic sense of the word as "the professional woman in nursing," (Brown: 1948:76).

William Glaser (1966:4) feels that nursing has the potential for professionalism, but as long as nursing is considered unskilled, menial, and dirty work it will not be able to recruit the better educated and more refined girls capable of providing services of professional level.

William Goode (1969:266) is quite emphatic, "...many aspiring occupations and semi-professions will never become professions in the usual sense; they will never reach the levels of knowledge and dedication to service the society considers necessary for a profession. Such occupations include school teaching, nursing, librarianship, pharmacy, stock-broking, advertising, and others." (Italics added).

Esther Lucile Brown (1948:76), Director of the Department of Studies in the Professions, Russell Sage Foundation, and a long time champion of the profession of nursing, (Nursing as a Profession, 1936) says, "Nursing has moved far enough in the direction of meeting the criteria so that it may be considered a profession."

A. M. Carr-Saunders (1933) says simply, "The vocation of nursing is becoming professionalized."

To many of the nursing leaders, this is an issue of real concern. While the concern of some lies in the status value of professionalism, most are interested in having nursing achieve the position of a profession because in order to do so it must first reach a level of performance, undeniable acceptable as superior in value and excellence by other professions and by society. The leaders are well aware of the potential of nursing and recognize the factors which are preventing the realization of it. Achieving professionalism would mean that those factors had been eliminated and nursing was functioning at its best of all possible

performance (Lindsey: 1962).

There is enough concensus of thought among nurses and non-nurses to warrant the opinion that nursing has moved from the realm of being "just an occupation." But, how far has it moved toward professionalism? Just barely, or is it almost there? To make any determination, it would first be necessary to understand what is meant by an occupation and what is a profession. How do they fit into the social structure, and how does each affect the individuals who lay claim to one, or the other?

OCCUPATION

It is obvious to even the most untrained observer that work - or occupation - assumes many different forms. A basic problem in the categorizing of the occupations is the lack of good typology for them. Occupations could be divided on the basis of whether a person utilized manual, mental, or social skills. But, with few exceptions, most use a combination of each. Other groupings could be made on the basis of simple dichotomies, such as blue-collar versus white-collar jobs, professional versus nonprofessional positions, but they also, have too many cross-overs in the lines of demarcation and cannot be completely exclusive. Amount of education, responsibility or authority might be relevant, but there, not enough evidence has been documented to make any of these criteria universally valid.

Among the 47 definitions given to work in The American College Dictionary, 1962 Edition, is the term occupation. Occupation, in turn, is defined as, "one's habitual employment; business, trade, or calling." Robert Dubin (1958:4)(as quoted by Hall, 1969) defines work a trifle

more definitively as, "...continuous employment, in the production [sic] of goods and services for remuneration."

A slightly broader perspective is offered by Arthur Salz (1944:424), who notes that, "occupation may be defined as that specific activity with a market value which an individual continually pursues for the purpose of obtaining a steady flow of income. This activity also determines the social position of the individual."

Everett C. Hughes (1964:445) also sees the meaning of occupation in broad terms. He states that, "an occupation, in essence, is not some particular set of activities; it is the part of an individual in any outgoing set of activities. The system may be large or small, simple or complex." Hughes emphasizes the social relationships surrounding an occupation, not in order to minimize the financial side, but to keep it in perspective as part of a more inclusive set of social relationships. Similarly, Anne Roe (1956:3) defines an occupation as "whatever an adult spends most of his time doing...the major focus of a person's activities and usually of his thoughts." This definition suggests the importance of an occupation to the individual. It also suggests that this major focus is transmitted into the social process and thus means that occupations are a major component of the social structure, serving as links between individuals and society.

Perhaps Richard Hall (1969:6) provides the most comprehensive definition of occupations as follows: "An occupation is the social role performed by adult members of society that directly and/or indirectly yields social and financial consequences and that constitutes a major focus in the life of an adult."

PROFESSION

Profession is probably the most widely used and commonly known occupational sub-category, and refers to the occupational class most readily identified as a type of occupation by the public at large. This is due to several factors. Professions have high status, and the members of a given profession have a very definite image which marks them as belonging to that profession and no other. A member of a profession is regarded not only as a specialist and an authority, but is respected because he secured the high degree of knowledge and expertise required by the profession, and also for his ability to command better than average financial remuneration for his skills!

Some authorities hold that there is no such thing as a "real profession" but only an "ideal or model type" of occupational organization which does not exist in reality, but which provides a model of what an occupation would be if it could become completely professionalized. (Vollmer and Mills: 1966:vii).

In view of the many attempts to define "profession," and the list of attributes which are felt to be necessary, this is probably very true. At best, an occupation can attempt to fit the model of professionalism, and the closer it succeeds, the closer it is to being a profession.

One of the common threads in all definitions of profession is the presence of a specific body of knowledge. However, authors differ on the application of that knowledge. Some say that this is an intellectual technique which performs a service for society. (Hall: 1969:72). Talcott Parsons (1959:547) recognizes an incompatibility in these terms when he points out that some professions, as medicine, are primarily

applied, while social sciences, as sociology, are primarily dedicated to the advancement of empirical knowledge, with only secondary emphasis on its utilization.

Earnest Greenwood (1957:10) suggests five major attributes of professionalism. One, a body of knowledge based upon research. Second, authority based upon that knowledge which allows the professional to make judgements for the welfare of his client. Third, formal and informal community sanction of the profession, its powers and privileges, including that of confidentiality. Fourth, a regulative code of ethics providing the appropriate rules of behavior of the professional toward his clients and toward fellow professionals. And, lastly, a professional culture, which involves norms governing membership in professional associations, organizations which are qualified to provide training, and appropriate sites for professional practice. In addition, this culture contains the language and symbols of the profession which differentiates between the professionals and outsiders.

Some argument can be offered about Greenwood's contention that the body of knowledge of a profession must be acquired by research. Most professions do rely heavily upon research, some very, very little. For example, two of the most easily identified professions, law and the ministry, apparently do not. Much of their knowledge base depends upon lore rather than on science. (Hall: 1969:73) This is not to reflect upon the authenticity of their knowledge, for scientific study and findings in the recent years have done much to verify it, as by the translations of ancient rock writings and the discovery of the Dead Sea Scrolls. The value of research can be in its verification of existing knowledge as much as in its use

to acquire new knowledge.

Harold Wilensky (1964:140) also feels that perhaps too much emphasis is put upon the professional mandates derived from science and sanctioned by law (medicine) and those derived from morality and sanctioned by public opinion (the priesthood).

Most of Greenwood's attributes of profession seem to be largely concerned with the way an occupation is linked to the social structure. In reality, a profession is controlled by society. If an occupation has all the attributes, but is not given community sanction, it will not be considered, and cannot operate, as a profession. And, this recognition and acceptance is not all that easily come by.

An occupation does not "naturally" come by so unusual a condition as a professional status - specifically autonomy. Since the work of one occupation commonly overlaps, even competes, with other groups, it is unlikely that one occupation would be chosen spontaneously over others and granted singular status by some kind of a popular vote. A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work (Friedson: 1970:72). This might make "knowing the right people," an added attribute of a profession!

Edward Gross (1958:79) adds another dimension to the professional characteristics, mostly attitudinal. For instance, a central characteristic is the degree of personality involvement. The professional, as opposed to the business man, is expected to consistently act in the best interest of his clients. He will have a well developed sense of obligation to do the best possible work that he can, and "is not supposed to

be interested in sordid money." Friedson (1970:70) feels that attitude is probably the variable characteristic which distinguishes the truly professional person from the non-professional, even among members of the same profession.

Other sociologists suggest still another characteristic of professions. Along with the extended formal training that the student of a profession undergoes is a more far-reaching adult socialization process than the person learning other occupations. This socialization creates an attitudinal consensus which further marks the professional throughout the remainder of his life (Hall: 1969:76).

William J. Goods (1960:903) makes a point - that a profession is typically the terminal occupation for its members. Trained professionals very rarely leave their professions in contrast to many in other occupations in which change of types of jobs is quite normal.

Among the many criteria offered for distinguishing professions from other occupations is a truly important and uniform one - autonomy; a position of legitimate control over work. Within this autonomy are recognized several definite characteristics, among which the most frequently cited are: 1) determination of its own educational standards, 2) some form of licensure and ethical code, 3) licensing boards and legislative bodies made up of members of the profession, and 4) relative freedom from lay evaluation and control (Friedson: 1970:77).

The question of control is the obverse of the question of autonomy, for autonomy is granted the profession with the understanding that it will itself, without outside interference, regulate or control the performance of its members. Just as autonomy is the test or professional

status, so is self-regulation the test of professional autonomy (Friedson: 1970a:77).

Beyond being a full-time pursuit of some significance or social prominence, it seems difficult to find very much agreement on a definition of the word profession. This is so for a number of reasons. First, the word is evaluative as well as descriptive (Cogan: 1953). It has a merit connotation and is often applied on the basis of the value the connotation has for the one claiming professional status, and also for anyone making use of the services of a given occupation.

A second reason for the difficulty in agreement, is that people frequently draw up definitions first by deciding which occupations already are professions and then attempt to find the characteristics these occupations have in common.

It was inevitable that the social scientists, in their analytical scrutiny of occupations and professions, should turn their attention to the medical field. The findings of some of the surveys carried on at the beginning of the twentieth century disclose that such evaluation was overdue. As a start, medical education was centered in proprietary institutions controlled by groups of doctors, not by university boards. In 1910, the Flexner Report disclosed a shocking lack of facilities and standards. As a result, the American Medical Association and the American Public Health Association effected the closing of 80 of the 160 existing medical schools. Standards and laws were established, clinical experiences secured, and research encouraged until American medical education gained one of the highest ranks in the world (Guinee: 1970:18).

In 1915 this same Abraham Flexner formulated criteria to determine

whether an occupation had become a profession (Appendix A). In an address given that year in New York, he applied the criteria objectively to the characteristics of different professions, including social work and nursing (Italics added). He stated that although neither conformed in all respects to his idea of a profession, both met some of the criteria (Guinee: 1970:19). Nursing leaders, attempting to qualify nursing as a profession have used Dr. Flexner's criteria as their pattern down to the present time (Jamieson and Sewall: 1929)(Brown: 1948)(Guinee: 1970).

Later studies retained the basic criteria, but added factors which made them even more applicable to nursing. In 1959, Genevieve and Roy Bixler discussed the following seven criteria common to professions and related them to nursing as a profession. According to them, a profession:

1. Utilizes in its practice a well-defined and well-organized body of specialized knowledge which is on the intellectual level of higher learning.
2. Constantly enlarges the body of knowledge it uses and improves its techniques of education and service by the use of the scientific method.
3. Entrusts the education of its practitioners to institutions of higher education.
4. Applies its body of knowledge in practical services which are vital to human and social welfare.
5. Functions autonomously in the formulation of professional policy and in the control of professional activity.
6. Attracts individuals of intellectual and personal qualities who exalt service above personal gain and who recognize their chosen occupation as a lifework.
7. Strives to compensate by providing freedom of action, opportunity for continuous professional growth and economic security (Bixler and Bixler: 1959).

In an attempt to position nursing on the occupational continuum

between a non-profession and profession, it is necessary to have an understanding of the structural distinctions of occupations, especially of the medical division of labor, of which nursing is such a vital part. The overall unifying principle in society's division of labor greatly interested Emile Durkheim, and in his classic work on the subject he identified two general patterns by which the work of society appears to be organized. The first he called, mechanical solidarity. The rule of custom was so strong, and the lack of specialization so basic, that everyone mechanically did the work, and all automatically obeyed the strong customs and moral order of the society - typically a primitive society. As societies became more complex and closer in form to the modern industrialized society, specialization arose and the division of labor took place. Each occupational group then "did its own thing" for all the other groups. This is likened to the organs of the body, in which each performs a singular function, but is intra-related to all the other organs of the body. The function of one depends upon the function of all, yet all depend upon one. Durkheim called this organizing pattern, organic solidarity. Here, instead of the society being held together by custom, the dependence of the groups upon one another became the key to understanding the organization of the society (Durkheim: 1933: 68-110). In order to function, the baker needed the miller, the miller needed the farmer, and the farmer depended upon the metal smith - who in turn ate the baker's bread.

Whereas the division of labor in nonprofessional fields is ordered by historical accident, economic and political power, competition, and functional interdependence, the division of labor surrounding the highly

professionalized activity of healing is ordered by the politically supported dominant medical profession (Friedson: 1970a:48). In the medical division of labor, the doctor is the only one recognized as the professional, by the criteria of professions. The ones whom he controls are the paramedicals - those who have been unaccepted as professionals by the physicians, or who have been added to the professionally ordered division of medical labor.

Certainly, the paramedical occupations do not include every one who is engaged in the healing arts. A few practitioners have been able to achieve professional status independent of the medical profession. Dentists are one case in point. Others, not recognized by the medical profession, nevertheless perform functions traditionally accorded to the doctors, such as the optometrist who diagnoses (refracts) and prescribes (glasses), or the podiatrist who diagnoses, prescribes, and cuts (trims corns and callouses). For the very reason that these purveyors of health services are independent of control by the medical profession, they are not commonly called paramedical.

For the most part, paramedicals perform tasks which were once the functions of the physician. The paramedicals do not practice their areas of skills until those skills have been turned over to them by the medical practitioners. This gives the physician the right to control the paramedicals by relegating to them tasks and overseeing their performance. The same is not true of nurses. The occupation of nursing preceded that of medicine far back in recorded history (Bullough and Bullough: 1969). The functions of nursing had been separate and apart from those of the medical practitioners, even when the two may have occasionally joined

forces for the purpose of providing care for the sick in the pre-professional days of medicine.

This primary objective of the two occupations - the care of the sick - eventually tended to ally nursing with medicine more closely, as science and medical knowledge advanced, but nursing remained a loosely structured occupation with little organization outside of those religious groups whose members devoted their lives to the care of the sick. Generally, secular nursing, however, could barely qualify as an occupation. Nurses did expect financial returns for their work, but it was a rare one who willingly selected nursing as her full time activity, and the goods and services they provided were often of questionable value to society. There was one characteristic to which nursing could lay claim, however - nursing was medically autonomous!

It is rather ironical that nursing's first steps toward professionalism were also the beginning of its dominance by the medical profession. That is, nursing exchanged its autonomy for other attributes of a profession, such as a scientific body of knowledge, formal organization, and social recognition and acceptance. How interesting is the speculation of what the present medical division of labor would be if nursing had not relinquished its autonomy!

PLAN OF THE STUDY

Because nursing is work - a job, an occupation - it seems important to trace the process of changes which occurred in the pattern of man's work in general, then pick out and follow the thread in the pattern which wove nursing into the fabric of work and society. The forces which

individuals and occupations bring to bear on one another, and the consequent role which occupations and professional groups play in the society can be traced and analyzed historically.

To determine where nursing is located on the continuum between non-profession and profession, it was necessary to first, understand what is meant by the terms, occupation and profession: second, what criteria is necessary for classification in one or the other; third, how nursing has qualified by meeting those criteria in the past and the present. In order to make the determination, literature bearing on the concepts and definitions of labor, professions, sociology, and nursing history, as well as periodical professional publications, were reviewed.

The information for this paper is principally secondary data obtained from the existing literature. Exceptions are the few items of personal observation by the author.

DEFINITION OF TERMS

Some of the confusion encountered in the definitions of the term profession, is due to the looseness in the terminology of professionalization, professionalism, professional groups, and professionals used by various authors. While it is not the purpose here to fix an inflexible definition of each term, for the purpose of this study, it would be advantageous to separate them by more precise meanings.

The concept of professionalization refers to the dynamic process by which an occupation changes in character as it moves in the direction toward a profession. The process of professionalization is frequently referred to as professionalism, and used interchangeable without any

noticeable loss of meaning.

Finally, professional group applies to associations of colleagues in an occupational context where a high degree of professionalization has taken place. Professionals, then, are those individuals considered to be members of professional groups (Vollmer and Miller: 1966:viii).

Because nurse has several connotations, and is applicable in many situations to many types of persons, it requires considerable attention. Nursing - to nurse, to nurture, to care for, to attend - knows no gender, except when applied to the act of breast feeding the mammalia young. The title of nurse then, could apply to any being providing the service of nursing. However, during the course of civilization, the title came to mean the individual who provided care particularly for the sick and helpless members of society⁶. In contemporary parlance it has been specified to identify an individual who has been trained or educated in the art and science of providing care for the sick and helpless. The term of nurse has also acquired a female characteristic, such that men working as nurses are segregated by titles, as orderly or male nurse. Other divisions of nursing identify nurse's position as RNs, LPNs, and aides, or "just practicals!"

In this study, nurse is used to designate an individual who provided non-medical care for the sick and helpless during the periods of history from antiquity to the advent of the "professional nurse" in the latter quarter of the 1800's. In the periods following, specifically from 1900 to the present time, nurse means a person who is qualified as a Registered Nurse, or RN. Those not so qualified are called by their position in the division of nursing.

The terms, professional nurse and nursing profession are found in this paper because of their common use by other authors and the general public. Their use is not an indication that nursing is considered a profession as a foregone conclusion of this study.

It is recognized that men have always played an important role in nursing, but, for simplicity of sentence structure in this paper, nurses are referred to with the female personal pronouns.

Because of the importance of the historical aspect of nursing, the early characteristics, consequences, and events are included in this study, regardless of the country in which they took place. However, the analysis of modern nursing will be limited to nursing in America.

In this study, the term health is used in its broadest sense. Health is not merely a condition of being free from physical or mental disease, but is a state of being in which an individual is able to function at the optimum of his potential, physically, mentally, emotionally, and socially; a state of total well-being⁷.

Besides indicating nursing's position on the occupation-profession scale, this study will show the direction nursing is taking into the future, as well as alternatives it can take. The study points out the importance of the professional status, and what implications failure to attain that status may have on nursing.

CHAPTER II

ASSESSMENT OF SOCIAL AND TECHNOLOGICAL CHANGE OVERTIME

The first function of work was the maintenance of the individual; the securing of food, shelter, and protection. While the individual was alone, or when he belonged to a single family unit, he could fairly well take care of each of these areas singlehandedly. He was from what Krause calls the "hunting and gathering societies," primitive and not too effective in production (Krause: 1971:13).

The beginning of the division of labor, with the start of the agricultural societies, and later the herdsmen, led to more effective technologies with more efficient use of time and energy. These made possible free manhours in which men could specialize in government, war, and religion as full-time jobs. Their personal and occupation needs were then provided by other specialists, and the crafts were born. The home of the craftsman was his factory, and there he passed on his trade skills to his sons in an apprenticeship-type training.

One of the oldest occupations - and woman's first - to rise from the home-based activities was nursing, although it scarcely qualified as an occupation for a good many centuries⁸. Nursing started when the first primitive mother put her baby to breast, comforted and tended to his needs. As the child grew, the mother learned to create means of meeting emergencies, as well as preventing them. The helpless became her special charge. Just as in any household art, some women thought out methods of giving care which were more successful than those of others. The successful ones shared the results of their experiences with their neighbors, and were frequently called upon to assist in the community homes. However, the nursing skills were restricted to the homes long

after the other skills of man had moved into outside settings.

Home remedies could not be applied with success to all the ailments which visited primitive man. Blame for the inexplicable was placed on spirits and demons, and magic was an imaginative source of help, called upon to hasten results from the treatments, or provide a substitute if they failed. An individual who became adept in the relieving of symptoms gained a reputation as a Medicine Man or Shaman, and his services were sought by members of the community.

When men began to worship forces that proved helpful in the stresses of life, and to seek to propitiate harmful ones, the Medicine Man became the Priest-Physician, who invoked the gods, interpreted their wishes, and made intercession for the sick. After temples were built to protect and house concrete presentations of gods, he lived in or near them. In time, corps of assistants came and worked with him, but, acting as his personal attendants as much as ministers to the sick. Under his direction, they carried on extensions of his priestly duties as well as his medical care.

Women participated in the ancient religions as priestesses, but in the records little mention is made of them as attendants. Women were seldom singled out, because of their relative unimportance in the ancient societies (Nutting and Dock: 1907:54). Besides, nursing was still an accepted part of "woman's work" in the home, and not worthy of note.

The structural and functional changes of the division of labor, down through the centuries, were accompanied by definite value changes in work, occupation, and profession. Most of these changes can be directly attributed to the changes in social values in general. During the periods when labor was necessary for individual maintenance, it had only

one value - survival. During the pre-Christian era, most societies tended to regard work as a necessary evil, usually to be avoided as much as possible by those who could do so. The popularity of the slave system is one point of evidence. Another is found in the dogma of reward and punishment as controlled by the whim of the gods and super-natural powers. This held that any unpleasant aspect of man's lot - sickness, poverty, misfortune, need to work - was a curse. The Greeks viewed work as a curse if it involved manual as opposed to intellectual labor. The Hebrew view was essentially the same, but with the additional rationale that work was drudgery because it was the way in which man could atone for the original sin (Hall: 1969:16).

With the advent of Christianity, new dimensions were added to the value of labor. It's fruits could be shared by others in the name of sweet charity, and it became a means of spiritual purification when performed for the honor of God, regardless of human benefit. The Reformation saw little change in the value, but the later Protestant ethic began to shift the value to the more mundane aspect of monetary profit, and expansion of new ventures for even more profit.

This striving for upward mobility changed emphasis from the spiritual to the moral with the development of socialism in the nineteenth century. Work was viewed, not as a form of expiation, but rather as something that man wants to do as the normal way of life. Each was to receive value equal to his work, and drudgery would be reduced by scientific advances, allowing more time for nonwork activities.

Hall (1969) notes that the "religion of work," so basic to capitalism, may be faltering in the twentieth century as a new orientation

toward even more recreation and leisure develops. Besides the values of work shared by a society there are also personal values unique to each individual. The concept of the value of work introduced by Christianity was probably the major factor in nursing breaking away from being a home-based activity and becoming an emerging occupation. About 60 A.D., Phoebe, a Greek convert to Christianity, and a friend of St. Paul, the apostle, became conspicuous for her work among the poor. Contact with poverty meant contact with sickness, and Phoebe, following the dictate of the Great Physician, "Inasmuch as ye have done it unto the least of these my brethren, ye have done it unto me," (Matthew XXIV:40) went out into the homes of the poor to bring to them food and clothing, and to comfort their pain whenever she could. She is honored as the world's first professional visiting nurse.

In Rome, where women enjoyed unusual independence of action and liberty to enter public affairs, the wealthy matrons, bored by fashionable society, could find outlets for initiative and social spirit in the church. In the fourth century, Marcella assembled a considerable group of such matrons for prayer and study in her luxurious home. This was the beginning of the first Christian monastery for women in Rome. One of her friends, and disciples, earned fame by independent achievement. Fabiola, established in her palace, a hospital to which she brought the sick from the worst sections of a great city, and personally nursed them. Fabiola can be considered the first institutional nurse.

The Julian-Christian ethic can also be credited with establishing the value structure found among the major professions today, just as their origins can be traced back to the dim era of pagan antiquity. The first

members of a community to set themselves apart from the rest were the leaders - the civic Chieftain and the religious Shaman. These men took on added duties which provided services to the community its individual members could not provide for themselves. The Chieftain led the people and acted as arbitrator in disputes between individuals. To the Shaman fell the task of securing luck during the hunt, rain for the crops, and health for the ailing. Progressively, the Shaman took on dual roles. Intermediary between man and the supernatural, and healer of man's ailments. From these leaders then, descended the major professions - law, medicine, and religion.

Christianity placed paramount value upon the latter. God was all-powerful, and theology dominated the value structure of society many centuries. In no period of history is this more evident than in the Medieval Age. The thesis that God had ordained the social order and structure, and that man should accept his station, was the official ideology of the Church as it had developed over the years after the fall of Rome. This thesis provided a theological justification for the rule from the top, which was a hallmark of the feudal system.

A second thesis - a more practical and less abstract one - was the coming into existence of local self-government and partial guild autonomy in the villages, towns, and cities. Together, these two theses made up the medieval society (Krause: 1971:16).

The rural villagers conducted self-government as the natural way of doing business, and they elected their own officials. In this self-government, the craft guilds played a very vital role. The guilds, based on a division of labor by occupational skill, became the primary organizing

bodies of the medieval town. In fact, in many towns, the council was made up of representatives from each major guild (Ullman: 1966). However, the guilds were not a force for progress or change; they were important in maintaining the economic and social status quo.

The beginning of the major universities during this period, essentially provided the base for the professions, as universities have done ever since. Because the Church governed the medieval universities, the faculty of arts and the schools of medicine, law, and theology all gave ecclesiastical degrees (Carr-Saunders and Wilson: 1933). Thus, all learned professionals were churchmen, by definition, and the trained practice of law and medicine was a monopoly of the Church, and thereby of the power of the period.

Throughout most of the Medieval Ages, then, a man's estate - as churchman, noble, guild member, or serf - was his primary way of relating to the overall society. The Church stood at the apex and presented the governing ideology. In this model of individual-occupation-society relationships, society, through the Church prescribed the role of the occupations, which then prescribed the role of the individual. The rights and duties, at each level, was from "above". And, in the Medieval period, God was the ultimate end of the chain of command (Krause: 1971:18). This, indirectly, might be the basis of so many believing, or acting, as if the professions are a divine right from God!

It was the Church more than society which prompted the changes in the structure of nursing. It provided an approved calling for women in an occupation outside the home, either in monastic hospital settings or by visitations to the sick and poor in the back streets of towns. It

attracted private beneficence to hospitals, and made possible the care of greater numbers of sick than had heretofore received attentions (Jamieson and Sewall: 1937). Christianity also provided the impetus for the increased need for nursing.

Christians, motivated by a religious zeal which ignored all else, save the elevation of the spiritual state of man, began a steady stream of pilgrimages to Jerusalem. Most, lacking the supervision of leadership, easily fell prey to sickness and misery of a magnitude unknown before in history. Other Christians, diverting their zeal in a different direction, set up hospices, way-stations, and monasteries along the route of pilgrimage to care for the victims. These care-facilities were improved and enlarged into hospitals by the Crusaders who followed during the years 1096-1271.

The crusaders made two notable contributions to medicine and nursing. First, their establishment of the hospitals provided the nucleus for some of the well known trade cities between Europe and Asia, and medical centers for the exchange of information between the different cultures. Second, the Mendicant Orders of Knights rose from their ranks. These Knights, devoting themselves to nursing the sick, made up one of the largest segments of male nurses in history.

It was inevitable that the experiences of those who took part in the mass movements outside of their native state and exchanged cultural components with foreign nations, would have strong and lasting effects upon all of society. The period of the Renaissance is marked by two major changes affecting the individual-occupation-society relationship. The rise of the first - the reassertion of the individual as an entity

in the face of larger organizations and offices - can be seen most concretely in the world of art, and in the imagination of independent thought during that time (Krause: 1971:18),

The second major change was the development of a money economy to replace the land based wealth of the feudal period. In a situation where the group with the money has the power, an opportunity is created for exploitation of resources through trade, investment, and credit finance - in a word, capitalism. An elite of capitalists was forming itself; it no longer took part in manual work, but was active in the sphere of organization and management, standing apart from the rest of the middle class and the working proletariat (Von Martin: 1963).

A further consequence of the loosening of the social order, the concept of upward social mobility through changes in occupations became a relevant one for the populace. Escape to the city from the still feudal-like countryside became a common phenomenon.

As the revolution spread northward from the Renaissance centers in southern Europe, a reaction set in against the new power relations developed between the Church and the merchant capitalists. The revolt took an overtly theological tone which brought about the establishment of the Reformation and Protestantism. This in turn, marked the beginning of the decline in the power of the clergy as the paramount profession. Gradually, the influence of the clergy waned so that by the end of the seventeenth century, the clergy could, as Increase Mather said, "no longer meddle in the affairs of labor and economics," but only advise sufferers to seek consolation in prayer (Miller: 1961:307).

Nursing, during this period prior to the Reformation, was pretty

much unchanged in structure from what it was following the Crusades. Monks and nuns continued to carry on the care of the sick in the hospitals of the Knights, and in monasteries in other parts of the Christian world. During the Medieval Age, nursing, like medicine, could scarcely be considered an art and science, but it was as good as anything else which society enjoyed. At least, it was under some measure of supervision and its practitioners were motivated by a sense of altruistic dedication. The facilities in which nursing was practiced were better than average structures. They were erected for the care of the sick and poor by the Church or endowments from wealthy sponsors. The hospitals were usually located on well selected sites, and their architecture and decorations resembled the ornate churches of the time. Aged noblemen and wealthy retired business men would often move to a hospital to spend their remaining years in the care of its nursing personnel.

Probably not much can be said for the nursing care, per se. In most part it was custodial in nature. For example, one of the night nurse's principal duties was to awaken patients to relieve their bladder, or to see they were properly dressed if they left their beds for other reasons. In the Middle Ages, both men and women slept in the nude, and a wrap was provided, not for reasons of modesty, but to prevent chilling (Bullough and Bullough: 1969:52).

There was some uniformity in the qualifications for nurses, however. Before entering any of the nursing orders, aspirants had to show that they were freeborn, celibate, free of debts, and not lepers or epileptics. After a period of novitiate, the applicant was examined by the bishop, in part to make sure the number of people in the nursing

orders was kept within limits. This was a deliberate policy so that hospitals would remain hospitals and not be turned into convents by having too many religious in them (Bullough and Bullough: 1969:54).

For whatever value nursing had during the Medieval period, at least it did carry the bulk of health care for the people. Medicine saw its darkest days in that age. Medical progress was severally hampered by the Church's ban on desecration of the human body by autopsy, and the teaching of anatomy was based almost entirely on Galen's observations derived from animal dissection (Frank: 1953:110). For this reason, and several others, doctors were not very popular. Very few were attached to the hospitals, therefore most of the care and supervision of the patients remained in the hands of the nurses.

The union between religion and nursing is very important. In the beginning, it was a union between religion and medicine, and nursing was a separate entity. With the advent of the Renaissance, and its birth of independent thought, dedicated men of medicine found argument with the rigid control of the Church; the Church retaliated by withdrawing its support of medicine's efforts at research and exploration, thereby stymieing medical progress.

Nursing, on the other hand, continued under the benediction of the Church, for obvious reasons. Nursing had never been defined as a science, any more than other homemaking skills, nor was it yet associated with medicine, therefore no one was particularly interested in introducing research and exploration into it. Its stability appeared as assured as the Church's own. Probably most important, the majority of those practicing nursing were in the religious orders, and consequently

bound to the Church by the vow of obedience.

During the Reformation, the power and possessions of the Church were stripped away in much of Europe. Among those losses were the monasteries and hospitals where nursing was practiced. In most places no new organization was provided to replace them. The problem of furnishing nursing care reverted to a public, which was little stirred by any appeal of human distress. Secularism was the religion of the day! With new worlds to conquer, both at home and across the seas, and wealth in the offing for anyone who would seek it, men could not afford the time to be charitable. Except in the few Church sponsored institutions which remained, nursing passed into the hands of those civilians willing to do it, and a steady deterioration became evident.

In England where there had been some 450 charitable foundations before the Reformation, only a few continued to exist after the death of Henry VIII. An even more radical effect of the Reformation on nursing, both in Catholic and in Protestant countries, was the removal of almost all men from the ranks of nurses. Most of the nursing orders organized by Catholicism after 1500 were for women, while in Protestant countries nursing became a woman's occupation or calling.

Civic leaders, as well as Religious leaders, were not unaware of the lack of adequate nursing care. In England, after Henry VIII had closed most of the monastic hospitals, it was found that the sick of London were deprived of the aid given them by the religious hospitals. As a result, in 1538, the mayor, aldermen, and citizens of London petitioned the king to reopen at least some of the hospitals, arguing that this was an absolute necessity for "the ayde and comforte of the poor,

sykke, blynd, aged and impotent persons beying not able to helpe themselves." Henry VIII eventually acted by granting endowments for some hospitals - St. Bartholomew and St. Thomas among them (Bullough and Bullough: 1969:64).

Royal endorsement did not ensure the secular hospitals good nursing service, however. Nursing continued its downward trend, and by the eighteenth century nursing can be thought of in terms of a trilogy of degradation of "persons, places, and things."

Only the lowest dregs of society entered hospitals as patients. Other levels, even the poor, remained at home to be cared for by their family, or by domestic servants. The hospital patients came from slums and disease-ridden cellars. Alcohol was routinely smuggled in to them and, under its influence, they frequently rose from their beds of pain to engage in free-for-all riots. Police had to be called in to break up the brawl among the patients - and to extract any nurses who were found involved in the center of the melee.

The nurses seemed as wretched as the patients under their care. It was an accepted fact that they supplemented their meager pay by stealing and prostitution, and cared nothing for the patients they were supposed to tend.

The hospitals were considered fitting "places" for the class of inhabitants they had. Large, bare, gloomy wards with as many as sixty beds, placed less than two feet apart, they were little more than morgues, for few of the patients ever left them alive. The bedding was seldom changed, and a new patient would be placed in the same unclean bed that a dead patient had just occupied (Webb: 1962:12).

It is small wonder that the "things" done for the patients in the name of nursing care were as wretched and inadequate as the "persons" providing them.

The decline of the religious motivation and the inadequacy of society to provide for the sick, created a need for nursing which would have been urgent enough if society had become stabilized at that point. However, this urgent need was heightened still further by the political and economic conditions which were being disturbed in the late eighteenth - early nineteenth centuries. Civil revolutions went on in Europe and America, and technical developments in all the civilized world were moving rural craftsmen to city factories, rendering jobless thousands who were unadaptable to the use of power machines, or not needed to run them. The ranks of the unemployed grew alarmingly. Thriving capitalism, unregulated production and working conditions, poor adjustment to city life, and bad housing increased the poverty, overwork, sickness, and slums. Slums meant the worst in morale, sanitation, and health. Society was in sore need of reforms on all fronts.

While many of society's ailments and miseries could be blamed upon its diminished religious consciousness, benefits also resulted from its worldliness, and would not have been possible under the former religious dominance. Science was able to start its progression along-side technology. Man began to think more in terms of helping himself and his fellow men by his own efforts, and less by supplication to the supernatural.

The professions gained in independence as a consequence of the secularization of the society. As they maintained their prestige as

specialists in the needs of men, the legal and medical professionals capitalized on the free scholarship of the recent Renaissance, on the searching of the past and the entertaining of new ideas. The significance of the Renaissance for understanding the role of creative occupations and professions lies in its parallel to modern times; a change in man's ideas combined with a change in his social structure, may indeed create the conditions, as well as the market, for new points of view from the creators (Krause: 1971:21).

Some people, with high degrees of social conscience, worked to bring about improvements in prisons, mental institutions, poor houses, and hospitals. And, nursing too, was in line for reforms. For the first time scholarly attention began to be paid to nursing. As early as the beginning of the eighteenth century, a textbook on nursing had been published at Vienna. In Diderot's famous eighteenth century encyclopedia, which attempted to "sum up all human knowledge," nursing achieved recognition as an important occupation. In the article, "Infirmier," the encyclopedia stated that nursing:

...is as important for humanity as its functions are low and repugnant. All persons are not adapted to it, and heads of hospitals ought to be difficult to please, for the lives of patients may depend on their choice of applicants [nurses] (Bullough and Bullough: 1969:81).

The article goes on to list the qualifications considered most desirable for a nurse. These are very similiar to those laid out by Thomas Fuller (1654-1734), an English physician, who was one of the first to upgrade the quality of nursing by securing women of higher social status than was commonly found in the occupation at the time.

In the Protestant hospitals, such as St. Bartholomew and St. Thomas,

an attempt was made to provide the same caliber of nursing care found in the monastic hospitals before the Reformation. When St. Bartholomew was refounded, the charter provided for a matron and twelve additional women to care for the sick. These women were to receive their board and room plus some four shillings or two pounds a year for their duties. Gradually as the staff increased, the term sister came to be applied to the person in charge of a ward, and those under her were called nurses. As the staff continued to grow, a hierarchy of nursing personnel developed. Candidates for advancement to sisterhood usually came from the nurses. In 1678 it was ordered that the older nurses were to be preferred for promotion to a sisterhood when a vacancy existed. This form of upward mobility on the basis of seniority is still in practice in nursing institutions today.

St. Bartholomew exemplified other innovations for the period which were to later become integral hallmarks of nursing. Physicians were required to make rounds in the hospital at least three times a week, with a sister in attendance. The physicians were further required to list in a book the names of their patients and the medicines required for them. The sisters were required to keep diaries of their own activities, and those of the patients. These original doctors' orders, nurses' notes, and patients' records are still found in hospital archives, and provided the models for much of the modern nurse's paper work.

Shift rotation for nurses was apparently the custom, and differential in pay for rotation and specialized care was recorded in 1805, when the original two pounds a year was raised to slightly over thirty-two pounds a year. Operating ward sisters received thirty-seven pounds;

sisters on the foul (disease) wards were paid fifty-two pounds. The nurses in the operating ward received nineteen pounds; in the men's foul ward they were paid twenty-four pounds, but had no night duty.

The sisters and nurses were expected to provide their own work clothes. Blue was the standard color for the sisters at St. Bartholomew. In the first part of the nineteenth century, the nurses, as distinguished from the sister, began to wear striped Uniforms with a blue belt (Bullough and Bullough: 1969:68). Student nurses in America are only recently giving up the variation of the stripes⁹.

The first attempt at state regulation of nurses in England is not credited to any hospital, but to the Irish Parliament. In 1715, it passed an ordinance which stipulated that nurses who did not conduct themselves well were to be committed to a house of correction for three months at hard labor, as well as whipped publicly through the streets on a market day between 11:00 A.M. and 12:00 noon (Bullough and Bullough: 1969:67).

In view of the caliber of those in nursing, previously described, it would be interesting to determine how frequently this law was carried out, or how effective it was.

MODERN NURSING

The most important reform in nursing took place in the mid-nineteenth century, and had its beginning in a divine revelation of a young girl of the wealthy and socially prominent class in England. Recording her revelatory experience, Florence Nightengale wrote in her private diary:

"On February 7, 1837, God spoke to me and called me to His service" (Webb: 1962:8).

It is alleged in nursing circles, that before Florence Nightengale, there were no professional nurses; after Florence Nightengale, every nurse was a professional! This, of course, is a cliché honoring her achievements in behalf of nursing. It is an epitaph to the past; a prologue to the future. It is certain that Miss Nightengale never raised aloft her lamp and announced, "from now on nursing will be a profession," but it is also certain that she lighted the way for the first steps toward the professionalization of nursing.

Undoubtedly, Florence Nightengale's greatest contribution to nursing was her introduction of formal training through a standardized curriculum of study, conducted under the direction of a matron educated in nursing and leadership. Up until her time, the training of nurses was in the form of apprenticeship. Even Kaiserswerth, the school where she was trained, did not have a formalized classroom type of education. Improvements in skills were not documented, but were passed on from matron to novice by verbal and demonstrational teaching. In 1860, the Nightengale Training School for Nurses was founded by Miss Nightengale, and it was operated in connection with St. Thomas Hospital (Frank: 1953:225).

The Nightengale School was not only the cradle of professional nurse education, but was also the foundation for the stereotypy which has marked nurses ever since. Florence Nightengale opened the school to secular women on a nonsectarian basis, but it was not nonreligious or antireligious. On the contrary, Miss Nightengale's personal religious devotion permeated every concept she held. She felt that a nurse must be first, a person of high moral character and God fearing; second, inclined in nursing. This prerequisite of character has carried on into

modern times. Many nursing schools still request their applicants to furnish references from a clergyman prior to admission, and graduate nurses are expected to conduct themselves in a morally acceptable manner, comparable to schoolmarms and preacher's wives!

Florence Nightengale also looked upon nursing as a career for women. She did not think kindly of male nurses, religious or otherwise. She also broke through the social caste system which was then and is still prevalent in many countries. She felt that any woman, of any class, of any sect, who had the requisite qualifications for the vocation of a nurse be given the best possible training (Frank: 1953:226).

One ideal which she held to was her insistence upon the freedom of nursing education from the control of medicine or public health. She believed that only nurses were qualified to teach other nurses.

It was Florence Nightengale's precedent regarding doctor's orders that had the most important and lasting impact upon the stereotyping of nursing. It not only positioned the nurse in the role of subordinate to the doctor, but may have for all time, placed the occupation of nursing outside the realm of a profession.

Before her time, nursing recognized very little authority beyond itself. During most of history, nursing was done independently of medical direction, following only the dictates of human nature and Christian concepts. As the monastic orders began to take over nursing, their members gave allegiance of the vow of obedience only to their religious superiors. As late as the mid-nineteenth century, a doctor's orders were frequently recinded by the mother superior or matron of a hospital, if she thought them unnecessary. The family members and maid servants,

who provided the nursing care for patients in their homes, were much more subject to the orders of the patient than of the doctor. But, when Florence Nightengale forbade her nurses at Crimea to give the soldier-patients as much as a drink of water, without the express orders of a doctor, she eliminated the autonomy of nursing almost totally.

It must be said in her defense that Miss Nightengale did not issue that directive because she was convinced that the doctors were the only ones capable of making decisions about the care of the sick. Her decision was based upon subtle politics and couched in hard diplomacy. Upon her arrival in the Crimea, Miss Nightengale and her nurses were unaccepted and ignored by the military doctors, who refused her services as well as the use of the funds she brought for hospital provisions. She knew she could accomplish nothing until she had gained their confidence, so she fought fire with fire. She withdrew, and withheld her nurses' services by refusing to allow them to even enter the wards. By not acting of her own accord, she could show the doctors that she and her nurses were not interfering busybodies. Playing this waiting game, she would demonstrate that her party wanted only to be under authority of the doctors. A full week passed. Finally, the overworked doctors gave in and asked for her help.

There can be no denying the contributions of Miss Nightengale in most areas of nursing. Nor the fact that she made most of them under very adverse conditions and in the face of much opposition. In history, she is best remembered for her heroic work in the Crimean War, but it is open to speculation just how much she could have accomplished in the progress of nursing, if it had not been for that experience. As direct,

dynamic, and revolutionary as she was, it is questionable whether she could have found an arena so large and attention-getting, in which to stage her fight, as the battle areas of the Crimea. Also, how much acceptance and support could she have mustered in her fight for improvements back home, if she had not returned from the war a national heroine? Nursing may owe more to the Crimean War than it recognizes.

The newly formed United States provided a good testing ground for the professions. Except for the Founding Fathers - those aristocrats turned patriots - it was a nation of rugged pioneers. Most, having turned their backs upon the aristocratic tenets of the Old World and forming their values in accord with their interpretation of the "democratic" theory, the citizens judged a man upon his ability alone. Professions had always been regarded with hostility by anti-aristocratic sentiment. Professions, by their central skills, were potentially in a position to exploit people, and could do them harm if strongly organized. Also, the professionals generally came from the elite aristocratic families. This made America important to the history of occupations and professions because it had a period of active deprofessionalization during which existing licensing laws for lawyers and physicians were revoked, and the remaining power of the clergy was broken (Krause: 1971:26).

During the periods of the rise of the early universities in Europe, the professions were all located in them, but the focus changed in the later centuries. In America, especially, the professions of medicine and law were outside the universities, and were learned through the apprenticeship system. In fact, the modern American university itself dates only from the 1880's, when Johns Hopkins and Clark were founded as

graduate universities, and Harvard introduced the elective system and a highly specialized scholarly faculty to staff it (Krause: 1971:29). Medicine and law became serious subjects of graduate study, with Johns Hopkins leading the way in medicine and Harvard in law (Jencks and Reisman: 1969:13). At about the same time, the Industrial Revolution hit America.

NURSING IN AMERICA

The story of American nursing as a self-conscious claimant to professional title began roughly in the 1880's. Since that date, one striking characteristic of national development has been the massive shift from a predominantly agricultural economy to industrialization. This shift has been accompanied by significant changes in the organization of work, work site and the services offered by people who work. Mass production of consumer goods eventually predominated, and the services afforded only by the rich before the twentieth century, became the common property of a substantial proportion of Americans. Associated with this has been a tremendous expansion of population resulting from immigration and internal growth. This development also required a rising level of education to meet the demands of the enlarging technology and the upcoming generations of man-power.

Higher education, therefore, became a prominent feature of American life. Finally, and here the consumer theme touched upon earlier is repeated, the whole surge of the economy over the past several decades had brought hospitalization, medical services, and health care to the verge of being every citizen's right, whether through private purchase, insurance plans, or federal support.

These are well known facts, but they are listed here as a cluster vital to any understanding of either the structure or the functioning of American nursing as an occupation. The origins of organized nursing in America are inseparable from the tide of reform which swept middle-class America during the 1870's, 1880's, and 1890's.

Many of the reforms in America, like those in Europe a century earlier, were directed at the deplorable social conditions, especially in the large urban areas and immigrant centers. Lillian D. Wald, founder of public health nursing, provided home nursing classes and visiting nurse service for the inhabitants of New York's lower East Side. After one visit, Miss Wald stated that "all of the maladjustments of our social and economic relations seemed epitomized in this brief journey" (Bullough and Bullough: 1969:158). Socially minded writers inspired university students to study conditions among the poor, and by the end of the century many settlements of social workers had been formed. Jane Addams' Hull House in Chicago was the most noted (Jamieson and Sewall: 1937:32).

The Industrial Revolution in America introduced a very critical question for consideration. It is especially critical today for those who are seeking to upgrade themselves, socially and economically, by professionalization:

What factors determine whether a group of people "in themselves" - those who can be seen as a category of workers - will become as well an organized group, such as the industrialists, professionals, and craftsmen, a group that will fight in its own interest? ...Will upward social mobility, minuscule but real, be always preferred by most to the riskier by potentially more rewarding advance of a whole group? (Krause: 1971:31)

This is a question many nurses have asked, and one which should be a concern to all nurses. The advancement of the whole group was a concern of the early leaders of nursing in America. America had no heritage of trained nurses, therefore nursing struggled along with little organization for almost four hundred years. The Civil War marked a turning point, and may have been one of the catalysts which started the organizing of nursing in this country.

The nursing force during the Civil War consisted primarily of women volunteers who were given short inservice training courses in hospitals for the duration. When the war ended, those nurses who survived its hardships returned to civilian life with a broadened viewpoint. From the seclusion and protection of the home, many of them had for the first time entered public life, and had been recognized as valuable assets in a new socially acceptable occupation. They now felt a new independence and were able to see opportunities for public service not recognized before.

The Civil War, recalling so vividly the horrors of the very recent Crimean War, aroused a growing realization of the inadequate preparation of nurses. The medical profession began to turn its attention to the organization of schools, and advocated their formation throughout the United States. Dr. S. D. Gross, president of the American Medical Association, at its 1868 meeting stated:

It seems to me to be just as necessary to have well-trained, instructed nurses, as to have intelligent and skillful physicians. I have long been of the opinion that there ought to be in all the principle towns and cities of the Union, institutions for the education of persons whose duty it is to take care of the sick (Bullough and Bullough: 1969:128).

The number of schools increased rapidly. Improved nursing gradually banished fear from the public's mind, and hospitalization during illness became more popular. The hospital was able to assume a respected place in the institutional framework of social structure. At the same time the graduate nurse was proving efficient in the home as well as the hospital. To many women who wished freedom and economic independence, this occupation offered an attractive opportunity.

During the late nineteenth century, a new class of nursing leaders arose to organize nursing education more in the fashion of the professions than in the style of the religious and military hierarchies that had influenced the Nightengale System. These leaders realized that the most important vehicle of professionalism was the university, and that university education would be the instrument for transforming the skilled nursing occupation into a profession.

This new type of professional training versus the Nightengale System progressed well in America. Some of America's university medical centers employed several of the early advocates of professional nursing education, and allowed them to experiment with didactic as well as traditional apprentice techniques. In 1899, a course in hospital economics for graduate nurses was added by the recently established Teachers College of Columbia University. The Teachers College nursing curriculum and collegiate nursing education grew substantially, and the nursing course, later the Department of Nursing Education, soon became the largest unit in the College. Its faculty had the customary academic titles; eventually it offered the usual doctoral, master's and baccalaureate degrees for graduate nurses already possessing nursing diplomas. Many

of its alumnae became the leaders in all areas of nursing. Most important is the contribution they made toward nursing meeting the criteria of professionalization.

The professional model had seemed inappropriate to nursing because of the absence of a scientific and written body of nursing knowledge, but advocates of the new approach began to write textbooks and articles, and they developed lecture and seminar methods of teaching nursing knowledge. The graduate degrees necessitated the writing of theses; much of the research concerned nursing education and administration, but some dealt with nursing practice, and thus new professional knowledge was created.

The professional model also seemed inappropriate to nursing as long as the hospital doctor was free to delegate his tasks to the nurse, but Teachers College professors of nursing (and some other professional leaders) recommended that nurses specialize in distinctively nursing work and resist excessive delegations at the discretion of the doctors. The Teachers College Department of Nursing Education devoted much attention to the development of public health nursing, because of its great practical importance and because it offered nursing the best opportunity for the autonomy idealized by the professional model (Italics added)(Glaser: 1966: 13).

At this point in history, it is of interest to consider a curious paradox. Johns Hopkins was one of the most famous medical complexes in the country. Its university was the center of medical education, its university hospital boasted a staff of distinguished clinicians, and its training school for nurses was one of the first of many nursing schools

affiliated in some sense with a university. The nursing school founded in 1889, provided exceptionally well-trained nurses for the hospital. At the medical school, medical students took genuine university courses and earned a genuine university degree. The student nurses did neither. The Board of Trustees had never considered the training school for nurses as more than merely a superior training school, not a place where nursing students got a university education. The one man who could have had a different conception of nursing education was the president of the university, Daniel Coit Gilman. Under his administration, Johns Hopkins became the graduate institution that so profoundly influenced American higher education, and he was the driving force behind the establishment of a scientifically orientated medical school which would be a genuine part of the university rather than under the control of the university hospital. But, what he established on the American scene for medicine he did not at all imagine for nursing. He viewed nurses only as a means to staff his hospital, and the better trained they were, the better the staff would be. Had he seen, had he even visualized in less suffragette terms, that a university education might be germane to the establishment and efficiency of professional nursing, then the course of American nursing might have taken a radically different turn! (Strauss: 1966:71)

Unfortunately, the far-sightedness of the nursing educators in the university settings did not filter down into the hospital diploma schools, although some standardization had been established. Most of the schools had a formal curriculum and the length of their courses were extended to three years. The nurse herself, was finally recognized as the most successful teacher of nurses. Affiliation between schools began, to

supplement the lack of broad training experiences, especially in the smaller hospitals. Some attention was also given to the regulation of hours a student could stay on duty. The eight-hour schedule began in 1890. However, the emphasis was not on education.

Efforts to increase the basic nursing education with postgraduate courses also began in 1890. But, a tendency to get the work done, rather than to give instructions, interfered with their success. This concept was common in most hospital schools, even for undergraduates. Student nurses were used to "man" the hospitals, and students were "pulled" from class to fill in on the ward found short of help.

Understandably, this brought about a breach between the departments of nursing education and nursing service. It also encouraged the establishment of a nursing school in any hospital needing the student manpower, regardless of the quality of students it could turn out. The result was a mushrooming of mediocre schools across the country.¹⁰

This practice did not change until in the 1930's when the National Committee on Grading of Schools of Nursing, after an extensive investigation of schools and inquiry into public sentiment regarding nurses, forced many school to close and the rest to place the educational ideal in more prominence (Jamieson and Sewall: 1937:29).

In the period 1893 to 1920, American women became more active in groups and clubs (Guinée: 1970:36). Organizations, although they existed prior to this period, were fairly well limited to domestic, church, and cultural type activities. Now they began to expand their activities to include community and social movements. The activities of the National American Woman Suffrage Association and the Women's Christian

Temperance Union during those years are prime examples.

Signs of a dawning group consciousness in nurses were shown about the time of the Spanish-American War (1889). Its first evidence appeared in the organization of Alumnae Associations, the earliest of which was formed at Bellevue Hospital in 1889.

The World's Fair of Chicago (1893) included in its features a Congress of Hospitals and Dispensaries. There, papers were read which emphasized the need and importance of organization and an American Nurses' Association (ANA). However, it was twenty years before an association by that name was actually founded. Its official organ is The American Journal of Nursing (AJN).

The American Society of Superintendents of Training Schools formed immediately after the Congress, and it marked a further advance in the education of women for nursing.

In 1912, the National League of Nursing Education (NLNE) was founded as an outgrowth of the American Society of Superintendents. In 1932 the NLNE became the Education Department of the ANA, although it retained its own officers. Its official organ is Nursing Outlook.

The National Organization for Public Health Nursing (NOPHN) was also established in 1912. Membership included doctors and lay people interested in public health.

The Association of Collegiate Schools of Nursing (ACSN) was formed in 1935 with the object of developing nursing education on a professional and collegiate level, strengthening relationships with institutions of higher learning, and promoting research. Membership was limited to schools or departments of nursing associated with a university.

Two other nurses' organizations of importance were started during this period. The National Association of Colored Graduate Nurses (NACGN) in 1908, and the International Catholic Nurses' Association (ICNA) in 1923.

The aims of union in any body of people are strength to accomplish projects for betterment, mutual protection from adverse influences, and the moulding of an ideal. Among the ANA's outstanding results in the nursing world have been the introduction of laws governing registration, many changes in educational methods, measures aiming at financial security for members, and the growth of a body of nursing literature (Jamieson and Sewall: 1937:24).

One of the first problems to come before the nursing organizations was that of protecting the public from unqualified nurses, and protecting the graduate nurses from unfair competition in practice with those who had had little or no preparation. Governmental recognition of their difference in standing was necessary, and a legal system of registration promised to answer the need. Today, in its application to nurses, registration, (licensure) requires legal accrediting of schools of nursing, and examination of their graduates by a special Examining Board which authorizes by certificate the use of the letters RN (Registered Nurse) after their names.

The history of registration had been a long - and often difficult - one. In 1899, state societies were formed in the United States, to enable nurses to approach legislative bodies with the dignity and strength of a formally united group. By 1903 these groups began to pay off, and in that year North Carolina secured the first licensure laws which have been acquired gradually by other states. By 1952, all states and

territories had such laws.

The professional criteria of autonomous functioning in the formulation of professional policy and control of professional activities was being sought in the practice of accreditation of nursing schools, mentioned previously. Government agencies accredit hospitals and schools in most of the world, but in America, much accreditation is extra-legal action by professional associations. The effect is virtually equal to legal regulation. The accreditation of hospitals and medical schools is conducted by the American Medical Association (AMA), the American Hospital Association (AHA), and the American College of Surgeons (ACS). With such a precedent, the national professional organizations of nurses have attempted to control nursing education directly. Since 1953, the National League for Nursing (NLN) has granted accreditation to schools of nursing that meet its standards (Glaser: 1966:16).

The major professions have long recognized the need for codes of ethics to guide the members in their practice. Some professions govern ethical practice by a pledge or oath subscribed to by the practitioners. Probably the oldest and best known is the Hippocratic Oath, expressing the commitments of the healing practitioner. Using this time-honored oath as a model, a committee of nurses, under the leadership of Mrs. Lystra E. Gretter, wrote and dedicated a nurses' pledge to Florence Nightengale in 1893 (Appendix B). Miss Nightengale was in no way involved with the writing of the pledge, as is sometimes mistakenly assumed (Guinee: 1970: 35). In 1935, Mrs. Gretter revised the last paragraph of the pledge to read: "With loyalty will I aid the physician in his work, and as a 'missioner of health' I will dedicate myself to devoted service to human

welfare" (Kelly: 1968:24).

Freidson (1970a:186) does not agree that a code of ethics is a criteria for professionalism. He says, "A code of ethics...is an important device for persuading the general public to believe that the members of an occupation are ethical, but it does not guarantee public belief." However, it is an important characteristic of professions, especially the one nursing was attempting to emulate, therefore it deserves consideration in professionalization process.

Medicine was the first profession in the United States to adopt a code of ethics. Other professions followed suit over the years. The ANA adopted its first code for professional nurses in 1950 (Appendix C). To be useful and realistic, a code must keep step with recent trends and current developments. In accord with this fact, the Committee on Ethical Standards of the ANA prepared revisions of the original code in 1955 and again in 1960. The last revision was made and accepted by the House of Delegates in 1968 (Appendix D). Whereas the earlier codes placed emphasis upon the doctor-nurse relationships, the 1968 revision focuses only on the nurse as a practitioner, is more concise and relevant to the present, and designed to delineate ethical principles related to standards of practice (ANA Convention...:1968).

It is a phenomena of history that great changes in all aspects of society follow in the wake of wars. The changing importance of nursing, as well as the increasing public awareness of the need for adequate nursing care, was demonstrated after the Crimean War and the Civil War.

It was demonstrated again after the Spanish-American War (1898) and World War I by the government attitude toward nurses. As was so

often the case in history, neither the government or the nursing force were prepared for the sudden demands made upon nursing by the conflicts. Investigations made after the wars tended to document the fact that the problems were not due to lack of trained nurses but rather to a lack of effective organization of them. Following the Spanish-American War, the efforts for improvement resulted in the establishment of a permanent Regular Army Nursing Corps through congressional action in 1901, and a Navy Nurse Corps in 1908.

Volunteers and aides had been used during most wars, but in World War I they created a problem for nursing. The American Red Cross provided a series of special courses in basic hygiene and home nursing, and "graduates" from these courses, with the blessings of the Surgeon General, were used in base hospitals. Nurses, alarmed by this adulteration of nursing care, countered with a proposal for the establishment of an Army School of Nursing in military hospitals, which was finally accepted.

Even though the Army School of Nursing was not a permanent institution, nursing in effect had been recognized as a profession by the government. This is nowhere more evident than in the growth of the federal government as a large scale employer of nurses. Nursing services were established in the U.S. Public Health Service (1919), the Veterans Bureau (1922), and the Indian Bureau (1924). While nurses under the civil service classification act of 1923 were classified as a sub-professional group, they more than proved their value in these departments. More fields of employment were rapidly opening up. Some twenty years later the ANA managed to have nursing recognized as a professional service in civil service classification (Bullough and Bullough: 1969:180).

The returning veterans of World War I brought back many problems for society. Some returned to their homes, mental and emotional cripples of "shell shock" and were unable to pick up where they had left off; others returned as "basket cases" requiring continual nursing care. While society tried to deal with the social and economic problems of the majority, it was up to medical and social science to deal with the vast others. This provided added impetus to the development of psychiatry and mental health, therefore rehabilitation also developed into a science in its own right (Jamieson and Sewall: 1937:26). Most of the casualties involved tissue destruction seldom encountered by medical science before. The repair and reconstruction required for these cases opened extensive new fields in plastic surgery and orthopedic procedures. Both civilian and government hospitals increased in number and nurses were needed to staff them.¹¹

Nurses for staff level positions were not in short supply, but those qualified for administration, supervision, and education were not sufficient to meet the demand. Although the social climate of the Roaring Twenties encourage a massive movement for the liberation and upper-level education of women, nursing was still not the attractive kind of work appealing to women of the middle and upper classes. Making it even less appealing, the Crash of '29 and the depression which followed, created a dearth of nursing jobs, especially among private duty nurses. Many nurses yet today can recall how it was, when unable to find work in nursing, they turned to whatever was available, including clerking and domestic labor.¹²

The developments in nursing during the decades following World War I were associated closely with those in the technical, medical, and

social sciences, and in the public attitudes toward the sick, the disabled, and the indigent. The combination of the developments in these areas in turn brought about the change in the hospitals. Hospitals, while showing a decrease in numbers, were growing larger in size with an increase of beds. Operations, deliveries, diagnostic work-ups, and patient care which used to be done in the patient's home or the doctor's office could be done more efficiently and safely in the hospital. The advances in medical and surgical procedures required close observation of the patients by a nurse, and the hospital was the logical place for this. The emphasis of nursing began to shift from the one-to-one basis of private duty nurse and patient to general duty nursing in hospital ward settings. Even the term, "general duty," began to change, for with the increasing number of patients in a hospital it became the practice to separate them into categories according to diagnosis. Therefore, a nurse would find herself working with only surgical or only medical patients, rather than a mixture of both. This division of nursing care by patient diagnosis was general practice in the larger hospitals abroad over a century before it became a policy in America (see page 35 this chapter). However, once started, the policy became an universal practice in this country, and soon nursing care was divided into sub-categories. Just as doctors were being known as physicians or surgeons, nurses began to fill the role of clinical specialists - medical, surgical, pediatric, psychiatric or maternity (Little: 1967).

Leaders in nursing recognized that the preparation of nurses up through World War I, was not geared to meeting the increased needs. University schools had been preparing nurses in the specialized fields

of education, supervision, administration, and public health, but the average staff nurse was still a product of the hospital school. The hospital school was not organized to provide more than training in generalized nursing care. The leaders knew that nursing must follow the lead of industry and give its workers added training in a speciality in order to obtain maximum performance. The result was a renewed emphasis upon university level education for nurses, and clinical specialities within the university curriculum.

In spite of the increased emphasis by nurses, the growth of university level nursing education was very slow until after World War II. Then the number of degree-only programs rose from 54 in 1949, to 109 in 1954, 204 in 1966, and has continued to increase since that time (Bullough and Bullough: 1969:189).

In many respects, World War II was a repeat performance of World War I. It placed heavy demands upon nursing which taxed the nursing resources severely. For the first time in history, the American nursing force was spread around the world. At the same time civilian needs were mounting. Health insurance plans, organized in the 1930's, were becoming key issues in industrial contract negotiations, and were putting hospital care within the reach of even the low-skilled laborers. Another factor was the institution of government programs aimed at giving care to military dependents in nonmilitary hospitals. Congress also passed programs directed at meeting the nurse shortage; the first were refresher courses for inactive nurses returning to work, and grants to teachers and nurses preparing for supervisory positions. While these programs made only a small dent in the nurse shortage, they were important because

they marked the first direct federal government support of nonmilitary nursing education, thus setting the precedent for other programs to follow, principally the Nurse Traineeship Act of 1956 (Public law 84-911) expanded by the Nurse Training Act of 1964 (Public Law 88-581) and now continued by the Health Manpower Act of 1968 (Public Law 90-490) (Levine: 1969).

It remained for the volunteers and the untrained civilian workers, drawn in to fill the vacuum created by the nurse shortage, to carry most of the nursing load on the "home front" for the duration. Of lasting consequence, however, was the fact that a great many of the untrained civilian workers continued to work in the hospitals after the duration.

ROLE AND IMAGE OF THE NURSE

With the ending of hostilities, doctors and nurses began returning from the battle areas, bringing back some of the most revolutionary changes of practice in medical and nursing history. The introduction of the miracle drugs, bold new surgical procedures, early ambulation of patients, and crash training programs for auxillary personnel, were some of the innovative changes which made many of the accepted practices passé.

The new concepts of nursing practice and the nurse's role, which resulted from the changes occurring in the 1940's, were received with much ambivalence by nurses. The change in role was harder for many to accept than the changes in nursing practice. It is probably true that in the United States most non-nurses were unaware that the nurse's role was changing at all.

The war made nurses and nursing more of a prominent feature in the press and in the public eye than ever before, but they were still

stereotyped by their image. In the mind of society, the image of the nurse is synonymous with her role. Society takes little notice of a nurse's educational preparation, her participation in the organizations, or even the complexity of her occupational activity. It considers only that basically a nurse is a nurse, is a nurse.

In stereotyping her, society has also positioned the nurse. She stands next to the doctor - slightly to his right and to the rear - as his trusted handmaid. This proximity allows her to identify with the doctor in a privileged way not accorded the other paramedicals, and in his shadow, she radiates some of his medical magic. The positioning has also inescapably aligned her with sick people, and their care is her sacred trust.

The traditional role of the nurse evolved in step with her history. As a simple home-based chore, nursing included the intimate, physical contacts of bathing, massaging, feeding, and comforting the fevered brow. Added to them was the administration of oral and topical medication, which had been assigned to her since the age of herb brew and mud poultices. With the advent of modern pharmacology, the administration of drugs by inhalation and rectal insertion was included. Now it is common practice for the nurse to give intramuscular injections and do venipunctures to administer parenteral fluids. Bandaging, along with the application of ointments and salves, was another inherited task of the nurse. Following the introduction of modern surgery, came the changing of dressings, the application of sterile compresses, the setting up of traction, external irrigation, internal lavage, and insulflation into body cavities.

The observations the nurse was able to make in such close contacts with the patient were soon recognized as valuable to the doctor, and gradually - if somewhat grudgingly - he began to turn over to her some of his jealously guarded diagnostic tools; the thermometer, the stethoscope, the pressure cuff, and the catheter. The evaluation of vital signs, based upon the nurse's judgement, passed into the jurisdictional bailiwick of nursing.

The first changes in the nurse's role occurred so gradually over the years that it is no wonder her image barely reflected them. However, by the 1950's, the changes were coming so fast that the role of the modern nurse bears slight resemblance to her predecessor. The two principle contributors to the changes were the appearance of auxillary nursing personnel on the hospital scene and the introduction of atomic age technology in medical science.

Hospitals, like most other big businesses during the war, had found that they could function remarkably well with less skilled and on-the-job trained staffs. Also, the work could be done quite a bit cheaper by auxillary personnel. In many of the occupations, these emergency workers became permanent employees. This was the case with hospitals and nursing. By the close of 1945, over 212,000 women had been certified as volunteer Red Cross Aides, and hospitals were offering to pay them if they would continue on in their work. Many of these women joined institutional payrolls, eventually becoming practical nurses when licensing for practical nurses was started in 1949-1950 (Roberts: 1954:514). Still following industry's practice of having a trained foreman supervise a gang of less skilled workers, hospitals began to introduce the concept of

team nursing.

Basically, these teams consisted of a team leader or captain, who was a nurse, one or more LPN's, practical nurses or aides, and orderlies. The principle was to divide the nursing care of the patients into levels which could be handled with different degrees of nursing skills (Barrett: 1968). In this way many more patients could receive good bedside nursing care under the supervision of a nurse than could receive it directly from the nurse. With the aide providing the minor services of feeding, toileting, and transporting the patient, and the LPN taking over direct personal bedside care, it became the nurse's duty to carry out all the technical aspect of his care, such as treatments, dressings, and administering medications. Then, almost as a matter of course, the LPN passed on the chores of bathing, massaging, and comforting the fevered brow to the aide, and turned back to pick up the stethoscope, the pressure cuff, the catheter, and the area of vital sign. In quick succession, she took over treatments, dressings, and the "passing of meds." the division of labor in nursing became firmly institutionalized.

Nurses, both individually and collectively, vehemently protested the division. But, obviously it was a matter of fighting or joining, and most nursing leaders were wise enough to see that the only way to guarantee quality nursing care - and safeguard their own positions - was to accept the team concept on one hand, and reach out to expand the role of the nurse on the other. In fact, many nurses were finding themselves too busy taking over the responsibility for the sophisticated machines that medical technology was producing, to miss their former bedside chores. During the 1950's the nurse began to routinely do EKG's, EEG's,

resuscitation, electronic monitoring, defibrillation, and hemodialysis in the emergency rooms, the intensive care units, the surgeries, and the newborn areas.

IMPACT OF TECHNOLOGY

Technological change defined by Hall (1969:354) as "any alteration in the equipment utilized to perform work," had been occurring in nursing at about the same rate as in other occupations down through history. When the Industrial Revolution ushered in automation with mechanized transfer of materials, assembly-line production, and then the application of computers to paper work, nursing began to lag behind industry by an ever-widening chasm. Two reasons for this stand out. First, technological changes must precede automation, and these changes are costly. The "production" of the hospitals could not be increased sufficiently to warrant the cost of replacing nurse-power with mechanical-power, as long as nurses' wages were kept low. Second, in general it is easier to automate processes dealing with products than with services (Hall: 1969:356). When automation did make a serious entry into an area of nursing care, it did so with an ironical twist.

The "passing of meds" by an LPN, or any non-nurse person, was an issue of heated debate by the nurse.¹³ She was still contesting the legality of this delegation of one of her most sacred duties at the same time it was being taken over in the other direction by automation. The concern of nurses, as well as others in the health care field, about errors in medication as a factor in the quality of nurse-care, led to extensive studies in an effort to eliminate the causes of error (Baker: 1963). The

automation of the drug dispensing practices appeared to be one answer. The introduction of the Brewer Cart System at Landenau Hospital, Philadelphia, in 1961, left little for the nurse to do but slip addressographs into a shuttle on the cart, wait for the desired drug in its prescribed dosage to be delivered through a chute, and hand it to the patient. Since the cart was filled by the hospital pharmacist, who had personally transcribed the doctor's original orders, and the cart would not dispense any drug unless the correct addressograph plate was used, most of the responsibility for the administration of medication was removed from the nurse. More was removed a few years later when the Brewer System became obsolete and hospitals began to install pneumatic tubes systems whereby individual doses of medication were delivered directly from the pharmacy to the patient at the prescribed time, day or night. Simultaneously, a record of the transaction was put on the patient's permanent chart (Letaurneau: 1963).

The area of vital signs also came under the influence of automation in the 1960's. Electronic thermometers had been used in recovery rooms and intensive care units early in the decade and provided a continual tracing similar to that produced by the cardiac monitor. Over two years ago, the oral electronic thermometer made its appearance in the hospital wards. The thermometer unit gives a thoroughly accurate reading in about 15 seconds, and records as readily for an aide as for a nurse.

Ultrasonic sound is used to monitor and record pulse and blood pressure by an electronic transducer in the occlusion cuff (Ultrasound...: 1970). "Depth sounding" by the same energy through amniotic fluid has been found to provide a very accurate measurement of the fetal head and

the position of unborn babies. Both procedures can be carried on, and reported, automatically and continuously.

A new respiratory monitor measures respiration, and also the amount and types of blood gases in a patient's blood stream without puncturing his skin to obtain the blood. A wrist band with a plastic membrane, which allows gases but not liquids to pass, is attached to supersensitive electrodes transmitting impulses to a graph (Bloodless...: 1969).

Internal drainage tubes - Levine, catheter, chest, tracheostomy, etc. - are equipped with radio transmitters small enough to fit inside the lumen, and which sends buzzing signals to an FM transmitter when the tube is blocked (Trach...: 1969), thus reducing the need for constant checking for tube patency.

Technological advances not only removed much responsibility from the nurse and placed it with auxillary personnel and ward clerks, but it also shifted another sizable amount to the computer machines. Although the machines were supplied and programmed by a multitude of human authorities, no single individual had the responsibility for their output information. Final decisions were the responsibility of the computers, whether they were used in industry, science, education, medicine, or whatever. Ironically, the responsibility of nursing practice assumed by the computers was taken from the area of the nurse's independent thinking and judgement. This is, of course, in keeping with the definition of automation, as stated by Mann and Hoffman (1960):

...the application of control devices of a feedback nature, to provide self-regulating production processes. Whereas mechanization replaced man's muscles...automation has replaced man's sensoria in monitoring processes and has replaced his brain in certain regulatory decision-making functions (Mann and Hoffman: 1960:191).

Among the first affected was her highly esteemed nurse's notes. This elaborate charting system, considered the great tie binding together the continuity of patient care, is thought to be almost as important as doctor's orders (Rosenbert and Carriker: 1966). In institutions using dictophones and/or ward clerks for transcription, the nurse is no longer required to chart her observations in notes. Even more devastating to the nurse's self-image, was the revelation that charting may be nothing more than "busy work!" A study carried on by Walker and Selmanoff (1967), reported some saddening facts. "Nurses' notes are not an effective means of communication; their significance has diminished; the frequency of omitted information is high; and they are relatively unimportant to the majority of the medical and nursing personnel involved," (Fox and Kelly: 1967:523).

Since the beginning of professional nursing, a century ago, one area of medical care has been a highly explosive one for both doctors and nurse - diagnosing! The medical profession has defended it as that profession's absolute right; nursing has been divided between coveting the right, and shying away from it to the point of irrationality. However, leaders in nursing, who advocated the independence of nurses in the health care system, began pushing nursing care plans back in the 1940's. Nursing diagnosis, per se, was a crucial component of their framework. This diagnosing was accepted by the medical and nursing groups - as long as it was not vigorous enough to infringe upon the medical diagnoses. Now, in hospitals which have developed automated nurse's notes and combined them with daily data from the computer, the nursing care plan for each patient is compiled automatically into a comprehen-

sive printout in which his current status is instantaneously available, as well as any changes in conditions and orders (Speed: 1969). In this area, nursing diagnosis is gradually retreating again.

Nursing diagnosis is not alone in being affected by the introduction of automation and cybernation in health care. The entire field of diagnoses is feeling the impact. The Adaptive System Research Group of Ohio State University is engaged in studies which promise to affect diagnosing responsibility even more. Systems analysis through development of a mathematical model is used to demonstrate the interrelationship of functions between the patient and the "real" world; the patient and the care personnel (Pierce: 1969). Although an explanation of the system and description of the patient-care model are too extensive to be included here, they do illustrate the possibility of placing the responsibility for decision making and care planning within the jurisdiction of a machine more than a person.

Innovations coming from the Laboratory of Computer Science, Massachusetts General Hospital, are appearing virtually daily. Two of the more recent ones are computer-acquired patient medical histories and the companion follow-up, a programmed physical examination with computer (Grossman: 1971)(Kraner: 1971). The combination of these two records can be put on an easily read printout showing a patient's physical condition within ten minutes.

The next logical step from computer-acquired medical histories and physical examinations is to computerized diagnosis, and this too, is now a reality to a limited degree. A system, devised at the University of Texas Southern Medical School, using IBM data processing, diagnoses

blindness by producing maps of the patient's field of vision. It not only detects the type of eye disease, but the degree of vision loss (Computer Tests...Blindness: 1969).

A computer that helps clinicians determine the difference between normal and cancerous cells has been developed at the University of Chicago. It consists of a standard fast-scanning microspectrophotometer integrated with an IBM 360-50 computer (New Computer...: 1969).

Phonoangiography, a new technique, makes it possible to diagnose atherosclerosis without invading the arteries. Instead of catheter-insertion and dye-injection, a sensitive microphone is used to pick up and record sounds produced when blood flow (normally silent) reaches narrowed arteries (RN...: 1971).

Another form of diagnosing is being done at a Boston hospital satellite, called telediagnosis. By means of a two-way television hook-up, electronic monitoring, and sound-relay devices, a doctor two miles away in the general hospital is able to examine, diagnosis, and prescribe for a patient in the satellite station (McLaughlin: 1969). By attaching the in-puT data from the satellite clinic to a computer memory bank with programmed matching data, it would be possible to replace the doctor with the machine. Even the nurses, who now man the satellite end of the operation, could be replaced by trained lay technicians.

It is also possible for a nurse - or trained "observation-technician" - to visit a patient in a home setting, and by dialing a computer and describing the patient's symptoms to it, receive a feed-back including diagnosis, and prescribed treatment (Mussallem: 1969).

Within the very near future, computers will be making the weighty

decision upon who will receive organ transplants. Tissue typing laboratories are being set up in three eastern universities. Using fifty-eight basic tissue types, an organ will be classified and the data fed into a computer that already has full tissue typing data and clinical information on potential recipients. It will then match the organ to the most compatible recipient (Computer to Decide...: 1969).

With these science-fiction dramas a here-and-now actuality, it is also a possibility that the "way-out" predictions of such writers as Hassenplug (1962) and Bennett (1970) are coming true. Thus, the suggestion that patients are soon destined to be untouched by human hands (Untouched...: 1962) is more fact than fiction!

The big advances from technology and automation appear to primarily affect the field of medical science. However, it takes only a small stretch of the imagination to see how they can have a profound affect upon nursing as well. And their implications are not only in the role of the nurse providing nursing care; they can alter her entire occupational profile. If a computer can provide a doctor with a correct diagnosis and prescribed treatment regime, it can do the same for a nurse - or a technician, or an aide, or even directly for the patient himself.

THE PARAMEDICALS

Those who speak out in defence of automation in nursing, such as Bertha E. Bryant (1969), argue that automation will free the nurse from routine tasks and permit her more time for individual patient care. "The advent of the computer will be a humanizing rather than a dehumanizing

force, bringing the nurse much closer to the bedside."

But, the place at the bedside has already been taken, first by the LPN, then the aide, and now by a contingent of paramedical technicians!

The well established hand-in-glove fit between doctor and nurse roles was not the only incident in the medical division of labor that the doctor's work was so nicely complemented by assisting groups. Doctors have deliberately elevated groups of technicians into paramedical positions, and these in turn, have set out to establish domains for themselves in the field of medical science. In rapid order then, the nurse saw more of her responsibilities being taken over by surgical technicians, inhalation therapists, "prep" teams, psychiatric aides, PT assistants, and IV teams, to name a few-(Barrett: 1968).

Even the public health nurse, one of the most autonomous and self-contained members of the health team, is finding home health aides doing the nursing care of the home patients, and community service workers providing services to the family and community which were once exclusively hers. Reports from Greenlick (1967)¹⁴ and Hurtado (1969)¹⁵ indicate that such ancillary personnel are able to provide more comprehensive service for the patients than individual professionals can. The aides and workers can be trained in the basic principles of many disciplines and are able to become more attuned and responsive to the patient's overall needs than if they were limited to one technical area.

What is more, the nurse is seeing the nonphysicians and nonnurses taking the hospital out to treat the patient. Emergency care outside an institution was formerly limited to such lifesaving activities as those taught in first-aid courses, but this is no longer so. For instance,

under a new state law permitting specially trained paramedical personnel to perform lifesaving procedures once permitted only M.D.s and R.N.s, firemen and ambulance attendants in southern California have been saving heart attack victims. They administer EKGs, five classes of drugs IV, (when necessary), and defibrillate, in addition to such conventionally permitted procedures as oxygen administration (Firemen...: 1971).

Mobile units provide a great many former hospitals-based services now. Bulky hospitals equipment can be reproduced in transistorized mini-units, some small enough to fit into private cars. This is tending to shift some hospital functions back into the community and decentralizing medical and nursing care.

Technological changes and automation alone cannot be blamed for this shift. Governmental intervention in health matters and the social climate developing after mid-century play vital roles. The entrance of the government into the field of health jurisdiction is not new. The Social Security Act of 1935 enacted some of the most widespread governmental and health partnerships in America. Public Law 89-97 or Title XVIII (Medicare) and Title XIX (Medicaid), passed in 1965, are actually amendments to this same Act (Petrowski: 1969:17). While community agencies over the country have in the past provided only nursing services, Medicare stimulated the introduction of other services to the patients at home, as occupational therapy, speech therapy, and medical social work, as well as home health aide service. Because Medicare programs could not be matched by the necessary manpower needed, Medicare focused on, and stimulated the growth of training courses for paramedical personnel. This also placed an increased demand upon nursing in areas where nurses had previously been

kept at a minimum, such as nursing homes and extended care facilities (Teitelbaum: 1969). More and more nurses were required to supervise the paramedicals, auxillary workers, and volunteers manning the growing health facilities.

Public Law 89-749, the Comprehensive Health Planning Law of 1966, marked the beginning of a new era uniquely characterized by man's responsibility for engaging in planning, and placed health services within the reach of the total population through non-federal governmental and non-profit private agencies (U.S. Congress, Senate...: 1966).

The scope of this legislation, even in brief (Appendix E), can not be explored here, but its far-reaching, health services are in line to be revised and expanded, at the same time that new ones are developed.

The social changes which took place in the 1960's can only be mentioned in highlights, too. The anger of the militants, the indifference of the non-conformists, the unrest of the youth, the affluence of the country, and the recognition of the hidden poor, all contributed to a new look in society and an increased social conscience among the masses. Society also developed health conditions of pandemic proportions. Drug addiction, serum hepatitis, venereal disease, young teenage pregnancies and illegitimate births were rampant. The hippie culture brought with it food fads, hygienic practices, and do-your-own-thing home deliveries, which compounded the problems already faced by public health. The hippy-types turned their backs upon the health services, as provided by the Establishment. Voices from the slums, the ghettos, the backwoods, the activists, and many of the leaders of the professions, began to rise up to demand health care as a right instead of a privilege. Many took it

upon themselves to provide the care through non-professional and non-official means. Community and organization-sponsored clinics began springing up in areas where the unmet needs seemed the greatest. While many such attempts did not accomplish their purposes, the success of those who did, emphasized the need to decentralize health services and bring them to the consumer (Rambousek: 1970).

The student rebellion, evident throughout the whole education system, and also a hallmark of the social unrest, permeated the halls of the professional schools, and even the classrooms of the schools of nursing (Rogers: 1971)(Jones: 1970). The students, in these formerly staid, tradition-bound institutions, began demanding changes in the curriculums to include subjects and experiences to better equip them to cope with the "real" world in which they would be practicing as professionals. They were also demanding a voice in their own education, and the right to question the infallibility of the previously accepted dicta. While not many graduates have yet emerged under this new philosophy, the trend has been set, and the doctors and nurses of the future can be expected to function with a definitely different view-point than their predecessors (Robinson: 1969).

Nursing made a start in this direction as far back as the 1950's, when it introduced its Associate Degree (AD), or "two year nurse" Program. This was an outgrowth of the efforts to further upgrade nursing education by securing college credits for students, and was encouraged by the success of the crash-training utilized by the military to train medics during World War II. The pilot program of the AD was set up in 1952, at Teachers College, Columbia University (Montag: 1954), and became one of

the most controversial subjects in nursing circles. Not since the LPNs had made their debut, had nurses - as a body - raised such a hue and cry. "Nurses in two years? It can't be done!!"

The AD Program had many good points and some bad ones (Oshin: 1964), the details of which would constitute a book alone. Foremost was the step-up in the number of professional nurses graduating every year on one hand, and the further division of nursing into status hierarchy on the other (Bullough and Bullough: 1969:233).

The newest version of the changing pattern in nursing education is the introduction of LEGS (Learning Experience Guides for Nursing Students). The LEGS program is the curriculum for the "career ladder," or vertical mobility in nurse preparation, and is used primarily in Community Colleges (LEGSletter: 1971). The career ladder concept is no recent innovation in the health personnel field; for several years nurse aides have been able to advance to the LPN rung through special training courses in some institutions (Aides Climb...: 1969). The LEGS programs, based on core courses for the ladders offer college credit for all subjects, from the basic to the advanced. The students all start out on the same level, then progress upward at their own speed. They may stop at the end of any phase and qualify for aide, with a certificate; LPN with license; or RN with an associate degree (New Kind...: 1970)¹⁶

Undoubtedly, many nurses, and non-nurses, regard the program as still another adulteration in the quality of the preparation of nurses. However, since the program prepares aides and LPNs in collegiate courses which carry the same college credits as those received in the preparation of the RNs, LEGS programs should be considered an advancement in the

upgrading of all nursing education (Drage: 1971).

The current supply of all health manpower is at a critical stage, and is so ineffectively used that the full opportunities of the professional are reduced and the hopes of the public are left unfulfilled (Michael: 1969). But the National Advisory Commission on Health Manpower has stated that the crisis is not one of numbers alone (Report...: 1967). The adequacy depends upon the organization of personnel and their combination with other sources just as much as it does upon numbers. The Commission recognizes that unless the system of providing health care is improved, the care will continue to become less satisfactory, even though there are massive increases in cost and numbers of personnel.

This view is shared by others. Haughton (1969) states:

..new delivery systems must be designed to produce maximum benefits for the total community. Efforts must be expanded to train additional health professions; their training has to change since they must be taught to work in new relationships with auxiliary personnel and within new organizational frameworks. Steps must be taken to modify the professional practice law in order that auxiliary personnel may legally perform the services for which they can be trained, and to relieve professionals of the legal liability for these delegated services. Also, a long look must be taken of the present credentialing requirements - which have systematically excluded people from service - and modify them so that they are relevant to the task to be performed (Haughton: 1969:1).

This theme is repeated in the literature in which others advocate the end of licensure for all kinds of health personnel, thus avoiding artificial barriers. Hershey (1971) feels that nurses should not be hemmed in by legal definitions. There are also found numerous reports of the attempts to increase the delivery of health care by establishing training programs aimed at improving the established groups, and creating new groups of health workers. Even names are lacking for some of the new

semi-professional occupations in the health field (Organ: 1969). One group of new workers - who acquired a label after some debate - is the Physician's Assistant (Stead: 1967). The first of this group were produced at Duke University in a program established to utilize the vast manpower of the discharged military medics and corpsmen (Medical Corpsmen...: 1969). Now other institutions are offering PA programs to non-veterans.

Like the LPN and the AD nurse, the PA brought forth a protest from nursing. Primarily, because many nurses considered the PA an usurper who was a threat to their traditional doctor-nurse kinship. Other nurses, however, looked upon the new occupation covetously, for it represented to many a foreward step out of the role of nurse closer to that of a doctor (Bullough and Bullough: 1971a)(IF...: 1971).

Programs for "nurses associates" became well established in the 1960's. The nurse specialist has been mentioned previously, but this change in function did little to alter her role - or to alleviate the pressing demand for increased medical care as it became acute. The specialities were in nursing care, not medical care. Probably because of her mother-image, the first medical area to offer the new responsibility of nurse associate was pediatrics (Ped. Nurse...: 1970)(AF Sets Program: 1970)(ANA/AAP...: 1970). The next logical medical area to draw upon the nursing manpower was obstetrics, with the revival of the age-old role of midwife (nurse-midwife)¹⁷(New ACOG...: 1970)(Nurse Midwifery...: 1971)(Bean: 1971).

In view of the admirable history of midwifery around the world, the recognition of the role of nurse-midwife in America is long over-due.

Her worth has been amply proven, although not well publicized, and the prime example is found in the Frontier Nursing Service of Wendover, Kentucky. This public health, visiting nurse service, founded by Mary Breckinridge in 1925, provided care for the isolated families in the Kentucky hill-country where medical care was practically nil, or at best limited to an occasional visit by an itinerate doctor. Miss Breckinridge, and the original three - later 31 - women of the service, were able nurses and staunch women. Trained first in nursing, then in midwifery (in England), and finally public health, they braved the dangerous, craggy mountain roads by foot or horseback, in all kinds of weather, to meet every known type of medical and nursing emergency (Poole: 1943). The Frontier Nurses have now advanced to riding the rough roads in jeeps, and they have a 27-bed hospital in Heyden, Kentucky, with two resident doctors, but, they are still pioneers. Not only pioneers in a primitive countryside, and among little less than primitive people, but in the trail they blazed in nursing by demonstrating the ability of nurses to efficiently carry the load of health supervision and care in a community setting (The Road: 1969).

Community health coordination is another area in which the nurse is now playing an increasingly important role as a family health practitioner. Grants from the U.S. Public Health Service are providing training which will qualify the nurse to diagnose, manage clinics, and provide comprehensive health care to all family members in such settings as neighborhood health centers, private and group health clinics, and isolated rural areas (Calif...: 1969)(Vanderbilt...: 1971).

Most of the changes in nursing today are the result of society's

changing demands upon it. More financial resources and a higher level of sophistication of the general population is creating requirements for remedial services beyond those offered by the traditional services. Now nursing is being confronted with the most recent trend - the increasing importance of the manipulation of ideas. This emphasis upon service-human resources domination (Neighbors: 1970) is evidenced by the increases in professional and managerial categories of labor, and the fact that work is more and more "people oriented." Less formal supervision is required in the idea and people sectors of the organizations (Hall: 1969:29). While this de-bureaucratizing trend is only slightly perceptible in the medical and nursing structures yet, it is evident and promises to become more so as increasing numbers of professionals - including doctors - begin to work in complex organizations where power is split among managers, professional experts, and lay boards of directors (Wilensky: 1964). This trend can be very influential in the future progression of nursing toward professionalization.

CHAPTER III

PROGRESSION TOWARD PROFESSIONALIZATION

There is little argument that nursing is an occupation: it is a social role performed by adult members of society; it directly and/or indirectly yields social and financial consequences. The fact that all of its nurse-members do not continually pursue the activity of nursing, or that it does not constitute the major focus throughout their lives, is not of any great importance in labelling nursing as an occupation. "Once a nurse, always a nurse," is a generally accepted cliché. Probably for the reason that when a nurse leaves the occupational role she usually does so to assume a role of housewife and mother. Society tends to accept the image of the nurse fitting as well in a domestic setting as in an occupational one. This lack of distinct identity of roles, the very duality of them, contributes to the slowness of many to accept nursing as a profession. The attitude probably will not change appreciably until either the natural role of homemaker is granted professional status, or until professional status loses some of its traditional acuity.

CRITERIA

Several definitions of occupations and professions were offered in Chapter I, and with but slight variation they all tend to agree on very definite attributes which constitute professional status. A profession must have a specialized body of knowledge, based upon abstract theory and research; it expands that knowledge by research and continued study. The body of knowledge is used in providing practical services to society; the authority to make decisions on delivery of the services is based on that knowledge. The preparation of the members of a profession is entrusted

to a university level institution, and a tight control is exercised over the recruitment of the applicants. In the institute, the members undergo a socialization process which creates an attitudinal consensus among them. They also consider the profession of their choice as a lifework, and develop a certain solidity with other members with whom they can communicate by a language and set of symbols specific to their given profession. The professional culture is maintained by membership in professional organizations, which also act as internal controls on the members. The power and privileges of a profession are given to it by community sanction, and the profession, in turn, protects society by rules, usually set up in a code of ethics. The last, and probably most important criteria, is that of autonomy.

The authorities also agree that very, very few of the occupations can meet all of the criteria, but the degree to which one does, determines the degree of professionalization it has undergone, thus how much of a profession it is.

BODY OF KNOWLEDGE

Nursing has moved far along the continuum toward professionalism. It has met most, and even all of the criteria of a profession, to some degree. One of the surest signs of progress in a scientific field, or profession, is the growth of its literature (Notter: 1967). During the century of professional nursing, the growth of its literature has been phenomenal.

The founder of professional nursing herself did not contribute much toward the body of nursing knowledge. Although a prolific writer,

Florence Nightengale devoted most of her efforts to the composing of letters to those who could further her causes in behalf of nursing. She did write some books of general directions on the delivery of health care of which Notes on Nursing was - and still is - the most popular. Curiously enough, even this book was not a textbook of professional nursing, but was designed to help the average housewife care for the health of her family (Webb: 1962:44). It remained for Miss Nightengales successors to provide the foundation for the present volume of nursing literature.

The efforts of the early leaders of nursing education in America were hampered by the dearth of reference literature resources as much as by any other pioneer deprivations. The art and science of nursing had never been documented. It is surprising that even a brief list of about 50 textbooks could be appended to the first curriculum committee report to the Society of Superintendents in 1896. The list was headed by Notes on Nursing, but less than a dozen of the other authors were nurses. The first textbook by an American nurse was Clara S. Weeks' A Textbook of Nursing for the Use of Training Schools, Families, and Private Students, published in 1885. Other textbooks of the period, several of which survived through many revisions well into the twentieth century, include Harriet Loundsberry's Ethics of Nursing (1889), Lavina Dock's Materia Medica (1890), Isabel Robb's Nursing, Its Principles and Practice (1893), and Diana Kimber's Anatomy (which passed through its 12th revised edition over twenty years ago)(Roberts: 1954).

Attesting to the newness and uniqueness of this emerging body of knowledge was the fact that publishers frequently declined some of the

early manuscripts, such as Adelaide Nutting's four-volume History of Nursing (1907), on the ground that the subject matter had no market value and would not pay its way (Roberts: 1954:65). This attitude has changed considerably now. Most of the major publishing houses, and many of the smaller ones, have sections devoted to nursing science, which yearly produce hundreds of nursing textbooks.¹⁸ Besides the instructions in basic nursing care procedures, their contents include extensive explorations into the allied disciplines of medical, social, physical, and behavioral sciences, and the paraprofessional fields; their subject matter ranges from abortion through x-ray, biochemistry through zymology.

Further evidence of the ever expanding body of knowledge is found in the volumes of professional periodicals coming out every year. The American Journal of Nursing Company, of which the ANA is the sole stockholder, is to all intents the "publishing house for the profession," and began publishing the American Journal of Nursing (AJN) in 1900. This, and several other publications, are directed at general nursing topics, but each has its distinctive format and focus of interest. However, with the increased emphasis on specialization in nursing which came about in the 1950's, it became necessary for publications devoted entirely to a single speciality. The result has been a mushrooming of journals of administration, supervision, intensive care, and others. On a lesser scale are the newsletters and bulletins put out on a monthly or seasonal basis by the growing nurse specialists' associations - Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG), Association of Operating Room Nurses (AORN), American Association of Nephrology Nurses and Technicians (AANNT), and American Association of

Industrial Nurses (AAIN), and others. On an even lesser scale, but vitally important to the general volume of information, are the publications of the health agencies and local chapters of the national organizations.

RESEARCH

All who are familiar with the growing volume of literature are aware of the contribution made by nursing research to the body of knowledge. In keeping with the trends in research practice in other fields, the research in nursing follows systematic studies in both empirical theory and concrete testing. The first is the natural result of nurses' problems solving efforts to improve patient care, such as observing that the very important vital sign of body temperature tends to fluctuate for no apparent reason, and identifying this inconsistency as a problem in the diagnosis and prognosis of disease; the second would follow as a controlled study to determine what variables other than pathological conditions, could influence oral temperature in order to eliminate them (Verhonick and Werley: 1963).

Research in nursing is not entirely new either. In 1862 Florence Nightengale reported on her study of the conditions in maternity hospitals, and from the evidence she obtained, recommended that lying-in wards should be separate and apart from the general hospital, under proper organization, and with midwives in attendance (Nutting: 1907b:239). Over fifty years ago, M. Adelaide Nutting said in an address to students at the Vassar Training Camp (September 9, 1918), "One cannot hand the art of nursing to anybody...Behind that sure judgement lie long stretches of

experience and careful study of persons and situations; of comparison of methods and results...Every branch of nursing stands in need of just such serious and scientific study of the problems inherent in its particular sphere," (Nutting: 1926:357).

In spite of this historical sanction, and the fact that research is an established department of nursing, there is no general agreement on its appropriateness, either in nursing or as a function of nurses. Lucille E. Notter (1963), editor of Nursing Research, states that, "the major purpose of research in nursing is the improvement of nursing practice and ultimately the improvement of patient care, therefore, nursing research is every nurse's business." Lois E. Graham (1969) feels that research is essential because nursing, along with the whole of society today, is being constructed from scientific findings, "and if we cannot understand this scientific world and participate in its methods as professional persons, the present and the future will step over us all,"

A difference of thinking is found among some of the non-nurse authorities. In earlier years of nursing research, behavioral scientist, Godfrey M. Hochbaum (1960) felt that research was an "inordinate" pre-occupation of nurses, and based his feelings upon a distinction between the "state of mind" of the behavioral scientist and the nurse, which, "although not irreconcilable, was a definite threat to the scientific objectivity of research by nurses." He stressed the need for special preparation in research methodology by nurses, and directly attacked the myth that "anyone can go into research on nursing." He concluded that a nurse must either be provided with extensive training in research, or

must utilize the help of research experts in the physical and social sciences in order to be effective. George P. Fulton (1961) also seemed to feel that nurse researchers were ineffective until they had passed the master's degree level and had appropriate specialization through doctoral work in one of the biological sciences, rather than further preparation in nursing. His whole philosophy on the subject is summed up in, "... nursing is a highly complex discipline, if indeed it is a discipline at all, and research in nursing is an ill-defined and almost unknown entity."

Non-nurses cannot be blamed for the entire note of discord regarding research in nursing. The report of Verhonich and Werley's research on oral temperatures in a VA hospital (1963) brought forth a flood of letters to the editor. A prime example is the one from Ruth A. Nunnery (1936) who asked "if nursing is becoming a profession of status seekers," because of its interest in research. "I think," Ms. Nunnery went on, "it is time some of us re-examined the definition of nursing. Nursing is an art and a science; its aim is to attain or maintain maximum health, and where a return to health is not possible, nursing care should relieve pain and suffering."

Major Verhonick responded that, "...The fact that research is an important dimension upon which a profession rests is well documented..., and refers to a statement by Robert K. Merton (Werley: 1963), "We must recognize that a profession is committed to the task of enlarging the body of knowledge that it applies to the problems and troubles with which it deals."

EDUCATION

The emphasis on the need for special preparation for nurses in research methodology and comprehension points up the big weakness in preparation of nurses in general. It also puts added demands upon their education system which has never reached the goal set out for it nearly a century ago. Even an enlarging body of scientific knowledge, based in a large part on research, cannot take the place of university-level educational preparation.

Nursing leaders, both in education and nursing service, have recognized the need for college prepared nurses to meet the requirements of the professional components of nursing practice. In view of this, concerted efforts have been put forth by nursing, and other interested disciplines, to survey the educational system with the intent of bringing it closer to the required level. Josephine Goldmark's report, Nursing and Nursing Education in the United States, published in 1923 under the auspices of the Committee for the Study of Nursing Education, made specific recommendations for the reorientation of such education. Three years later the National Committee on the Grading of Nursing Schools started its ten year study, which did result in the closing of weak schools, but did little to move nursing education into university settings (Brown: 1948).

Concurrently, the national professional associations, particularly the NLNE and the NOPHN, were continuously making smaller specialized studies, seeking to elevate the preparation of nurses. Each study seemed to indicate more and more that there was something drastically and

chronically wrong with the system of education which could not meet the demands either of qualitative or quantitative service. Every study achieved something of significance, but, mostly by indicating the direction movement should be taking rather than initiating or accelerating that movement.

The National Nursing Council commissioned another study in the mid 1940's, supported by the Carnegie Corporation and the Russell Sage Foundation, under the direction of Esther Lucile Brown. The "Brown report" was published in 1948, and the potency of its recommendations for professional education were augmented by the "Ginzberg report" (1948) and the report of the Committee on Nursing of the AMA (Comm. on Nurs...: 1948).

The mid-century brought increased governmental interest to the area of nursing education with a large section of the report of the President's Commission on Higher Education being devoted to the proposals for the increase of community colleges and an expansion of their activities in preparation of professional and semi-professional technicians (Roberts: 1954:513).

A much more comprehensive study was carried on by a group of experts appointed in the spring of 1961 as the Consultant Group on Nursing to the Surgeon General of the Public Health Service. Its purpose was to advise on nursing needs and to identify the appropriate role of the federal government in assuring adequate nursing service in this country. In its report, "Toward Quality in Nursing: Needs and Goals," the Consultant Group presented its nursing manpower goals for 1970 and recommendations for federal aid to education (Action...: 1963).

The Consultant group estimated that for safe, therapeutically effective and efficient nursing service, the nation would need 850,000 professional nurses, including 300,000 with academic degrees, by 1970. However, realizing that such goals would be impossible to achieve within a decade, it presented what it called a "feasible goal" of 680,00 professional nurses in practice by 1970, with 120,000 having academic degrees. The report went on to state that if schools of nursing could admit more than 6 percent of the high school graduates (at the time of the report the percent admitted was 5.3), there would be some 53,000 nursing school graduates a year; the number needed to reach the 1970 goal (Action...: 1963). However, by 1970, the number of students graduating from schools of nursing had reached only 43,639 (Ed. Prep....: 1970).

While the Consultants' report pointed out the number of nurses needed it did not place emphasis upon collegiate level preparation as a requirement for the professional nurse - which many nurses had been hoping it would. They were also disappointed in the low estimate for degree graduates. The figure of 120,000 represented only 18 percent, or less than one graduate out of five having collegiate degrees. Encouraged by the "Brown report," nursing educators had begun to look more to those outside nursing for support of their efforts to establish educational preparation on a professional level. The Consultants' report had let them down.

Whether stimulated by the Consultants' lack of emphasis, or not, nursing increased its thrust toward the four-year college degree preparation. The intensity of this thrust was revealed in the 1965 position paper on education issued by the ANA - the pertinent point being -

"Minimum preparation for beginning professional nursing practice at the present time should be baccalaureate degree education in nursing..."

(ANA - Position Paper...: 1965).

Further desire for follow-up to the Surgeon General's Consultant Group on Nursing led the ANA and NLN to establish an independent commission for a national survey of nursing. Independent financial aid was obtained and made possible the National Commission for the Study of Nursing and Nursing Education and its ultimate report, An Abstract for Action (1970). Early in 1970, when the report was released, its major recommendations were supported by endorsements of the ANA Board, the NLN, the AMA Board of Trustees, and the AHA General Council (Christy, et al: 1971).

While some of its recommendations have long been desired by nursing and deserve support, others are based on inadequate and improperly interpreted data. Perhaps most important, since it has recommendations on nursing education, is a rather obvious underlying bias favoring the hospital school setting rather than the college campus for nursing education. Recognizing that a number of hospital schools possess "...requisites for accreditation as collegiate institutions..." the report recommends that these seek "...regional accreditation and degree granting power" (Nat'l. Comm....: 1970). The commission, which incidentally, included no one from the related behavioral sciences, further recommended that educational programs should be conducted and planned by interdisciplinary teams; in other words, members of the health professions. This recommendation, and the one favoring hospitals' power to grant degrees, are a direct defeat of the underlying philosophy of the ANA Position Paper

which advocated the advantages of the wide, liberal education available only in a college setting (Litwack: 1971).

Reviews and critiques of these latest efforts in behalf of nursing education, would indicate that it does not have the leadership it once had.¹⁹ Many of the observations show that nursing educators are inclined to operate from a defensive position, and are suspicious of all external influences on nursing education, regarding them as invasions into a private system; thus their reluctance to develop a working education partnership with professionals in the allied helping fields. In his article, Litwack (1971:55) sums up the opinions expressed by many observers.

"There seems little question that nursing education is presently operating from a closed, parochial system."

The ambiguity of the direction of nursing education in 1970, poses a question of just what the aims of its leaders are now. Professionalization of nursing through the elevation of the preparation of nurses, whereby they will have the knowledge-based-authority to make decisions affecting the welfare of patients, or the authority to achieve a greater measure of collegueship with their medical "bosses" and other allied professionals?

Aims, such as the latter, are not uncommon, and are recognized in other disciplines. "Thus, for instance," writes David Matza (1964), "...social workers 'need' more education partially because they wish to work on a collegeal basis with psychiatrists... The time spent in school is thus only partially related to concern for the interests of youth." (Matza: 1964:197).

RECRUITS AND LIFE WORK

In 1958, the diploma schools of nursing graduated 85.5 percent of the nursing students; in 1968, they were still responsible for 67.8 percent of the graduates. The baccalaureate schools accounted for 13.0 percent of the 1958 graduates, yet only 20.8 percent from the 1970 classes (Ed. Prep....: 1970). The associate degree programs accounted for the remaining graduates. Further more, the increase in the number of graduates in the university programs has not been steady. Statistics show that enrollment in nursing programs declined during the years 1862-1963 and 1966-1967 (ANA Facts...: 1969:84). Also, enrollees in nursing programs constituted a very small number of college-eligible girls. The increase in nursing program enrollments had shown an upswing of as much as 6 percent some years, but during the same periods the number of girls entering non-nursing programs increased by 50 percent (Action...: 1963).

Many studies have been conducted to determine the reason for this uneven distribution of enrollees. R.A.H. Robson (1967) pointed out in his study that American girls entering nursing generally appear to have homogeneous socio-economic, educational and self-image backgrounds which placed them in the middle social class and, who in turn tend to enter medium status occupations. Length of training was also directionally proportional to the class of girls who selected nursing. Middle class girls entered nursing at the hospital training level; upper class girls entered at the university level, or went into other university programs. Robson's finding collaborate those of other researchers. Friedson (1970a)

states that the problem is not in recruiting girls for nursing, but recruiting those who will stay in training and subsequently pursue a lifetime career.

Independent studies carried on by Marlene Kramer (1969) and Nola Pender (1971) found that over half of the nursing students did not enter nursing with the intention of making it their lifework. It was a job to fill in the time until marriage came along. This attitude is inherent in women's occupations, and will not change in a social system like the United States until the organization of the occupation changes to accommodate to the demands of marriage and family (Friedson: 1970a:55).

Pender found that nursing students experience role conflict between the desire to be academically and professionally successful and the desire to be socially acceptable as women. If conflict does exist, the student may be ambivalent about wholehearted participation in graduate work and accepting an administrative or teaching position following graduation (Pender: 1971). Nurses frequently carry this attitude with them throughout their working years.

Not only does nursing fail to attract the most professionally eligible candidates, but it has very little control over the recruitment of any of its practitioners. Almost anyone desiring to do nursing can find a program, and if graduated from it, can offer herself for hire under the title of "nurse." What is more, nursing is now compounding its own problem in this area.

For years it has been the practice of university programs of nursing to admit graduates of diploma schools for advanced work toward a

baccalaureate degree. The RN's were admitted to the upper level standing and received a block of credits for the nursing subjects they had already completed in the diploma school. By "picking up" any missing lower level academic subjects, they could receive a degree with little over half of their credits earned in a professional program. And, the block of credits "given" them was in their degree major - nursing! It is a practice which the major professions would frown upon for their own practitioners.

The introduction of the career ladder concept has been pointed out as having beneficial educational features - providing its rungs were based on collegiate level courses, from nurse aide through baccalaureate degree (Bullough, Bonnie: 1971a). However, the most recent trend of offering LPN's, medical corpsmen, or any other person with adequate knowledge in the health fields, a block of lower level college credits on the basis of "challenge exams" (University...: 1971), is downgrading all levels of nurse preparation (Bullough, Vern: 1971a)(Dustan: 1970).

PROFESSIONAL ORGANIZATIONS

September 1971 marked the seventy-fifth anniversary of the American Nurses' Association. The American Journal of Nursing included in its September issue, a most praiseworthy supplement, "Illustrious Past, Challenging Future," as a salute to its mother organization. Nurses, across the country, could not help but feel a surge of pride in their profession and in the organization which had been their official representative for three-quarters of a century. Throughout those years, the ANA had fought many hard battles to reach its objectives. Many of them were futile battles, some were only half won, in others the Association

carried away the banner of victory.

Lack of standardization in nurse training as well as the need for licensure laws were the first objectives of the ANA, and the progress it made in securing these goals have been discussed previously, as well as the adoption of a Code of Ethics for Professional Nurses (Chapter II, page 50).

The Association's most important victories were made in the post World War II period. It had a major hand in launching the school accreditation program; and initiated some of the important studies which began the biggest moves toward preparation of nurses in collegiate institutions. The delegates of the 1946 convention offered the first platform with planks calling for bold economic measures for the betterment of nurses - 40 hour week, minimum salaries, and the right of collective bargaining.

Another of the 1946 planks called for the removal of restrictions against Negro nurse membership, still in force in many states. Although it was not until 1964 that the last district capitulated to the request, it had forced nursing to face the problems of integration years before it became a dominant social movement, and made possible for nursing to claim complete integration into the organization long before many other national groups (Illustrious...: 1971).

Hanging over since 1939, was the determination to study the structure and functioning of the several national nursing organizations to find the most effective means by which to advance the profession. A proposal was presented at the 1946 convention; a choice between a single organization, providing for lay membership, though not in controlling

positions; and a two-organization structure, with one organization confined to registered nurses, the other with fully participating lay members. A study was begun within the six organizations: the ANA, the NLNE, the NOPHN, the ACSN, the AAIN, and the NACGN. The subject of the study dominated the 1948 convention. The president of the NOPHN spoke emphatically not for "lay membership" but for "consumer participation" - a concept which twenty years later sounded like a remarkable new idea in the health service field. In 1951 the NACGN members voted that organization out of existence and elected to become an indiscernible part of the ANA. The next year the same action was taken by the NLNE, NOPHN, and ACSN, and the National League for Nursing (NLN) was organized in their place (Roberts: 1954:668). The AAIN, which has a large membership of male nurses working in industrial nursing, is still active and meets annually at the American Industrial Health Conference (Kelly: 1968:280). Today, two national organizations, with a coordinating council between them, are still in effect: the ANA for nurses, with membership limited to RNs only, and the NLN for nurses, with members from every discipline whose common interest is the advancement of nursing, especially in the area of education.

Emphasis upon research by the ANA began in the 1950's, and in 1955 the American Nurses' Foundation for Research was set up. Within the ANA, a research and statistics unit became engaged in fact-finding, and it publishes annual editions of Facts About Nursing, overseeing the nurse inventories which, by the end of the decade, included all registered nurses.

In the historical essay of the supplement is the section entitled,

"The Confident 60's." It could as well be called "The Bold 60's." During that decade, accent was placed upon nursing practice, and a Congress on Practice was established in 1968, with status second only to the Board's. The aim, still unfulfilled by the end of the 1960's was for a reorganization design which would be the Academy. The practice emphasis brought about more direct contact with medical groups, with both national nursing organizations meeting with the AMA and the AHA in an effort to bridge some of the gaps between them and arrive at some common understandings.

In response to the social climate of the 1960's, and as a reflection of the protest movements, nurses across the country began to engage in activities in protest against their own discriminations in the areas of salary and other economic conditions. By 1968, the ANA had adopted a national salary goal of \$7,500, with a \$1,000 differential to those with baccalaureate degree. Further more, the members recinded the no-strike policy, which up to then, had been a firm tenent of the organization.

The scars of defeat were also visiable in the ANA. Poor advice and management of funds brought it into serious financial crises in 1970. For a year, all programs had to be severely curtailed, and major cut-backs made in the ANA staff. The members met the situation stoically, and went ahead with their expanding plans for the future, including moving the National Headquarters to Kansas City, and voted a yearly dues increase to \$25.00 (dues had been \$.75 a year in 1946). The members also displayed a commendable ability to be humble in the face of need, as they directed their president to appeal to nurses across the country for donations to an emergency fund to offset the financial deficit. Nurses, members and

non-members, responded en masse.

Probably the greatest defeat ever suffered by the ANA is its inability to attract members. Rather consistently over the years, it could officially speak for only a third of the registered nurses in the country. As of December 31, 1968, it had a membership of 203,909 out of over 680,000 nurses in practice. Of the 203,909 members, 13,547 held associate standing (not practicing, but paying dues) which leaves even less than a third of the working nurses belong to their organization (ANA-Facts...: 1969).

This failure of the ANA to match the record of the AMA in present of membership, is divided among the nurses, the employing institutions who do not make membership in the organization a prerequisite for employment, and the ANA. Nurses, generally, do not see the need of, or feel they can afford membership;²⁰ hospitals, especially, are reluctant to place any obstacle in the way of their freedom to hire any qualified person. Many nurses who are members, do not recognize any tangible advantages in belonging. The ANA has not been able to provide its members with the usual "fringe benefits" of retirement pay, insurance, or even income compensatory to their service, as labor unions have done for their members. The comment of one nurse-acquaintance summed up the feelings of many others. "Being a member of ANA won't make me a better nurse, so why join?"

PROFESSIONAL ATTITUDE AND SANCTIONS

Gross (1958) and Freidson (1970) would probably tend to say that the quality of a nurse does not depend upon her membership in an organization,

or many other extrinsic factors. A nurse, like any other aspirant, becomes a professional because of her attitude. As shown previously, (Chapter I, pages 10 and 11) these two authors agree that a professional consistently acts in the best interests of the client (patient) and emphasizes public service rather than private profit. There is no denying that a high degree of this attitude is found among those engaged in nursing. Generally, it would be hard to find cause to accuse a nurse of being in the work because of ulterior motives.

Even today, the nurse regards patient care as her sacred trust, and in respect to the patient, her position is thoroughly professional. She uses her specialized knowledge of nursing to determine what is best for him in the way of remedial, rehabilitative, and preventive care; she applies her knowledge in whatever practical services she judges to be necessary to provide that care. While the nurse can be suspected of having some unprofessional "interest in sordid money," she is also renowned for her selflessness and dedication - at least, more so than most other service-oriented workers.

Society has recognized these attributes of the nurse, and for this reason - and because the services she performs are vital to the welfare of its members - has granted her the powers and privileges of a professional, including the right of confidentiality. In this, the nurse is regarded on a par with the doctor. Many times a nurse will be in possession of more subjective information, obtained voluntarily from the patient, than the doctor will have.

While society grants nursing certain sanctions, it also employs pretty rigid controls over some aspects of it. A prime example is shown

in the efforts of the New York State Nurse Association to get enactment on a revision of the Nurse Practice Act by the state legislature. In June 1969, the NYSNA Board of Directors offered the proposed revision which was designed to ensure "recognition of nursing as an independent, primary and distinct health discipline." The revision would change the definition of the practice of nursing to "diagnosing and treating human responses to actual or potential health problems through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being" (NYSNA...: 1971). The proposal was supported by thousands of nurses who personally went to the state capital at Albany to demonstrate - to meet their legislators face-to-face, and ask for their support of the bill which would grant a small measure of professional autonomy to nurses (Nurses March...: 1971). The legislators responded favorably, and the proposal passed both houses. All that was needed was the governor's signature (Independence...: 1971). On July 6, Governor Rockefeller vetoed the bill. In his veto message he acknowledged that the present definition of nursing is "both outmoded and unnecessarily restrictive," but added that any new definition must "maintain a responsible distinction between the professions of medicine and nursing, commensurate with the respective training and experiences of both professions." He further admitted that the state medical society had voiced disapproval of the legislation because it "...would seriously endanger the quality of health care made available to the people..." Headlines announcing the veto read, "Governor follows doctor's orders - executes 'noble nursing profession,'" (Gov'n...: 1971). Verily, society giveth, and society taketh away.

AUTONOMY

Freidson (1970a) states that, "just as autonomy is the test of professional status, so is self-regulation the test of professional autonomy." Other authorities agree that autonomy is the crux of professional status, and if so, the incident related above is, in itself, example enough to prove that nursing does not possess the criteria of autonomy necessary for that status.

Well before the New York affair however, the autonomous position of nursing had been established by its historical, structural, and functional perspectives. It has, from the age of antiquity, been an occupation of women, and the subordinate role of women is a well established fact which needs no further documentation here.

The majority of nursing services are carried on in hospital or institutional settings. In hospitals, especially, nursing has been trapped by an industrial pattern which served assembly lines well, but is ill suited to delivery of patient care. There, the nurse is subject to the hierarchial chain of command, division of labor, span of control, and authority of administration, medicine, and nursing departments (Graves: 1971). In the other settings in which the nurse works, health agencies and educational institutions, she is confronted with the same bureaucratic structure, supported by the same pillars of management, with only variations in their composition or titles.

The "departments of nursing service" in these settings, frequently give the outward appearance of possessing a good deal of autonomy. A really dynamic, authority-wielding Supervisor of Nurses, Director of Nursing Service, or what ever her title, can be a power not to be taken

lightly, as many administrators, doctors, and board members will readily admit. The fact still remains, however, as long as nurses and others in paramedical occupations remain ranged round the doctor, they cannot fail to be subordinate in authority and responsibility, and cannot gain occupational autonomy no matter how intelligent and aggressive their leadership (Freidson: 1970a:69). Legally and otherwise, the doctor's right to diagnose, and prescribe gives him primacy in the medical division of labor. No matter how well nursing supervises its own education, regulates its own licensing, controls its own members, or applies its own body of knowledge in providing service, it cannot function in a truly autonomous manner.

ALTERNATIVES TO PROFESSIONALISM

The literature illustrates the push toward professionalization which has developed into a near obsession in society. The implication appears to be, that lack of professionalism or inability to attain professional status, is somehow related to failure and defeat. A hint of warning from Carr-Saunders and Wilson (1864:494) states that the trend to over-professionalism could result in segmentary social organization. Professionalism requires specialized training, which in turn requires selection for training of those with suitable gifts. A cast system could evolve wherein an individual is born into a vocation, not because of inheritance, but because it has been selected for him according to his supposed inborn gifts. But, little, if anything, is said about any positive value of the non-professional position. If, for instance, nursing never does become a profession, in the accepted sense of the word, what position will it have?

It is certain that many, including some nurses, feel that it will not be affected one way or another. Nursing has progressed a very long way, but not intentionally to become a profession. The very fact that so many women were willing to go into nursing, at a time when its demands were great but its rewards were small, would indicate that nurses are not status seekers as a group. If there was no such thing as professional status, nurses would still continue to do the best possible job they could to provide health services.

There are others, also including some nurses, who do not share such opinions. Rather than nursing being more professional because of the inherent attitudes of its practitioners, they assert that it maintains its high quality only through constant striving toward a professional position. By not striving, nurses become de-professional rather than just non-professional. If nursing became de-professionalized to any degree, nurses would derive a very different reward from their occupation, and society would witness a marked transfiguration in them. A de-professionalized nurse would be self-interested instead of service-interested. She would be able to free-lance and advertise her services to the highest bidder; she could use her knowledge as authority to endorse commercial products. She would be free to use her position as identification in non-nursing organizations, social movements, and political activities. And, she could even strike.

It must be explained, that the recent change in the ANA's no-strike policy is not to be taken as literally as it sounds - in spite of the fact that nurses' strikes have occurred. The possibility of any strike poses a threat, therefore, nursing's admission that it now feels free to use

such a maneuver if necessary, gives nurses more weight at the economic bargaining tables. But the need would have to be great before a strike would actually be put into effect at this time (Lewis: 1968:473).

Nevertheless, that action by the ANA is probably a more realistic indication of what non-professionalism would do to nursing's position in society than either of the other two. The opponents of the no-strike amendment raised the old spectre of "unionization" in their arguments against it. There were many others who felt that nursing is headed toward unionization, and that such a movement is inevitable and perhaps even desirable.

The organization of local and national unions for nurses has been a topic of much debate among them for years. Invitation to affiliate with the powerful national labor and industrial unions has also been thoroughly discussed, but when the debates and discussions were over, nursing always ended up rejecting the possibility. "It wouldn't be professional" (Seidman: 1965). Those, who are more far-sighted and pragmatic in their thinking, are advocating that nursing make definite plans for maintaining its identity in the event that it elects to follow the union route. Some are bold enough to say that without sufficient strength, which the ANA is not able to muster but which a union could, nursing will never be able to provide public service at the peak of its potential to do so (Kelly: 1965). Unionization is probably a most logical alternative to professionalism unless nursing does some drastic changing very soon.

It is an accepted fact that nursing will not, and cannot remain at its status quo - and remain. The fragmentation of the role of the nurse

by auxillary health workers, automation, and cybernation leaves less than a skeleton of the original role. With the possibility of automation moving health care into the realm of science-fiction in the future, the chance of the role of a nurse remaining at all is remote. Nursing could be headed for oblivion.

This alternative is prophecied repeatedly in the literature. "...if we cannot participate...as professional persons, the present and the future will step over us all" (Graham: 1969). "Despite all our professional mobility and visibility, I am not sure nursing is not already moribund. I do not believe that science will save us, but I do believe that the saving of nursing, if it is not too late already, will come in the radical improvement of nursing practice" (Diers: 1970). "The Registered nurse, as a nursing practioner, is fast becoming extinct. Within the next ten years, a registered professional nurse may well become an economic luxury which society may decide it is unwilling to support" (Altano: 1970:2116). And, in the concept of basic evolution, "...a species (nurses) will survive, or die out, according to its ability to adjust to the environment. Therefore, the environment sets the limits on the number and types of organisms it will support" (Friedson: 1970b:62).

EXTENDED ROLE NURSE

The third alternative, is for nursing to settle down to the serious business of concertededly making itself into a profession; to create a role for itself which would be indisputably unique and professional by its own merits. Efforts have been made in this direction, but without much

consensus of objectives or directions.

Some feel that assuming the role of a doctorette, junior-doctor, or physician surrogate would be the answer. Among them are those who are advocating the "moving up" of nurses to the position of the PA's. (Hershey: 1971). Others argue that the position of a PA is not in the line of upward mobility for the nurse and cannot be thought of in terms of professionalization. This is not to say that the nurse has no right to "move into" the PA position if she so desires. It means that by doing, she moves away from nursing goals into an area which has no need for her expertise as a nurse.

In their article, "The Doctor's Assistant'," Robert Coye and Marc Hansen (1969) say, "Nurses can certainly be trained to accept the duties implied in this study...An Argument can be made, however, that a nurse should never be the doctor's physician's assistant but should be his professional associate, bringing her own unique skill (nursing...) to the patient. Doctors are not educated in nursing."

Hildegard Peplau, president of the ANA, reiterated this opinion in her address at the Oregon Nurses' Association Convention, Portland, Oregon, March 4, 1971. "Nurses have always assisted doctors, by their own unique science of nursing. When they take over any of the doctor's functions in conjunction with that science, they become associates of the doctors in their own right."

Therefore, this type of extended role nurse is not creating a new role or profession, just an expansion of her present one. An expansion not unlike that experienced by nursing as it gradually took over the use of the thermometer, the pressure cuff, and the catheter.

The extension of the nursing role, now being advocated in many areas of nursing, differs from delegation of just procedures to actual delegation of the power to make decisions. This means that nurses must develop diagnostic and treatment skills as well as the nursing arts they now possess (Bullough and Bullough: 1971 :3), if nursing functions are to meet the needs society is expecting. Contrary to the fear of doctors, and many nurses, nursing diagnosis and treatment would not infringe upon medical diagnosis and prescription, but would cover that area of patient care which doctors are not qualified by either education or temperament to provide.

Dier (1970) states that "...the saving of nursing...will come in the radical improvement of nursing practice." (Italics added) By this, she means that nursing practice is to be limited to nursing functions as opposed to the many non-nursing functions now performed by nurses. The dictionary defines practice as with "the doing of something" or "the exercise of a profession or occupation." For too often and too long, nursing has seen it in the former rather than the latter light (Lewis: 1968:466). It is time to critically examine nursing function in terms of role definition and role relationship; the role of the nurse on the health team, the role of the nurse vis-a-vis the doctor, and the role of the clinical nursing specialist (Levine: 1969). Therein is to be found the profession of nursing - the raison d'etre for the existence of a nursing profession (Brown: 1970:35).

Essential to implementing the emphasis on the professional practice of nursing are expert nurse practitioners - those nurses who are broadly educated and experienced in meeting the total needs of patients throughout

their illness and into health. Through these expert nurses - some call them clinical specialists; others prefer the term nurse-clinicians - nursing brings its total body of knowledge and skill to bear where it is most needed - health care of the patients.

This brings out the question, usually phrased, "What precisely can the nurse-clinician do for patients that differs from what the nurse-generalist can do?" The practice of the nurse-clinician is distinguished first by the knowledge and cognitive ability she brings to bear on each situation falling within her particular area, whereas the nurse-generalist tends to know a little about a lot of things, and is therefore limited in the number and variety of conceptual explanations or interventive measures she can consider.

Johnson, Wilcox, and Moidel (1967) described the nurse-clinician and her functions as follows:

The clinical specialist in nursing has more knowledge than the nurse-generalist about particular types of problems experienced by patients. This knowledge, acquired through advanced study and training, leads her to consider various alternatives in explaining a given patient situation, in predicting the future course of events, and in prescribing nursing actions. She thus, can be more discriminating and more definitive in identifying the nature of the patient's problems and in selecting appropriate intervention.

The information she collects about the patient suggests even more possibilities to her and calls her attention to interrelationships between the bits and pieces of evidence and between the evidence and her knowledge of similar situations. In turn, her knowledge of other such situations leads her to seek even more evidence, evidence which often may be covert and frequently difficult to obtain. Thus, her accumulated knowledge allows her to penetrate to the meaning of a diffuse, undifferentiated pattern of signs and symptoms (Johnson, et al: 1967:2298).

Obviously, the nurse clinician's competencies cannot be devoted to a single patient or the concept of the nurse-clinician would defeat its

own end - that of making professional nursing care available to all patients, despite the proliferation of auxillary personnel. Therefore, she usually functions in several different capacities: she gives nursing care herself; she assists and guides others in giving it; and, in conjunction with her colleagues in other disciplines - the doctor, physical therapist, dietitian, social worker, and others - helps to determine and implement the maximum health goals the patient can be expected to achieve. She functions in what ever part of the health care environment the patient may be, from the intensive care unit to his own home. She is charged with the maintenance and improvements of standards of nursing practice, just as the chief of the orthopedic service is responsible for the standards of medical practice within that area (Lewis: 1968:466). She is what might be called "counseling practitioner," or more creatively - nurse-ologist.

It has long been recognized that patient care did not end when the patient was discharged from the hospital. For almost a century, public health nurses have picked up the care of the patient upon his arrival home, but sadly enough, real continuity of care was frequently lost in transit. The breach between hospital nursing and public health nursing is as notorious as the breach between nursing service and nursing education - with the patient lost in the chiasm. Now, efforts are being made to close the gap with such variations in the role of the nurse-clinician as that of liasion nurse, as developed at Rancho Los Amigos Hospital [California] Each liasion nurse - there is one for each clinical service - develops her own way of functioning, but each is the bridge between the hospital and families and community nursing agencies to achieve continuity

of care (Brown: 1970:72). This nurse works with public health nurses and visiting nurses, or makes home visits herself with comprehensive, integrated, and uninterrupted care of the patient her primary goal (David: 1969). In other hospitals, public health nurses have been introduced as co-ordinators and play a similar role (Brown: 1970:72). Another title for the nurse in a double role is that of family health practitioner (Calif. Course...: 1969).

There are several major factors emerging now which exert great influence upon nursing practice. The swing of focus from the hospital and agency-centered type of care to the health supervision of the community is causing many changes in the nurse's role. Over the century, nursing has evolved from care of the sick person in the hospital, to concern for his restoration, to maintenance of good health; expanded to include the patient's family, then his community, now his country. While medicine and nursing have long been concerned with the whole man in his total environment, they were largely unsuccessful in translating this holistic concept into practice or in exciting the public about it. Now the consumers of health services have created the excitement by demanding such care (Robischon: 1971). Some consumers are also demanding a part in the planning of that care. This is placing a great responsibility upon nursing, and especially public health nursing - the traditional guardian of community health. This is bringing about a change in nomenclature; public health nursing to community health nursing.

Community health nursing is not limited to care of persons outside the hospital. According to Freeman (1970:111), "Community health nursing is seen as a population-based obligation, realized through multidisciplinary,

ecologically oriented effort and utilizing concepts and skills that derive both from generic nursing and from public health practices. It focuses on nursing the community in contradistinction to nursing in the community."

Community health nurses need a good general education, and that many of them have achieved this is shown by the number of generalists in the community health agencies who have graduated from baccalaureate programs. This as opposed to the hospital nurse-generalists who generally come from diploma programs. The community health nurse of today has the educational background needed for observing certain behaviors and variables in the patient and in his environment...in addition to recognizing all other community health nursing problems. Thus, she has the same roles that the general medical practitioner has acquired through his basic education and internship. The capability of making broad differential diagnosis, but not the definitive diagnosis (Meleis: 1971). Here the role of the community health nurse-clinician would come in; the consulting practitioner who would advise in the planning of the specialized care required.

While public health nursing has long been considered one of the most progressive of the nursing specialties, community health nursing is still too new to be able to boast a wide variety of specialization, and more research is necessary to identify the possible areas of further specialization.

UNDEVELOPED POTENTIAL

The practice of nursing is traditionally thought of in terms of the

intimate physical contacts of bathing, feeding, and comforting the fevered brow, along with many technical skills. There is yet another skill which is so inherently basic of nursing that it is mostly overlooked as being anything needing further consideration. Yet this skill is probably the nurse's paramount attribute, and the singular one upon which nursing could build a good case for professionalism. So basic that it has never been given a distinctive title, this attribute is called empathy, sympathy, understanding, love of humanity, and more, and is the backbone of the nurse's supportive role. With the present trend in society toward person-service this role is becoming increasingly needed.

Long before the medical profession began to think in terms of "total patient care," and sociologists began associating the physical ailments of man with his environment and socioeconomic circumstances, nurses were responding with overall support of those in their charge. Much of Florence Nightengale's philosophy of nursing was tied to this function. It was the nurse's ability to "support" the patient during his long and tedious therapy that proved such great value in psychiatric medicine (Sleeper: 1952). This is one factor responsible for the establishment of psychiatric nurse-therapists as one of the first clinical specialties for nurses (Jamieson and Sewall: 1937).

Although medicine and nursing share common goals of preserving and restoring health, doctors, more than nurses, usually are more comfortable meeting the patient's needs for medication and medical attention when they are in developing trusting relationships. Nurses are more inclined to cultivate good interpersonal relationships with patients

(Bates: 1970). By her unique position in relation to a patient, regardless of the health service setting, the nurse can provide this important facet of care as no other discipline is prepared to do. Although the patient is now surrounded by a whole contingent of health workers, many of them women, none, including the woman physician, seem to possess the same moral, maternal touch of nurses. The observations of one lay authority on nursing practice, Nathan Hershey, Legal advisor to the ANA, given from his vantage point after an experience as a patient, expresses this well. Mr. Hershey says:

I gather that the supportive role of the nurse and personal interaction with the patient on something other than strictly technical or mechanical basis, is of great importance to a patient's well-being. I believe that the nurse who can bring this leavening into the relationship between the patient and the physician by serving as his physician's associate, and while doing so engaged in selected medical tasks and functions, can be a most important kind of health worker (Hershey: 1971:1411).

The medical profession should be the first to acknowledge the importance of the support-role in nursing. Doctors have benefited from it for years. Right or wrong as he may be, a doctor can universally count on a nurse backing him up - or covering for him. If the facts were analyzed, the nurse's support of the doctor is proof of her value in this area. The doctor's role as a healer requires great self-confidence, and trust by the patient. Both must be continuously re-enforced. The doctors depend heavily upon nurses for this re-enforcement.

MEDICINE-NURSE COLLEAGUESHIP - PROFESSIONAL EQUALITY

In the past, one of the primary goals in nursing has been the control of nursing practice by nurse practitioners. But, in spite of the

efforts, the character of nursing practice is still molded largely by the demands of the employers, and the rigidity of the medical division of labor. The trends to change this structure are well established and moving, but at the present, the combined efforts of all the trends are making only small alterations. One of the more hopeful appearing trends of change is in the most hide-bound tradition in the medical division of labor - the association of doctor and nurse. Ultimately this will also affect the entire paramedical force. The current literature abounds in examples of this trend toward the development of partnership group practice between doctor and nurse. Not as doctor and "handmaid," but as colleagues.

Emory University in Atlantic has appointed James A. Alford as assistant dean of both medical and nursing schools. Ada Fort, nursing dean said, "We consider this a giant step in moving forward..." (One Ass't Dean...: 1970). "The oldest and most effective health team is composed of the physician and the nurse. Together they can accomplish what neither can effectively do alone" (Wilbur: 1969:23). "Medical educators indicate that the practice of medicine is rapidly becoming a team activity in which the doctor may be, at best, first among equals" (Mussallem: 1969:515). "The most encouraging trend today is the attempt by increasing numbers of physicians and nurses to define practice in terms of knowledge, judgment, and skills...because comprehensive personal health service require a coordinated health team" (Lambertsen: 1969). "The pyramid view of patient care disciplines /"Doctor" at the apex/" is yielding to the 'pie' concept. Collegueship is evolving; the expertise of each health professional, from his 'wedge of the pie,' shared and

interrelated all together, comprise the 'patient care' or 'health maintenance services' society needs and demands" (Peplau: 1970). "Nurses' caste-like separation from doctors must give way to the collegueship that now prevails among the various medical specialties. It may be asked whether the nurse's assistance of the doctor (e.g. in the operating room) does not inevitably make her into a physician's assistant rather than his colleague" (Katz: 1969). Peplau (1971) predicts that the nurse will retain more and more of her own professional identification in this alliance, even to collecting her own fees for services, much as doctors in consultation or collaborative surgery do now.

Numerous accounts, which are appearing with increasing frequency, tell of the impact upon patient care that nursing is having, when given its proper authority. The fear that autonomy in the hands of nurses "...would seriously endanger the quality of health care...for the people," is the fear of narrow-visioned individuals, who are at best, uninformed.

Nurses and doctors have always been somewhat suspicious of each other, and since the emergence of modern nursing, the relationship between the two groups has had many of the characteristics of a stormy marriage. Yet there is an unlimited amount of mutual respect and interdependency, one for the other. Nurses need doctors to provide medical diagnosis and prescribe medication and treatment; doctors - often grudgingly - depend upon nurses to provide the care of the patient which is beyond the medical scope of knowledge; to fill in the gaps which medical knowledge alone cannot cover. Even the doctor's difficulty in accepting

suggestions from nurses is a defence against his own anxieties about making mistakes (Bates: 1970). And, mistakes are an occupational hazard of doctors; despite their best efforts some of their patients die. Resistance to transfer of authority and acceptance of the value of the nurse's role in the delivery of health care will decrease as the functions for that care become more comprehensive (Levy 1966). Following this trend of doctor-nurse collegueship, the time will come when doctors can say as honestly as does Abraham Heller, Director of the Community Health Center of Denver General, "God forbid the doctor should try to completely influence what happens to the patient. He has the nurse to deal with, and she has her own ideas of what should be done for the patients" (Ledney: 1971).

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Nursing rose from the hearth of primitive man's first home, carried in the capable hands of the women of his family. As it was passed on from mother to daughter, it evolved into an art which became a traditional part of homemaking; yet a skill apart, reserved for the helpless members of the family. Nursing remained within the home long after other arts and crafts moved into community settings and become organized occupations. In fact, nursing did not take on the aspects of an occupation until after the beginning of the Christian era. Under the influence of the church, during the first fifteen centuries of Christianity, nursing became established as the first vocation for women and an honored occupation for both men and women.

During the holocaust of the Reformation, nursing was purged of its position in society, and its functions were remolded to emerge as distasteful tasks, to be performed almost exclusively by women of ill repute for meager reward. The three hundred years following the Reformation were marked as the Dark Period of Nursing. In only a few nursing institutions did the original spark of altruistic dedication and concern for humanity still smolder. In the mid-1800's, that spark was fanned into a flame which glowed brightly in the Nightengale Lamp that guided nursing out of the darkness, and became the symbol of the professional nurse of today.

The terms profession and professional came into common usage in their application to nursing as early as the 1800's. Florence Nightengale used them frequently in her writings (Nightengale: 1859). In 1882, the Century Magazine featured an article about the expansion of nursing, entitled, "A New Profession for Women" (Strauss: 1966). The terms

continued to be applied well into the twentieth century, without much challenge. However, when the analytical explorations of sociologists began to draw society's attention upon the true meaning of the terms, nursing was brought sharply into focus. The ensuing debates about its professional status were carried on between nursing and the other members of society, and among nurses themselves - with complete lack of consensus in all sectors.

Partially because of social pressure toward professional status, but mainly to improve the functions of nursing care, nursing leaders have made heroic efforts to move nursing from a non-professional occupation to a profession. Whether the distance to go was so far, or the obstacles to overcome were so great, is not completely determined, but plainly, the progress has been very slow along the continuum.

DIAGNOSIS, PROGNOSIS, AND Rx

Nursing in America has probably made more pronounced progress between non-profession and profession than elsewhere in the world. During the past fifty years, and particularly the last twenty-five, nursing practice has changed dramatically. The role of the nurse, as handmaid of the doctor and ministering angel of mercy, has given way as auxillary personnel and automation have replaced her at the bedside, and electronics and cybernation have infringed upon her area of critical judgement and nursing diagnosis. On the other hand, the nurse is assuming more roles in administration, coordinating, and "doctoring." Most of these new functions she carries on in the traditional settings, and much of the time without recognition of them by society. Therefore, her image has

not kept pace with her role. Nor is she granted authority to perform these functions to the fullest of her potential to do so. She is still controlled by the power structure of the medical division of labor, and the sanctions of society. The role changes of the nurse has not appreciably altered the structural features of nursing. As late as 1966, Anselm Strauss offered a resumé¹ of these features, which is still basically appropriate:

Nursing is one of the greatest women's occupations of the nation. It is predominantly a salaried occupation. It has a relatively open recruitment.

Nurses have a great potential for geographical mobility. A nurse can migrate from one state to another and easily find employment....

The majority of nurses still work predominantly at three locales: hospitals, public health agencies, and educational institutions. Free-lance nursing, including private duty nursing, is at a minimum.

The work of nurses is rigidly spelled out. They teach, they administer, they counsel, they research, and traditionally, they do bedside nursing which is thought generally to be nursing's main rationale for existence!

Nurses tend to look upward to physicians for orders, and downward to assistants for response to their own orders. Said another way, the occupation of nursing is scarcely autonomous, but is embedded within a hierarchy of authority.

Specialization within nursing tends both to follow the hierarchial lines of hospitals or agencies, and the clinical specializations of medicine itself. Too, the current strain between "education" and "nursing service," based on increased career specialization is notable.

There is a curious melange of educational institutions and nursing degrees. This host of educational progress seems to represent both the occupation's attempt to get "professional" legitimation through higher education, and a genuine desire to improve the services which the occupation offers to its clients (All italics added), (Strauss: 1966:60).

Among the most concerted efforts of nursing to reach professionalism were attempts to pattern itself after the major profession of medicine by following the criteria of that profession. Some of that criteria it has met most satisfactorily.

A possession of a body of knowledge - abstract and concrete - is undeniable. A trip among the shelves in the nursing section of a professional library is but one testimonial to this fact. While nursing may not be able to lay claim to any ancient tomes devoted to its art and science, as medicine can, it can be proud of the scope, depth, and timelessness of its literature.

The research efforts which went into the building of that body of knowledge - whether "inordinate" or not - deserves recognition. There is no denying the impact those studies have had, not only in the area of improved bedside care of the patient, but in the understanding of general and specific entities of medical and nursing functions, and lately in the correlation between the patient, the sciences, and the dynamics of society. And, most of what is found in that body of knowledge is not to be found in the literature of any other discipline; it is uniquely nursing.

Another claim of nursing to professionalism, which it has certainly earned, is attitude. The attributes of the nurse, eulogized by society, both glamerously and reverently, are not mere figments of imagination of the mind; the regard of the nurse is well deserved. Concrete proof of this is evidenced in the faith and trust which society has placed in the nurse, including the privilege of confidentiality. Even the control that society exercises upon the nurse's practice is an indication of the recognition of her existing and potential power to affect the welfare of

society. The nurse's "concern for her patient and his welfare" is very real, and not to be taken lightly. As Krause (1971:26) says, "Professions, by their central skills, were [are] potentially in a position to exploit people, and could do them harm if strongly organized."

It is rather ironical that the criteria of professionalism, which nursing fails to meet to the degree of other professions, are the ones which stand out most evidently in the evaluation of professionalism, but are the least important to those receiving the services of nursing. Society does not judge a nurse by her educational background, her membership in her professional association, or how much autonomous authority she wields in the background. To society - and especially to the patient - a nurse is a nurse, is a nurse!

The educational preparation of the nurse was one of the first areas in which the struggle toward professionalism took place. It was the contention of the earliest nursing educators, from Adelaid Nutting on, that the professional nurse should be educated within a university. Not just a setting, but an actual university. In 1970, the nursing leaders were still advocating the need for college level educational background for nurses! In almost a century of progress, still only a fifth of the nurses have such preparation. Also, the preparation of nurses, for years confined to just two institutions, is now spread from university and hospital school over associate degree, career ladder, life-experience, and challenge-exam programs. This proliferation of programs will produce more nurses, but it will tend to cut down the ratio of those who have what may be considered professional educational preparation.

The control of recruitment of nurse candidates cannot begin to compare

with that exercised by the medical profession on its applicants. The aspiring medical student can consider acceptance to a medical school in itself a major achievement. A would-be nurse needs only look for a program which fits her preference and circumstances. She can enroll as a nurse-aide trainee, and only her lack of ability or motivation can prevent her from rising to a baccalaureate, or above, degree. Nursing has little choice but accept her as a bona fide member once she has qualified for her RN.

Nursing has even less control over career longevity of its members. Like other professionals, nurses seldom change disciplines, but most do not remain active in nursing as their life work. At best, in the past, nursing took second place after homemaking. Although this is a characteristic more than a criteria, failure to meet it puts just one more barrier between nursing and other occupations which are accepted as professions.

Next to education professional association membership is the greatest failure of nursing achievement. The official organizations, which represent nurses and nursing interests, are good - but, apparently not good enough. The ANA speaks for only a third of the nurses; the NLN has a membership of only 21,000, nine out of ten of whom are registered nurses (ANA-Facts...: 1969). Two reasons for the organizations' failure are noted. One is tied to the career pattern of nurses which includes a divided interest between home and job, and the availability of work with a constant unmet demand for nurses. Unlike union members, nurses do not need a membership in an interest group. The other reason reflects nursing's structural pattern, composed primarily of women engaged in a

gentle skill, who are slow to revolt against male authority or display inhumanitarian behavior, even for their own benefit. So far, nurses have answered Krause's (1971:31) question, "Will upward social mobility, minuscule but real, be always preferred by most to the riskier but potentially more rewarding advance of a whole group?" in the affirmative.

Autonomy, the final criteria of professionalism which nursing fails to meet, has been rather thoroughly explored in the previous chapters. The reasons for the failure stand out clearly. The role of women in most cultures has traditionally been subordinate to men; the founder of modern nursing positioned nursing under medical direction. As long as doctors have the right to diagnose and prescribe, they will remain in a position of authority in the health field; as long as nurses are ranged round doctors they cannot function autonomously. And, society is not willing to accept nurses as equals of doctors because the public is lacking in the professional knowledge of just what the role and functions of the nurse are. Her image is still stereotyped inspite of the fact that her actual role has changed.

The changes in nursing have come about as a result of the shifts in the occupational structure of society from agricultural to industrial domination, then to one of automation and service-human resources control. These shifts have brought about a growing demand for highly trained, specialized occupations with advancing technology and a complexity of legal, social, educational, medical, and scientific developments. The growth of service-based occupations is attributed to the growing affluence and sophistication of the society which requires increased personal services (Neighbors: 1970). Now, nursing is being faced with

more managerial functions which require professional authoritative interaction with patients and professional members of society. Both nurses and non-nurses recognize that nursing must keep pace with the society which places such a premium upon professional status, or it will pass into oblivion. And, profession-wise, nursing is in trouble.

As it stands now, nursing can continue to provide the services to society that it has in the past, and seek to strengthen its position in the occupational structure by unionization, forgetting the professional status. Such a move, while improving the bargaining power of the nurses, would certainly tend to reduce the traditionally idealistic attitudes of nursing, and it could easily enter into another Dark Age from which it may never again emerge.

If, on the other hand, nursing does not establish itself more firmly as a profession, with or without union support, it stands to fall victim to the atomic-age ideology now sweeping the country. Society, with its growing veneration of mechanical technology and irreverence toward the traditional social paragons, is now often observing doctors as having feet of clay, while the nurses' spotless white does not represent purity and goodness to everyone. Therefore, it is entirely conceivable that patients in the near future will be placing their trust of health care in the computers, and nurses - and doctors - will be relegated to the role of health-scientists whose only function lies in programming the machines.

The third alternative, and the one which holds forth the best opportunity for nursing to achieve professionalism, is to fashion a new role in which nurses with greater professional competency will be more active participants in coordinated efforts to provide health care for all levels

of the population. Nursing leaders are attempting to point out the means by which this challenge can be met, but there is still no total agreement upon which direction should be taken.

Some leaders have developed the concept of the extended role in which nurses willingly move to take on tasks previously done by doctors, in connection with their own science of nursing. This function makes the nurse an associate of the doctor. A few mistakingly identify the functions of a PA with the extended role of the nurse, but others recognize the professional difference between the "assistant" who carries out tasks delegated to him by the doctor, and who has no other functions, and the "associate" who works with the doctor and besides "assisting" him, also contributes an unique service which he is not qualified to give.

Other nursing leaders advocate the concept of the nurse-clinician. These nurseologists apply the entire science of nursing in depth to the diagnosing, evaluating, and instituting of measures for the total nursing care and health supervision of their patients. In order to implement this concept of total comprehensive care, the nurse-clinician will have to be allowed to exercise unlimited authority in planning the programs of care, and free to move with the patients through every area of the hospital, out into his home and community, and back, as his needs require.

Eventually, the nurse-clinician may be the only health practitioner who will provide continuous service in sickness and health as she now does for sickness in the hospital (Mussallem: 1969). If the Comprehensive Health Planning Law is implemented to its furthest potential, the division between the hospital and public health aspects of care will be in name only, with both departments merged into one, functioning under a central

health commission (Petrowski: 1969). The nurse then may well function in a reversible uniform; hospital white on one side, and public health blue on the other.

The increased emphasis upon nursing participation in the community is the result of several of the current societal trends. One is the new social conscience which is admitting that health care is the right of every citizen, and that the present system of health care delivery is far from adequate. The nurse, once concerned with care of the sick patient, can now lift her sights to the broader perspective of major concern for health care of the entire population and thereby accept her share of responsibility for the record set by health professionals in this country (Milio: 1970).

Another trend is the growing awareness of man's environment and its affect upon his well-being. Environmental protection is an inherent part of nursing, and nurses should be taking greater responsibility in solving health problems associated with the environment (Abdellah: 1971).

A third trend is found in the demands being made by the consumers of health care, not only for more and better care, but for a controlling voice in the delivery of that care. Traditionally, professionals and service agencies have defined the public's health needs for them; in consumer-controlled services, such needs are defined with the public (Loreg: 1969). All health personnel, including doctors, will be considered assistants to patients as they and their families assume a more dominant role in trying to maintain or regain health (Henderson: 1970). The consumers set the framework in which the nurse makes individual, professional judgements; literally as an independent practitioner under

contractual obligation to her patients (Wolford: 1964).

In the striving for professionalism, one fact is frequently overlooked by the aspiring occupations; occupations do not automatically become professions just because of increased expertise. For example, midwifery, no matter how advanced, will never become obstetrics. True professions remain inviolate because their structural positions permit them to absorb, dominate, or supplement any relevant knowledge and skills which might threaten their standing. Thus, in medicine, the bonesetter, midwife, and leech have disappeared, while the new fields of anesthesiology and radiology have simply become medical specialities (Goode: 1961). The same must occur in nursing. Its structure must be such that no other group of persons or patients in the health care system can move in and provide the services that are exclusively nursing practice functions.

Not only must the mechanics of nursing practice, as it is known now, be improved to the ultimate, but the hitherto undeveloped potentials of nurses must be explored and brought to their fullest level of maturity. Specifically in this area is the inherent attribute of nurses to establish profound interpersonal communication and relationship with patients in every health setting. The nurse is the logical person to act in the capacity of both buffer and catalyst between the patient and his antagonists in his struggle to regain or maintain health. The importance of the role of the health ombudsmen is plainly evident by the fact that other disciplines, such as social workers are moving rapidly into assuming control of it (Stone: 1968)(Hirsch: 1969). If nurses do not begin to move just as fast, they will find the role taken from them. They resent the positions of leadership in institutions being placed in the hands of

those from other disciplines, certainly they should have the same feelings about the chain of authority extending into the community.

Speed - except when associated with fleetness of foot - is not a hallmark of the nurse. This is particularly true in the area of professional progress. Nurses tend to resist change, and any which has come about is due to pressure from external forces. However, change by its very nature, is dynamic, one triggering another, and as any primer on social organization will point out, change from within is infinitely preferable to change imposed from without. Therefore, it is up to nursing to assume the control of the changes it must make from now on (Ruano: 1971).

This, of course, is the theme upon which nursing leaders have harped for years in their push for professional autonomy and self-control. Now is the time to evaluate the futility of past efforts and plan a new course of action. There is no denying the strides toward self-control that nursing has made in the areas of curriculum planning, licensing, and some others, and progress will continue along these lines, hopefully at an accelerated rate. It is in new areas that more effort must be made. The major professions had their origins in the roles of the leaders of primitive society, and have maintained their status by continuing in leadership responsibility, which will undoubtedly come as a startling revolution to nurses and society alike. Nursing has provided excellent public service over the years, but it has failed in public leadership. Refusal to exercise public leadership has been cited as an indication of the "deprofessionalization" of a profession, with modern medicine and law as current examples (Kelly: 1965:77). Nurses have not yet learned to

utilize their majority status in the health manpower field, or their scarcity in the face of demand, to wield the power they might. Nurses must now become involved; must be where the action is. Not only where the health care is needed, but at the policy making levels of society (Peplau: 1970). Nursing has protested long and loud because nurses are generally engaged to fill specific positions or to assume fairly well-defined roles after planning for a new health program is already advanced (ANA/AAP....: 1970). They form protest groups and send thousands of letters and telegrams to the legislatures urging support of their interests (Nurses March....: 1971). Some are very active in local and community civic and political activities, but for the most part, the sum and total of all their efforts along these lines have not created many noteworthy waves in the public's opinion. Even "historic firsts," such as the passage of the state of Oregon's HB 1060 amendments, which requires that an RN be named to both the Oregon State Board of Health and Comprehensive Health Planning Authority (Pro. Nurs. Gains....: 1971), was considered by many as a gesture of patronization rather than a step forward for nursing. It would seem to behoove nurses to think in terms of putting more of their members in positions where they can participate, not only in health planning, but in state and national leadership roles.

Since professionalism is achieved, in part, by community sanction, society must be made aware of the changing role of the nurse, and shown an image which more closely fits her actual profile. Society must be made aware of the functions of nursing which go far beyond the traditional stereotypy to which the public is accustomed. Therefore, nursing is charged with the dual responsibility of adjusting itself to the changing

environment in which it must function, and in securing the support of society in giving it the authority to demand its rightful place among the professions.

This might sound like a very formidable charge for nurses, most of whom already carry the scars inflicted upon them by the "system." The majority of nurses, including those with university education, have not had any formal training in leadership beyond that required for head nurse positions. Many "inherit" an administrative or leadership role, but have a most inadequate knowledge base for organizational expertise, and cannot create a milieu conducive to the growth of leadership among those in their administration (Jacox: 1970). As leaders, nurses must be willing to take risks, not be captives of the system (Parker: 1969) and demonstrate independence based on substantial knowledge. This means that nursing education will have to focus attention upon leadership courses which will prepare the kind of nurse-organizer-planner-manager who can provide leadership, not only in nursing practice, but in social and professional organization (Milio: 1970)(Brown: 1971).

Fortunately, the very societal trends which are placing so many demands for change upon nursing, can also provide an unsuspected measure of support to its efforts toward change and professionalism. Probably paramount among the trends is the changing value system of society. The renewed Renaissance-type reassertion of the individual, as an entity in the face of large organizations, is in part responsible for the new attitude in society. Status is not all that important to very large segments of the population. Even students in the professions are anti-elitists, and are increasingly conditioned to see themselves and their

future work as an essential but integral part of organized efforts to provide services through the pooling of many kinds of human and material resources. Independent thinkers can better accept nursing on its value as a service-oriented discipline than on its position in the hierarchy of the medical division of labor.

Even within the professions themselves, ideals long considered sacred and binding, are being turned off by their members. As an example, the AMA, traditional foe of any system hinting of collectivity, is losing membership¹⁹.

Another point is the fact that society has entered into another period of "secularization," not unlike the one following the Reformation, marked by rebellion against the Establishment. Most of the major professions gained independence as a result of that first secularization of society, and it is entirely possible that newer professions of today, particularly nursing, will gain a great measure of independence during this latter period.

Conflicts between the professions and the society are a part of history over the centuries. Especially now, there seems to be a reassertion of the conflict between doctors and other groups - the government, the citizenry, the other health workers - which have been seen before in similar though not identical ways. As part of history, it naturally reflects its main themes (Krause: 1971:113).

Much of what Krause is saying, ties in with the theme of Wilensky's (1964) article, "The Professionalism of Everyone?" With each and every occupation laying claim to the label of profession, and the loose application of the criteria to increasing specialization, there is less

importance accorded the status of any profession. In other words, the very attempts to raise occupations to the pinnacle of professionalism are actually pulling down that peak in a great leveling process, producing all plains and no mountains.

The leveling process is being carried forward on other fronts, too. Some of the most pertinent to the women's occupations are the movements of Women's Lib, and its counterpart, the entrance of more males into previously woman-dominated occupations (Earl: 1966). Lessened outside domination by males and internal addition of male strength within their ranks is bound to affect the future role and function of the nurse and the professionalization process of nursing.

These trends are offered only as analgesics for the process of that professionalization. It still remains for nurses to make their occupation into a profession, If professionalism is important to them, both from the standpoint of status, and from their desire to provide the best possible nursing service they can, then nurses must go after it. If their lady-like demeanor of the past (Bullough and Bullough: 1971:83) has not been able to secure professionalism, then perhaps it is time for nurses to heed the often repeated admonition of the late Dr. William Cherin, a truly devoted friend to nursing, "Nurses have got to learn that there are times when it does not pay to be ladylike. They will have to take their gloves off and fight" (Brown: 1948:116). "No occupation becomes a profession without a struggle..." (Goode: 1960:902).

Krause (1971) states that, "The relationship of an individual to his occupation or profession is a two-way street. Is the individual taking a major part in creating his own occupation or is the occupation

or profession bearing down on him to the point where he is made over in the image of the occupation?" In nursing, the answer to that is still not established; it remains for nurses - singularly and collectively - to determine which one it will be.

FOOTNOTES

1. Samuel Huntington (1951) explains the present status of the military profession as being a combination of short-term draftees and lifetime professionals. Most, but not all, of the officers and senior non-coms make the military their career, but the bulk of the armed force consists of men from other occupations and professions who are merely putting in a tour of duty as military personnel, and return to their individual areas of work when the tour is over.
2. Joseph Addison (1672-1719), British essayist and poet.
3. Theodore Caplow (1954:48) feels that this may be partially due to the worthy efforts of sociologists who seek to uncover similarities among all occupations, and thus succumb to the tendency to label as professionalization what is happening in most of the labor groups. Personal service functionaries, for instance, like barbers, bellboys, boot-blacks, and taxi drivers, are "also professionalized."
4. I quote this particular instructor, not only because a very typical orientation-bias of nurses was showing in her re-ranking of Addison's professional categories by placing "the physic" first (and she was a Catholic Nun, besides), but she exemplified the rigid, narrow thinking found in many of the old guard, even in the age of modern nursing. "The authority of those who teach is often an obstacle to those who would learn."--Cicero.
5. Although the terms semi-profession, sub-profession, and pseudo-profession, are commonly found in the literature, I do not use them in this study unless in a direct quote from another source. Their use seems to have intended or unintended derogatory overtones in their connotations and implications, and would indicate an already established position of nursing on the non-profession - profession scale.
6. In her Notes on Nursing, Florence Nightengale defined nurse in this broad context, "Now a nurse means any person in charge of the personal health of another...For, besides nurses of the sick and nurses of children...there are friends or relatives who take temporary charge of a sick person, and there are mothers of families." (Nightengale: 1940: 139:1859).
7. Health is currently defined by the World Health Organization (WHO) as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (Blum and Leonard: 1963:29).
8. Credit for the facts about the progress of nursing quoted in this study must be given to many fine nurse historians, whose texts are listed in the references. While most of nursing history is now well known and is public domain, each author has presented it in her own delightfully unique manner, and I gratefully acknowledge their contribution which I have selected for use here.

9. The University of Oregon School of Nursing gave up the basic grey dress and white wrap-round apron less than ten years ago, and the Emanuel Hospital School of Nursing just this year changed from the same type, but with blue checks, to a new single piece uniform.
10. When nursing schools were just getting started, in 1873, the United States Bureau of Education census reported 178 hospitals with only a half dozen established training schools. By 1909 there were 1,100 schools of nursing, or slightly more than one out of every four hospitals, although few hospitals had more than one hundred beds. By 1930 there were over 2,100 hospital nursing schools (Bullough and Bullough: 1969:183).
11. By 1909 there were 4,359 hospitals with a total of 421,453 beds. By 1928 the number of hospitals had increased to 6,852, the number of beds to 755,722 (Bullough and Bullough: 1969:183).
12. Actually, domestic labor had an edge on nursing. A survey made in 1926 found that...for her long hours of work, the nurse earned just forty-nine cents an hour, slightly less than the charwomen who were then earning fifty cents an hour (Bullough and Bullough: 1969:166).
13. In nursing parlance, administering medication, or "passing meds," involves a multi-phase operation which includes: 1) interpreting the original order from the doctor, 2) selecting the drug from the stock supply, 3) measuring out the prescribed dosage, 4) handing or giving the medication to the patient, 5) personally verifying that the patient has taken or been given the medication, and charting the procedure. The medication is checked for correctness when it is selected from stock, when it is measured, and when it is returned to stock, or just prior to administration. Each of these phases is to be carried out by one person only - the nurse. Delegation of any phase to someone else, even another nurse, is contrary to nursing practice, and the nurse's conscience.
14. A program utilizing home health aides within an established comprehensive prepaid group practice plan at Bess Kaiser Hospital, Portland, Oregon, has been in operation since 1967. The aides, many without any previous experience in community work, were provided with an intensive, full-time training session of six to eight weeks. The basic training concentrated in the general subjects of home economics, practical nursing, and elementary social science, under the direction of a multi-disciplinary faculty. This was followed by further work training of six months, during which time the aides assumed more and more supportive personal care services needed by the patients to maintain normal body and emotional comfort, and assist them in independent living (Greenlick: 1967).
15. A follow-up report of the preliminary results of the program two years after it had been put into operation, showed that these aides, under the supervision of health professionals, could provide high-quality care in the areas of nursing, social work, and physical therapy. The report also showed that better care is provided for the patients who require many kinds of care, such as physical therapy, nursing and social services, when these services are not fragmented among several professionals, but are rendered by a single person (Hurtado: 1969).

16. Portland Community College started their first LEGS program this last fall. Hunter College, New York, graduated its first class of ex-practical, professional nurse students a year ago.

17. There is a distinct difference between midwife and nurse-midwife. The former is anyone trained or experienced in the delivery of babies, and in many countries is an occupation completely apart from any form of nursing. Nurse-midwife, in America, designates a professional nurse who has taken advanced training in midwifery, and holds a certificate as a CMW (Certified Mid-Wife) as well as her RN. Until just recently, midwifery was not generally accepted in America. Its practice was authorized by local health authorities in such backwoods areas as the hill country of Kentucky and the Indian reservations of Arizona. Now there is a fully accredited organization of The American College of Nurse-Midwives.

18. During an interview with Charles Bollinger, Editor-in-Chief, Nursing Education Department, Appleton-Century Crofts-Publishing Company, in the spring of 1969, he stated that the publishing companies were having difficulty getting enough books on the market to meet the demand for new material, even though he frequently has over fifty manuscripts a month to review.

19. From an article by Virginia Cleland, "Sex Discrimination: Nursing's Most Pervasive Problem," AJN, August 1971, p. 1542. Dr. Cleland says, "Nursing in the 1940's, 1950's, and 1960's did not have the leadership it had at the turn of the century, or even during the first three decades of this century. I believe that these past 30 years of weak and unimaginative leadership parallel the growth of the cult of women as sex symbols." Which, makes an interesting topic of further exploration, but is, unfortunately, not within the scope of this study.

20. Membership in the ANA is provided through the individual state nurses' association rather than directly from the Association. Therefore, dues to the ANA are included in the package dues paid to the state organization. The national dues of \$25.00 represents only a portion of the total, therefore, in order to be a member of the ANA, a nurse must pay up to three times its fee. A nurse, joining in Oregon, pays up to \$75.00 a year in dues.

21. In 1963, 73.9% of the nation's eligible physicians belonged to the AMA; only 69% currently hold membership (New Type Doctor...: 1971).

APPENDIX A

ABRAHAM FLEXNER'S CRITERIA FOR PROFESSIONALISM

1. It essentially involves intellectual operations accompanied by large responsibility.
2. Is learned in nature, and its members are constantly resorting to the laboratory and seminar for a fresh supply of facts.
3. Is not merely academic and theoretical, however, but is definitely practical in aims.
4. Possesses a technique capable of communication through a highly specialized educational discipline.
5. Is self-organized, with activities, duties, and responsibilities which completely engage its participants and develop group consciousness.
6. Is concerned with the public interest more than unorganized and isolated individuals are, and its motives are altruistic.
7. Has a definite status - social and professional.

APPENDIX B

THE NIGHTINGALE PLEDGE

I solemnly pledge myself before God and in the presence of this assembly:

To pass my life in purity and to practice my profession faithfully;

I will abstain from whatever is deleterious and mischievous and will not take or knowingly administer any harmful drug;

I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling;

With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care.

APPENDIX C

THE CODE FOR PROFESSIONAL NURSES

Adopted by the American Nurses' Association, 1950

1. The fundamental responsibility of the nurse is to conserve life and to promote health.
2. The professional nurse must not only be adequately prepared to practice, but can maintain professional status only by continued reading, study, observation, and investigation.
3. When a patient requires continuous nursing service, the nurse must remain with the patient until assured that adequate relief is available.
4. The religious beliefs of a patient must be respected.
5. Professional nurses hold in confidence all personal information entrusted to them.
6. A nurse recommends or gives medical treatment without medical orders only in emergencies and reports such action to a physician at the earliest possible moment.
7. The nurse is obligated to carry out the physician's orders intelligently, to avoid misunderstanding or inaccuracies by verifying orders, and to refuse to participate in unethical procedures.
8. The nurse sustains confidence in the physician and other members of the health team; incompetency or unethical conduct of associates in the health professions should be exposed, but only to the proper authority.
9. The nurse has an obligation to give conscientious service and in return is entitled to just remuneration.
10. A nurse accepts only such compensation as the contract, actual or implied provides. A professional worker does not accept tips or bribes.

11. Professional nurses assist in disseminating scientific knowledge through any form of public announcement not intended to endorse or promote a commercial product or service.
Professional nurse or groups of nurses who advertise professional services do so in conformity with the standards of the nursing profession.
12. The Golden Rule should guide the nurse in relationships with members of other professions and with nursing associates.
13. The nurse in private life adheres to standards of personal ethics which reflect credit upon the profession.
14. In personal conduct nurses should not knowingly disregard the accepted patterns of behavior of the community in which they live and work.
15. The nurse as a citizen understands and upholds the laws and as a professional worker is especially concerned with those laws which affect the practice of medicine and nursing.
16. A nurse should participate and share responsibility with other citizens and health professions in promoting efforts to meet the health needs of the public--- local, state, national, and international.
17. A nurse recognizes and performs the duties of citizenship, such as voting and holding office when eligible; these duties include an appreciation of the social, economic, and political factors which develop a desirable pattern of living together in a community.

APPENDIX D

THE CODE FOR PROFESSIONAL NURSES

Adopted by the American Nurses' Association, 1950

Revised 1968

1. The nurse provides services with respect for the dignity of man, unrestricted by considerations of nationality, race, creed, color, or status.
2. The nurse safeguards the individual's right to privacy by judiciously protecting information of a confidential nature, sharing only what is relevant to his care.
3. The nurse maintains individual competence in nursing practice, recognizing and accepting responsibility for individual actions and judgements.
4. The nurse acts to safeguard the patient when his care and safety are affected by incompetent, unethical, or illegal conduct of any person.
5. The nurse uses individual competence as a criterion in accepting delegated responsibilities and assigning nursing activities to others.
6. The nurse participates in research activities when assured that the rights of individuals subjects are protected.
7. The nurse participates in the efforts of the profession to define and upgrade standards of nursing practice and education.
8. The nurse, acting through the professional organization, participates in establishing and maintaining conditions of employment conducive to high-quality nursing care.
9. The nurse works with members of health professions and other citizens in promoting efforts to meet health needs of the public.
10. The nurse refuses to give or imply endorsement to advertising, promotion, or sales for commercial products, services, or enterprises.

APPENDIX E

Public Law 89 - 749

Comprehensive Health Planning Law

1. The development of comprehensive health planning at the state level which will be underwritten by federal grants.
2. The grants to states will be made on a more flexible basis and not on a categorical restriction as has been done in the past. For example, in the past federal money was categorically designated for tuberculosis when there were also many other kinds of health needs in the area or state besides tuberculosis.
3. The extension of planning to regional and local areas which is intended to encompass all health services needed in the particular area.
4. Project grants will be given for new kinds of health services and for special types of problems.
5. Money will also be given to public agencies, other than the state health department, and to non-profit private agencies for the development of health services.
6. The training of personnel necessary for these planning efforts with grants to educate the personnel.

GLOSSARY

AAIN	American Association of Industrial Nurses
AANNT	American Association of Nephrology Nurses & Technicians
ACS	American College of Surgeons
ACSN	Association of Collegiate Schools of Nursing
AD	Associate Degree
AHA	American Hospital Association
AMA	American Medical Association
ANA	American Nurses' Association
AORN	Association of Operating Room Nurses
EEG	Electroencephalogram
EKG	Electrocardiogram
ICNA	International Catholic Nurses' Association
IV	Intravenous (injection)
LEGS	Learning Experience Guides for Nursing Students
LPN	Licensed Practical Nurse
NACGN	National Association Colored Graduate Nurses
NLN	National League of Nursing
NLNE	National League of Nursing Education
NOPHN	National Organization of Public Health Nurses
NYSNA	New York State Nurses' Association
PA	Physicians' Assistant
PT	Physical Therapy
RN	Registered Nurse
WHO	World Health Organization

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