

REFRAMING DISORDER: GENDER, CLASS, AND THE HISTORY OF THE
RESURFACING DEBATE IN NURSING

by

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The nursing profession has sustained a state of disorder. The debate within the disorder historically exists in relationship to multiple educational pathways for entry into RN practice. Diploma, BSN, and ADN pathways still exist today as a means to enter into nursing practice through RN licensure. Historical research of the three pathway developments is significant and timely in that the evidence from the study helps to shed light on professional issues resurfacing in the “BSN in 10” proposals.

The purpose of this research is to understand the socio-cultural-political context surrounding the decisions to develop the diploma, BSN, and ADN educational pathways; the historical debate concerning the role and functions, educational pathway, and professional identity of the entry-level RN; and the relationship between the educational pathway developments and the resurfacing historical debate.

Historical case study research focused on three historical decision points for the educational pathway developments: Diploma-Bellevue Training School for Nurses in New York, 1873; BSN-University of Cincinnati School for Nursing and Health in Ohio, 1916; and ADN-Orange County Community College nursing program in Middletown, New York, 1952. Archival retrieval of primary documents for each case study was completed.

Each educational pathway development revealed divisions of gender and paternalistic control over nursing, divisions of class within nursing, and an undefined division of nursing labor. Prolonged paternalistic control rooted in divisions of gender, coupled with the divisions of class and unstructured divisions of labor within nursing, prevented full realization of a professional, collegiate education for entry into RN practice.

The historical debate continues as a distinct professional identity and role does not exist for the entry-level RN. Lack of clear differentiation of role and functions within nursing practice for each pathway nurse creates an education-practice disorder, sustains division within the profession of nursing, and permits continued paternalistic control over nursing. Facing the “BSN in 10” proposals, nursing must reach a decision regarding the needed division of labor within nursing for today’s health care system. Nursing can resolve the historical debate by reframing Montag’s practice model and delineating an educational preparation for each practice role.

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RESURFACING DEBATE IN NURSING

A Dissertation Presented to the Faculty of the College of Nursing
East Carolina University

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Doctor of Philosophy Degree in Nursing

by

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DEDICATION

To my brother, Jason Irej, and grandfather, Kenneth Lee Hill, PhD

Your spiritual presence within my heart provides me strength.

I love you and miss you both.

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CHAPTER 1

Introduction

Debate within the nursing profession historically exists as a result of the multiple entry-level educational pathways to registered nursing (RN) practice. Currently, nurses enter RN practice through one of three different educational pathways—the diploma program that originated in 1873, the baccalaureate degree in nursing (BSN) program that originated in 1916, or the associate degree in nursing (ADN) program that developed in 1952. Entry-level nurses from each of these educational pathways earn the title “Registered Nurse” after successful completion of the same licensure examination. Entry-level nurses from these three different educational pathways coexist under the same title and practice within the same role because the nurses hold the same RN licensure. Historically, the existence of three different educational pathways to entry-level RN practice has created debate within the nursing profession.

Even the emergence of the first educational pathway addressed in this research, the 1873 diploma pathway, created debate regarding the division of labor in nursing. As will be discussed further in *CHAPTER 2 – Literature Review*, prior to 1873, non-secular professional nurse vocational training existed, yet secular nurse training was individualized to the hospital. A standardized training model had not yet been adopted in America. The addition of the diploma pathway in 1873 created debate in American secularized nursing. The additional educational pathway developments of 1916 and 1952 subsequently stimulated a resurfacing of the debate within the profession of nursing.

This research study includes the three elements of the historical debate concerning the entry-level RN—the role and functions, educational pathway, and professional identity. The

combination of these three elements will be referred to as the “historical debate” throughout this research study.

The Disorder

Historically, the existence of debate surrounding multiple educational pathways to entry-level RN practice created disorder for the division of labor within the nursing profession. Disorder occurred because a unique professional identity defined by educational pathway failed to exist in practice for the entry-level RN. Biddle, a social psychologist, in summarizing his role theory in five succinct statements, explains the connection between role and identity. “Roles,” he wrote, “are often associated with sets of persons who share a common identity.”¹ The lack of defined role and functions by educational pathway under RN licensure has prevented the development of a unique professional identity for the nurse from each educational pathway within the division of nursing labor. Because the role and functions of the practicing RN are essentially the same and not differentiated by educational pathway, disorder also exists between the practices and pathways. Each educational pathway graduate self-proclaims professional status because of the RN licensure despite opposing claims from the other pathway graduates. The different educational pathway graduates lack a common identity despite the shared RN title. This remains evident today in the statements written by two major nursing organizations.² The declared debate regarding the entry-level educational pathway for the professional RN has continued to resurface over the years. Recent “BSN in 10” legislative proposals serve as a current example of the resurfacing debate.

Significance of the Research

Both the New York and New Jersey State Nurses Associations submitted “BSN in 10” legislative proposals in 2007.³ Traditionally, the diploma and ADN educational pathways serve

as terminal degree pathways to unrestricted and undifferentiated RN practice. The “BSN in 10” legislative proposals mandate advancement of diploma and ADN nurses’ education to the BSN undergraduate level within ten years of obtaining initial RN licensure. The legislative proposals extend support to the continuation of diploma and ADN educational pathways as a means to enter the profession of nursing; however, the role and functions of the diploma and ADN-prepared nurse prior to obtaining the BSN degree are not defined nor differentiated from that of the BSN-prepared nurse.⁴ If these legislative proposals pass, the historical relationship between entry-level nursing education and practice will change.

The “BSN in 10” legislative proposals serve as a means, according to the New York and New Jersey State Nurses Associations, to demonstrate their commitment to the advancement of the education of nurses and the deliverance of the best-quality care to patients within their states.⁵ New York and New Jersey’s commitment to the “BSN in 10” proposals may ultimately resolve the historical debate; however, because the proposals suggest a connection between advanced education of nurses and best-quality care to patients, they suggest an insufficient division of labor within nursing and may also prove to add further disorder for the debate. The new legislative proposals represent a historical event whether the “BSN in 10” contributes to the debate as a resolution or as further disorder. This historical research study surrounding the developments of three educational pathways (1873, 1916 and 1952) may be significant and even timely in that the evidence gleaned from the study may help shed light on professional issues resurfacing in the current “BSN in 10” legislation.

Attempts to Resolve the Disorder

Over the years, nurses attempted to resolve the debate and the multiple entry-level educational pathway disorder specifically through defining a difference between the educational

pathways. Within the past fifty years, the most prevalent attempts to resolve the disorder and delineate a clear division of labor within nursing centered on implementing differentiated practice in nursing and categorizing nurses by subtitle or category.

In the nursing literature, the most common definition of differentiated practice is attributed to Boston as the “structuring of roles and functions of the RN by education, experience, and competence.”⁶ Several studies reported in the nursing literature in the 1990’s concerned the implementation of differentiated practice. Although positive outcomes have been reported in the literature, differentiated practice has not been widely implemented across the United States.

Another attempt to resolve the disorder has revolved around the creation of subtitles or categories for nurses. Position statements written by major nursing organizations identify the BSN-prepared nurse with the subtitle of “professional” nurse.⁷ Both diploma and ADN-prepared nurses have been identified by the subtitle “technical” nurse.⁸ The use of the word “technical” to describe an RN created an undesired class division within the profession, thus the diploma and ADN nurses and educators strongly opposed its use.⁹

Preceding this opposition, the ADN educational pathway developed utilizing the concept of differentiated practice with the intention to create a “technical” nurse role for the division of nursing labor. The ADN-prepared nurse, intended to be a registered nurse, would perform a limited range of functions within the technical nurse role as delineated in Mildred Montag’s (1908-2004) nursing functions continuum.¹⁰ This continuum served as a basic assumption for her research and will be referred to in this study as Montag’s “Nursing Functions Continuum Practice Model” (NFCPM) or simply “Montag’s model.” Her model could have resolved the historical debate by providing a distinct role with range of functions, a distinct educational pathway, and a distinct technical and professional RN identity—the three elements of the

historical debate—to clearly define a division of labor within nursing. This research study includes an analysis of the development of the ADN educational pathway using Montag’s model in relation to the historical debate and disorder for three major reasons. One, the ADN educational pathway serves as one of the pathways to entry-level RN practice. Two, a body of evidence demonstrates that the technical nurse role of the ADN-prepared nurse was never realized in practice for the division of labor in nursing. Three, Montag’s model did not represent a significant role or range of functions for the diploma-prepared nurses who, at the time, constituted the majority of RNs in the United States.¹¹

An additional effort to define the differences between the educational pathways to RN licensure rests in the creation of the ADN graduate competencies. In 1978, the National League for Nursing (NLN) defined graduate competencies for the ADN graduate to guide development of the pathway’s curricula.¹² These competencies have been revised over the years.¹³ The expected competencies of the ADN graduates do not translate into a differentiated practice role under RN licensure: “Differentiation of graduate *competencies* among the entry-level educational programs ... may exist, but differentiation of nursing *practice* among entry-level prepared RNs does not.”¹⁴

The historical debate regarding the role and functions, educational pathway, and professional identity of the entry-level RN has resurfaced for more than a century without resolution. The resurfacing of the historical debate seems to have led to a continued state of disorder for the division of labor within the nursing profession. Therefore, it seems reasonable, if not imperative, that the three educational pathways—diploma, BSN, and ADN—and the decisions, debate, and disorder surrounding them be studied historically in relation to one another.

Order Within Disorder

Despite the resurfacing of the historical debate and the resultant division of labor disorder, nursing education continues to produce new nurses for entry into RN practice. The profession has attempted to create legal “order” through graduate competencies, licensure via standardized examination, and a scope of practice for the RN. Specific competencies do exist for graduates of the ADN educational pathway as previously addressed; yet, under individual state law, diploma, BSN, and ADN graduates may all earn RN licensure after successful completion of the same standardized examination.¹⁵ The RN may legally practice under the state’s RN Scope of Practice. The RN Scope of Practice defines the role and functions of the licensed RN and does not differentiate the scope by educational pathway. Division of labor legally exists between the licensed practical nurse (LPN) and RN based on different licensure and scope of practice, yet the same legal differentiation does not exist between the differently prepared RNs. The “BSN in 10” legislative proposals challenge whether these traditional legal documents and processes remain sufficient to maintain quality registered-nursing care by the three different educational pathway nurses in today’s American society.

The “BSN in 10” legislative proposals may be an attempt to resolve the historical debate or may be evidence of a higher-level disorder. Doubt regarding the quality of nursing care provided by RNs from the three educational pathways in America’s health care system today serves as one motivation for the “BSN in 10” legislative proposals. The existence of legislative proposals requesting an advance in the educational preparation of nurses for RN practice to ensure high-quality care may suggest a higher-level, system disorder with the division of nursing labor. The “BSN in 10” proposals stimulate questions as to whether or not nursing education historically met the needs of nursing practice. On the contrary, the “BSN in 10” proposals may simply be an

attempt to resolve the historical debate through the means of a unified, legal decision regarding the educational preparation to maintain licensure to practice as an RN.

Research Questions

A preliminary historical review of published histories and documents in selected nursing archives associated with nursing education programs related to the three pathways had been conducted. This preliminary review illustrated a complex historical context for the historical debate surrounding the decisions to create and maintain three entry-levels into RN practice. This review resulted in the identification of three dates associated with the initiation of the three distinct educational pathways that served as the foci of this research study. The three pathways include the development of the diploma pathway in 1873, the BSN pathway in 1916, and the ADN pathway in 1952. The historical reviews of the literature leading to the identification of these dates as the beginning of the development of each educational pathway will be addressed in greater detail in *CHAPTER 2 – Literature Review*.

Although the context surrounding the development of the three educational pathways that still exist today—diploma, BSN, and ADN—evolved since 1873, the disorder and historical debate surrounding the issue of entry-level and differentiated practice within the division of nursing labor continues. The nursing profession challenged and debated the role and functions, educational pathway, and professional identity of the entry-level RN for more than a century. This research study examines the historic decisions to develop the three entry-level RN educational pathways, and explores the relationship between the historic decisions and the ensuing historical debate.

The preliminary historical review also included a reading and assessment of Montag's model. This research study analyzes and reframes Montag's model in terms of the findings from

the study of the three pathways. The historical evidence from this research may either simply add to the dialogue of the debate or assist the nursing profession in unifying its decision regarding the historical debate about entry-level into RN practice and, more specifically, the current “BSN in 10” legislative proposals.

The preliminary historical review aided in the construction of four research questions:

1. What is the history of the resurfacing historical debate regarding the role and functions, the educational pathway, and the professional identity of the entry-level RN in 1873, 1916, and 1952?
2. What is the history of the decisions to develop the diploma, BSN, and ADN educational pathways in 1873, 1916, and 1952?
3. Does the historical study of the entry-level RN educational pathway developments and their relationship to the historical debate reframe Montag’s Nursing Functions Continuum Practice Model and, if so, how?
4. What impact might the evidence from this historical study have on the decision regarding the present “BSN in 10” legislative proposals?

Research questions 1 and 2 led the study and analysis of the three educational pathway developments and the historical debate, and will be addressed in the case study chapters, *CHAPTER 4 – Diploma Pathway, CHAPTER 5 – BSN Pathway, and CHAPTER 6 – ADN Pathway*. As will be revealed in the case study chapters, research questions 1 and 2 guided the discovery of deeper- rooted divisions within nursing as a result of each educational pathway development, thus leading to the resurfacing historical debate. Divisions of gender and class challenged the development of a clearly defined division of labor for nursing practice by educational preparation and therefore challenged professionalization of the entry-level RN.

Research questions 3 and 4 address contemporary professional issues regarding nursing's division of labor and will be addressed in *CHAPTER 7 – Conclusion*. The analysis of the developments and the debate provided a new lens in which to examine the contemporary issues.

Purpose of the Historical Research

The purpose of this historical study serves to understand the socio-cultural-political context surrounding the following: the decisions to develop the diploma, BSN, and ADN educational pathways; the historical debate concerning the role and functions, educational pathway, and professional identity of the entry-level RN; and the relationship between the educational pathway developments and the resurfacing historical debate. Greater understanding of the context facilitated exposure of the roots to the debate and disorder; divisions of gender and class serve as the foundational challenges to resolution of the historical debate and education to practice disorder.

Historical research holds the ability to broaden the personal experiences of today's evidence-based nurse leaders through a greater understanding of the past. The representation of the past that results from historical study as evidence or “data over time” will enhance the understanding of the debate and disorder of nursing education to RN practice.¹⁶ The existence of the three educational pathways included in this research study repeatedly contributed to the resurfacing historical debate and resultant disorder within nursing's division of labor. Historical analysis of the pathways' relationship to the debate as well as to one another yielded an accurate representation and thus further understanding of the roots to the century-long disorder. Additionally, the debate and disorder continues for the nurse graduates from each pathway who coexist today in practice and who will be influenced by the outcome of the current “BSN in 10” legislative proposals.

An understanding of historical evidence of the past provides a new lens with which to reframe historical events. Nurses may use this historical lens to view the future and guide decisions that may need to be made in the present time. This research study provides a new lens to assess and reframe Montag's model and the division of nursing labor. And as noted previously, this research may serve helpful in decision making concerning the current "BSN in 10" legislative proposals.

Through the collective professional history of nursing, a sense of unity and identity can be discovered. Olga Church, a nurse historian, who supports this discovery, stated:

Another promise of history is its potential as a unifying force. This is based on the belief that having determined a collective past, one can look to developing a sense of unity.¹⁷

Historical study holds the potential to unify the profession of nursing regarding the resurfacing historical debate. This research study does not suggest a prescribed outcome but that unity through collective understanding remains a possibility. The purpose of this research study to gain understanding of the historical decisions, developments, and debate provides an original perspective of the past that may guide the future.

Historical Method

Historical research with a case study design served as the method for this study. This research and the three case studies focused on three educational pathways associated with the three historical decision points for the developments previously mentioned. The three case studies include: Diploma - Bellevue Training School for Nurses in New York, 1873; BSN - University of Cincinnati School for Nursing and Health in Ohio, 1916; and ADN - Orange County Community College nursing program in Middletown, New York, 1952. *CHAPTER 2 – Literature Review* addresses the rationale for choosing these three schools as case studies for this study.

The historical timeline of the study began in 1873; the year America's nurse training schools introduced and adopted the Nightingale model for training nurses. The institution of the Nightingale model remains marked as the beginning of "modern" trained nursing in America.¹⁸ Although professional nursing existed within religious nursing communities, secular nurse training did not hold the same recognized status until 1873.¹⁹ American "elite social reformers" adopted the Nightingale model for training nurses as the accepted way to train secular middle-class nurses.²⁰ This research is limited to the study of secularized nurse training in America during the period from 1873 to 1952.

This study focused on the decisions to develop three entry-level educational pathways to RN practice—diploma, BSN, and ADN—and their relationship to the historical debate concerning nurses' practice role and functions, educational pathway, and the professional identity of the entry-level RN. Historical examples from nursing practice provided some of the context that related to the decisions to develop the educational pathways and to the historical debate. The practical or vocational nurse training/education program also provided some of the context; but, this study excluded a thorough analysis of this program because the graduates do not hold RN licensure. This study also excluded the newer "accelerated BSN" or "alternate-entry BSN," "RN to BSN," and "alternate-entry MSN" programs. The accelerated BSN, alternate-entry BSN, and RN to BSN programs have the same end-product or graduate as the BSN pathway—the BSN-prepared nurse. The educational format serves as the only major difference with these programs and therefore did not serve as separate events or case studies in this research study. The alternate-entry MSN students can enter RN practice prior to completing the requirements for the MSN; yet, the students do not earn a BSN degree. The alternate-entry MSN

program's goal serves to produce a graduate, MSN RN, not an undergraduate, BSN RN, and therefore did not serve as a separate event or case study in this research study.

Theoretical Framework

The historical debate created disorder within the profession of nursing and thus the division of labor within nursing remained in a state of chaos for more than a century. Chaos has been defined as the simultaneous existence of order and disorder.²¹ Chaos or disorder within a system can result from conflict that arises when one or more parts of a system break down or exceed the defined functional role within the system.²² Defined roles and functions of each part maintain homeostasis or balance of an entire system.²³ Due to the complexity of the historical disorder in the nursing profession, several theories guided this research study.

Role theory served useful to guide the study of the social context of this research study because of the connection between roles and disorder. Homeostasis of a system is maintained with defined roles and functions of each system part.²⁴ Biddle's role theory guided the study of the role and functions of the nurse associated with each educational pathway; roles and functions are two of the five propositional concepts of Biddle's role theory.²⁵ Role theory also provided a theoretical framework to view the absence of a defined role. Role conflict and role confusion serve as two examples of theoretical explanation for the absence of defined roles. Role theory guided the study of the lack of defined role and functions by educational pathway. Role theory guided the study of the social context of nursing education in 1873, 1916, and 1952.

The influence of the disorder on the nurses' professional identity at the decision points in each case study served as the cultural focus of this research study. The study explored the professional culture and the resultant professional identity of nurses from each pathway around

the time period when the decisions to develop the pathways occurred. King's Interacting Systems Framework guided the study of the cultural context.

King separates her framework into three interacting systems: the personal system includes the individual nurse, the interpersonal system encompasses two or more individuals interacting together, and the social system constitutes the environment in which interactions between individuals take place.²⁶ Although King's framework focuses on the nurse-patient relationship, this study required adaptation of the framework to examine the professional culture in nursing with the existence of nurses from different educational pathways. King's framework emphasizes the complexity and dynamic nature of interaction. The graduates from all educational pathways must interact and share the common identity of RN despite the distinctly different educational preparations. This interaction creates a complex professional environment for the discipline of nursing. The sub-concepts within each of King's systems—professional identity, roles, and decision making, to name just a few—mirror the concepts of this historical research study.²⁷ Professional identity and role and functions exist as essential elements of the historical debate. Decision making that resulted in the creation of the three educational RN pathways served as a major focus of this research study. King's Interacting Systems Framework provided a nursing and cultural perspective for this research study.

The framework of feminist theory guided the study of the political context surrounding the educational pathway developments in American nursing since 1873. Histories of women and of nurses demonstrate that the provision of nursing served not only as an expectation of women because of a woman's instinctual nature to care and nurture others, but was a practical necessity for survival. When nursing gained recognition as a vocation for secular middle-class women and hospital nurse training programs following the Nightingale model developed, the challenge for

the nursing profession to break free from divisions of gender and paternalistic control of medicine and hospitals became a prominent struggle for nursing education and practice. The enduring gender bias of nursing as a profession for women and the intense challenge of paternalistic control over nurse training schools identified during the literature review led to the decision to utilize feminist theory in this research study. Feminist theory will be used specifically to study the political context of nursing education and divisions of gender and class in 1873, 1916, and 1952.

Potential Challenges of the Research Study

The historical timeline of this research study extended nearly a century. A long timeline may potentially dissipate the focus necessary for rigorous historical research. These three event points selected during preliminary research—1873, 1916, and 1952—serve as critical decision points that contributed to the historical debate in nursing. The identified foci for this research, or the three specific events, served as an effective effort to maintain clarity and organization.

The availability of data as well as access to this data also served as a challenge for this historical research study. The Bellevue Hospital in New York serves as one example; the archivist denied the researcher access to critical historical documents. The challenges related to archival access and retrieval of data will be discussed in more detail in *CHAPTER 3 – Methodology*.

Summary

The nursing profession's division of labor in America sustained a state of disorder for more than a century. The debate within the disorder historically exists in relationship to the multiple educational pathways for entry into RN practice. The diploma pathway that originated in 1873, the BSN pathway that originated in 1916, and the ADN pathway that developed in 1952

still exist today as pathways to enter into nursing practice through RN licensure. Disorder identified within the socio-cultural-political context of the historical debate regards the role and functions, educational pathway, and professional identity of the entry-level RN. Nursing attempted to establish legal “order,” yet current legislative proposals pose further changes and potential further disorder within American nursing. The undetermined meaning of the “BSN in 10” proposals to the historical debate identified in this research stimulated this historical inquiry. The study of the three critical events to this historical disorder—the decisions to develop the diploma, BSN, and ADN educational pathways—and the resurfacing historical debate within the disorder resulted in a reassessment and reframing of Montag’s Nursing Functions Continuum Practice Model. This study clarified whether the “BSN in 10” serves as a resolution allowing the nursing profession to unify in decision regarding this historical debate or if it is a fourth critical event contributing to the debate and suggesting growth of an even higher-level division of labor disorder between education and practice. Establishment of a timeline of critical events when the decisions of 1873, 1916, and 1952 resulted in new entry-levels into RN practice illuminates the disorder with an original perspective of sustained divisions of gender and class in nursing and thus provides a new lens that may ultimately be used to guide the decisions nurses currently ponder regarding the “BSN in 10” legislative proposals.

Notes

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³ State of New York Assembly. 2009-2010 Legislative Session (January 23, 2009) S01074; State of New Jersey Assembly. 213th Legislature pre-filed for Introduction in the 2008 Session (updated as of October 10, 2008) S620/A3768.

⁴ New Jersey State Nurses Association (NYSNA), "*BSN in 10*" *Fact Sheet*," <http://www.njsna.org>.

⁵ State of New York Assembly, S01074; State of New Jersey Assembly, S620/A3768.

⁶ Carol M. Boston, "Introduction," In *Current Issues and Perspectives on Differentiated Practice*, ed. Carol M. Boston (Chicago: American Organization of Nurse Executives, 1990), 1. East Carolina University, William E. Laupus Health Sciences Library.

⁷ As cited in Patricia T. Haase, *The Origins and Rise of Associate Degree Nursing Education* (Durham, NC: Duke University Press, 1990), 92-96. Personal Copy.

⁸ *Ibid.*, 98-101.

⁹ *Ibid.*

¹⁰ Mildred L. Montag, *The Education of Nursing Technicians* (New York: G. P. Putnam's Sons, 1951), 3-8. East Carolina University, William E. Laupus Health Sciences Library.

¹¹ June M. Harrington, *American Nursing and the Failed Dream: A Critical Assessment of Nursing Education in America* (2009), 125. Personal Copy.

¹² National League for Nursing (NLN) Division of Associate Degree Programs, *Competencies of the Associate Degree Nurse on Entry into Practice* (New York: National League for Nursing, 1978). Personal Copy.

¹³ National League for Nursing (NLN) Task Force on Competencies of Graduates of Nursing Programs, *Competencies of Graduates of Nursing Programs: Report of the NLN task force on the Competencies of Graduates of Nursing Programs* (New York: National League for Nursing, 1982). East Carolina University, William E. Laupus Health Sciences Library; National League for Nursing (NLN) Council of Associate Degree Nursing Competencies Task Force, *Educational Competencies for Graduates of Associate Degree Nursing Programs* (New York: National League for Nursing, 2000). East Carolina University, William E. Laupus Health Sciences Library.

¹⁴ April D. Matthias, "The Intersection of the History of Associate Degree Nursing and the "BSN in 10:" Three Visible Paths," *Teaching and Learning in Nursing* 5, no. 1 (January 2010): 40. Personal Copy.

¹⁵ National Council of State Boards of Nursing (NCSBN), under "NCLEX Examinations," <https://www.ncsbn.org/nclex.htm> - The National Council of State Boards of Nursing (NCSBN) develops two licensure examinations, The National Council Licensure Examination for

Registered Nurses and the National Council Licensure Examination for Practical Nurses that are used by state and territorial boards of nursing to assist in making licensure decisions”; Email communication from Kenneth Kenward of the National Council of State Boards of Nursing on May 4, 2010 – “No states require a BSN to practice. No states have different scopes of practice for diploma, ADN, or BSN RNs.”

¹⁶ Martha M. Libster and Sister Betty Ann McNeil, *Enlightened Charity: The Holistic Nursing Care, Education, and ADVICES CONCERNING THE SICK of Sister Matilda Coskery, 1799-1870* (Farmville, NC: Golden Apple Publications, 2009), 332. Personal Copy.

¹⁷ Olga Maranjian Church, “Historiography in Nursing Research,” *Western Journal of Nursing Research* 9, no. 2 (May 1987): 277. Electronic Database, JSTOR accessed through East Carolina University, William E. Laupus Health Sciences Library.

¹⁸ Sandra Beth Lewenson, *Taking Charge: Nursing, Suffrage, & Feminism in America, 1873 – 1920* (New York: National League for Nursing Press, 1996), 12. East Carolina University, William E. Laupus Health Sciences Library.

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²⁰ Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (New York: Cambridge University Press, 1987), 3. Personal Copy.

²¹ Sherrilyn Coffman, “Marilyn Anne Ray, 1938-present: Theory of Bureaucratic Caring,” in *Nursing Theorists and Their Work*, 6th ed., eds. Ann Marriner Tomey and Martha Raile Alligood, (St. Louis: Mosby Elsevier, 2006), 116-39. Personal Copy.

²² Lynn Davies, *Education and Conflict: Complexity and Chaos* (New York: RoutledgeFalmer, 2004), 15. East Carolina University, J. Y. Joyner Library.

²³ *Ibid.*, 15.

²⁴ *Ibid.*

²⁵ Biddle, 8.

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CHAPTER 2

Literature Review

The three distinct educational pathway developments identified previously in *CHAPTER 1 – Introduction* as significant historical events in the debate concerning entry-level into nursing practice—the diploma pathway in 1873, the BSN pathway in 1916, and the ADN pathway in 1952—serve to organize this literature review. Interspersed with the literature reviews for these three case studies is a general literature review of significant transitional events identified in American nursing history to directly influence the educational developments and historical debate concerning entry-level into RN practice. This literature review illustrates the feasibility of the historical research study by identifying the timeline and significant events within the historical debate and division of labor disorder.

Case Study #1 – Diploma Educational Pathway

Prior to the implementation of the three pathways, professional nursing held a very different defined role. Nursing as practiced by the French Daughters of Charity in the mid-seventeenth century and then in the nineteenth century as practiced by the American Sisters of Charity nurses held the identification of “professional” nursing.¹ These Catholic nurses received their education through vocational training.² A similar training program did not exist for Protestant women in America to the extent it existed for the Catholic Daughters and Sisters of Charity until later in the nineteenth century. Specific hospitals created and maintained numerous training programs; yet, the nursing care provided by “nurses” in the majority of secularized, American-owned and operated hospitals received “despairing” reviews.³

In 1873, the Nightingale model for training nurses was adopted by three American hospitals for their associated nurse training schools—the Bellevue Hospital in New York, the Connecticut State Hospital in New Haven, and the Massachusetts General Hospital of Boston.⁴ The hospitals adopted the Nightingale model in an effort to provide quality nursing care.⁵ This model was chosen because Florence Nightingale (1820-1910) was recognized as a “heroine of the Crimean War” and she founded a successful nurse training program at St. Thomas’ Hospital in London for middle-class women in 1860.⁶ While Catholic nursing education continued, the Nightingale model prevailed as the dominant model to train Protestant, “secular” American nurses for practice. The inception of these hospital training schools began the differentiation and division of nursing labor between middle-class “trained nurses” and those not trained in the Nightingale model and other lay caregivers. Institution of the Nightingale model led to a debate regarding the role and functions, the educational pathway, and the identity of the trained nurse. Nightingale envisioned nursing as a developing profession for middle-class women, thus professional identity would soon relate with the trained nurse identity. The Bellevue Training School for Nurses opened first in America in 1873 in New York and provides an example of the historical debate.

Bellevue opened the doors to its school with the desire to train nurses to not only care for the sick in hospitals, private homes, and poor communities but also to teach future nursing students and supervise schools for nurses.⁷ Bellevue graduates were considered “different” because of the training they received within the Nightingale model.⁸ Bellevue graduates supervised training schools, trained nurses, and cared for the sick across the country and around the globe. A graduate instructed in the Nightingale model received the identity of the “trained nurse.”⁹ An archive of correspondence consisting of ten letters written over the course of two

years between key individuals of the Bellevue Training School for Nurses and the Training School at New England Hospital for Women and Children in Boston illustrates the debate that resulted because Bellevue claimed recognition as the “first Training School for Nurses in [America],” thus the first graduates earned the new identity of the trained nurse.¹⁰ The basis of Bellevue’s argument lies in the “standards” or guidelines that Nightingale personally provided to Bellevue for operation of the school.¹¹ The hospital training school following the Nightingale model ultimately became the diploma programs of the twentieth century.

Case Study #2 – BSN Educational Pathway

The woman’s rights movement that began in 1848 at the Woman’s Rights Convention at Seneca Falls, New York, continued into the twentieth century, yet refocused into the woman’s suffrage movement. Parallel to the Woman’s Movement, nurses organized through the development of the first nursing organization, the American Society of Superintendents of Training Schools for Nurses, in 1893. Nurse leaders, through the organization, advocated for nursing’s right for professional identity through autonomy of nursing education and practice. The nurse leaders fought to gain control of the nursing students, the school’s curriculum, and the nursing practice of trained nurses from the paternalistic control of hospital administrators rooted in the ideology of divisions of gender. Along with the nurse leaders’ push to move nursing education away from hospital control to gain professional autonomy, the education of other professionals, such as clergy, physicians, and teachers, occurred in the university setting.¹² With the combination of the Woman’s Suffrage Movement, an organized nursing organization fighting for professional autonomy, and movement of professional education to the university setting, nursing education also migrated to the university setting.

According to the 1921 publication of the *American Journal of Nursing*, the movement of nursing education to the university setting occurred incrementally.¹³ The availability of advanced courses in a college or university for nurse graduates or senior nursing students began the movement of nurse training to nursing education in the university setting. Nurses who desired to specialize their training to prepare for teaching or administration within nursing schools, or for public health nursing, enrolled in these courses. A preliminary literature review identified Teachers College of Columbia University as the first American university to offer such classes for nurses in 1899.¹⁴ In 1909, the University of Minnesota, often noted to be “the first,” assumed administrative control of an already established hospital-based training program “to establish a school of nursing as an integral part of the university system.”¹⁵ Less than a decade later, a combined liberal studies and professional program that provided both a university education and hospital training was established.¹⁶ The graduates of these programs earned a professional diploma for the hospital training completed and a college degree for the liberal studies, general college courses taken. This combined program will be defined in this research study as the curricula that eventually led to the baccalaureate degree in nursing (BSN). The University of Cincinnati School for Nursing and Health receives recognition as one of the first schools to offer, in 1916, a five-year, combined liberal studies and professional program leading to a Bachelor of Science (BS) college degree and a professional nurse training diploma.¹⁷ It is historically important to point out that these university programs did not replace the diploma programs. The university programs became a second pathway for those wanting to become a trained nurse and created further class divisions between practicing nurses. The development of the dual BS/diploma program in coexistence with the diploma pathway to entry-level nursing practice created a new intensity to the debate.

Reports on Nursing Education

The education of nurses gained popular attention after the 1916 origination of the BSN curricula. Several reports on nursing suggested disorder in nursing education yet provided resolutions for the disorder. Resolutions focused on the differentiation of nurses' roles to clearly delineate a division of labor within nursing by educational preparation.

In 1923, a landmark study, *Nursing and Nursing Education in the United States*, commonly referred to as the "Goldmark study," exposed the blemish of hospital-based training schools that placed the students' training second to nursing service for the hospital.¹⁸ The Goldmark study determined the type and amount of education needed for the public health nurse in order to differentiate the public health nurse from those who provided care in the public setting with only hospital nursing training or with no nurse training at all. The Goldmark study may have illustrated the beginning recognition of the need to differentiate nursing practice for the division of nursing labor based on educational preparation.

In 1934, the *Nursing Schools Today and Tomorrow: Final Report* described the problems with "semi-professional" or "sub-professional" hospital-controlled training schools and outlined "the essentials for a basic professional school" that should be applied to schools for nursing.¹⁹ The report recommended courses of varying levels for graduate nurses to either make up for deficiencies in basic training from semi-professional schools or build on training received from a professional school. Both types of graduate courses were expected to increase the marketability of the nurse by expanding knowledge and skill, and thus the nurses "find themselves better equipped to earn a livelihood."²⁰ The report further emphasized the need to regulate nursing education and practice to ensure adequate preparation of nurses to "take care of the specific condition in question."²¹ The report suggested accreditation of all schools, thus permitting

graduates to take a state licensing exam. This, too, would require state registration for every graduate. Through the suggestion that the accreditation of the education program would determine whether the graduates could test and then practice registered nursing, the report, in essence, differentiated the division of nursing labor based on educational preparation.

It is historically important to note the initiation of nursing licensure in America. There was a 35-year gap between permissive and mandatory nursing licensure in America.²² In 1903, North Carolina initiated the first permissive nursing licensure in America that required the nurse to have graduated from a nursing school that met predetermined standards in order to receive licensure.²³ Licensure permitted the nurse to legally use the title “Registered Nurse.” New York served as the first state to pass a mandatory nursing licensure law in 1938, yet most states maintained only permissive licensure legislation until after World War II.²⁴

In 1948, *Nursing for the Future*, otherwise known as the “Brown Report,” proposed the benefit of differentiated functions between all levels of nursing care, which included practical nurses and what we know today as nursing assistants.²⁵ Brown suggested differentiating nursing practice based on background, training, and experience for nursing’s division of labor. This allowed coordinated teams with each member performing certain functions essential to the total nursing care of patients. In this team approach with differentiation, roles were “utilized more extensively and effectively.”²⁶ Brown provided, in the report, the functions in which only professional nurses are competent to perform. This report directly proposed and planned a division of labor with differentiated practice between various titled/licensed nursing care providers. The Brown Report more formally introduced the concept and advantages of differentiation of practice by educational preparation for nursing’s division of labor.

The reports on nursing offered resolutions that included distinction of roles between the graduates of the different educational pathways and movement of RN nursing education to the university setting and away from the traditional, hospital-based diploma programs. Dialogue continued for decades and, in 1952, an implemented research pilot project provided a response to the reports.

Case Study #3 - ADN Educational Pathway

A third educational pathway, the associate degree in nursing (ADN) education program developed in 1952. The addition of this third pathway to RN practice did not resolve but magnified the division of labor disorder within the profession and created the largest resurfacing of the debate regarding the role and functions, the educational pathway, and the professional identity of the entry-level RN.

Following the end of World War II in 1945, health care incurred many changes that affected nursing practice. Advances in medicine, insurance availability, increased life expectancy, and incidence of chronic disease increased the use of hospitals.²⁷ Along with these changes, nursing functions increased in number and complexity.²⁸ A demand for nurses and a hospital nursing shortage existed. Some perceived that the nursing shortage appeared unrecoverable without two tiers of nurses, professional and “technical.”²⁹ As noted previously, the nursing profession had begun to investigate the education of nurses and the reports of these investigations seemed to provide some resolutions for the division of labor within nursing. ADN education developed in response to a need to increase the number of nurses, establish a new technical nurse role in nursing, define roles of the nurses of the different educational pathways, and move nursing education away from the hospital.

In 1951, Mildred Montag, a nurse, proposed the development of the third educational pathway leading to RN licensure, the two-year ADN program. Montag based her doctoral research on the assumption that nursing functions could be viewed on a “continuum” differentiating the practice of nursing into three division of labor roles with specified functions: the nurse aide, the technical nurse, and the professional nurse.³⁰ According to Montag, the nurse aide could be trained “on-the-job” without completing a training course distinct from the employing agency.³¹ Montag defined the BSN-prepared nurse as the “professional” nurse and the ADN-prepared nurse as the “technical” nurse.³² The technical nurse performed within the role with technical, also called semi-professional or intermediate, functions that fell in the center of Montag’s model. The technical functions, more limited in scope, remained restricted to largely repetitive and routine situations of the bedside nurse that required skilled techniques and exercise of judgment. The technical nurse carried out these functions under the supervision of a physician or a professional, BSN-prepared nurse. Montag based her research on the assumption that different educational programs could prepare individuals to perform a specific range of functions along her model from the nurse aide to the professional nurse.³³ The research proposed a new worker in nursing—the technical nurse.

Although Montag did not use the exact term “differentiated practice,” her model and explanation of it compares to today’s definition of differentiated practice as defined by Boston; the “structuring of roles and functions of the RN by education, experience, and competence.”³⁴ Montag’s research proposed that the educational preparation of the nurse determine the role and functions of nursing care and proposed to differentiate RN practice between the ADN- and BSN-prepared nurse as illustrated in her model.

Montag's model served as the foundation for a multistate pilot project to implement the technical nurse education program as defined in her research. The Cooperative Research Project in Junior and Community College Education for Nursing (CRP) formulated and resulted in the creation of seven ADN programs across the United States. The seven programs began in the following states and year: Orange County Community College, Middletown, New York, in 1952; Fairleigh Dickinson University, Rutherford, New Jersey, in 1952; Henry Ford Community College, Dearborn, Michigan, in 1953; Weber College, Ogden, Utah, in 1953; Pasadena City College, Pasadena, California, in 1953; Virginia Intermont College, Bristol, Virginia, in 1954; and Virginia State College, Norfolk Division, Norfolk, Virginia, in 1955. These initial ADN programs proved successful. The graduates passed the RN licensure examination, obtained employment, and performed functions satisfactorily according to their head nurses.³⁵

Despite the proclaimed success of the programs by the CRP, Montag's model did not become a reality when the ADN-prepared nurse entered nursing practice alongside the diploma- and BSN-prepared nurses. The ADN-prepared RN did not maintain a different practice role or range of functions from that of the diploma- or BSN-prepared RN; however, Montag's model did lay the foundation for the development of the ADN educational pathway.³⁶ While it may have provided a potential platform for the emergence of a unified decision regarding division of nursing labor and the historical debate through differentiated practice under the RN title, Montag's model was not realized in practice.³⁷ Lack of representation of the diploma-prepared nurse who, at the time, constituted the majority of all American RNs challenged the implementation of Montag's model.³⁸

Numerous ADN programs opened throughout the United States, sending a large population of ADN-prepared RNs into practice. Undefined roles for the RNs of the then three different

educational pathways resulted in increasing conflict between the members of the profession. A plethora of articles concerning the role and practice of the ADN-prepared nurse in the literature between the 1960's and 1970's, the Position Papers of the American Nurses Association (ANA) and the National League for Nursing (NLN), and the numerous studies on differentiated nursing practice in the nursing literature in the 1990's serve as historical evidence of the division of labor confusion and division of class within nursing that challenged the nursing profession after the development of the ADN educational pathway.

The Plea for Differentiated Practice

The literature in the 1960's and 1970's demonstrates how nurse leaders pleaded for differentiation of nursing role and functions between the diploma, ADN, and BSN RNs to clearly delineate nursing's division of labor. Martha Rogers (1914-1994) served as one nurse leader who adamantly encouraged differentiated practice by educational preparation. Rogers believed that differentiated practice by educational preparation would not only enhance nursing as a profession but also enhance the welfare of society. Without differentiation, the public would have "little cognizance of the services it seeks or receives."³⁹ Differentiated nursing practice, according to Rogers, would assist the profession to recruit students to nursing and write nursing curricula as well as assist the individual with career planning within nursing's division of labor. Rogers defined lack of differentiated nursing practice by educational preparation as "monuments of conflict and confusion."⁴⁰ In 1961, 50 years ago, Rogers labeled the refusal to differentiate nursing practice as "one of the most significant problems facing nurses."⁴¹

Position Papers

In 1965, the American Nurses Association (ANA) and the National League for Nursing (NLN) both issued position papers that encouraged differentiated practice and classification of

the roles as technical and professional, and delineated the educational programs to prepare each role or the call to action to do so.⁴² Due to a strong opposition from practicing nurses and nurse leaders of diploma and ADN education, neither organization maintained its position. Debate continued with attempts to differentiate nursing practice, agree on titling, and appease both nursing education and nursing service. In 1978, the ANA once again published a position paper very similar to the 1965 paper proposing differentiated practice, yet put a timeline of the resolutions proposed and added support for career mobility.⁴³ In this paper, the ANA retained the title and terminology “professional” for the BSN-prepared nurse but deleted the terminology “technical,” leaving the diploma and ADN-prepared nurses untitled as the “other category.”⁴⁴ The resolutions did not meet the deadlines proposed. By 1982, both the ANA and NLN shared official agreement that the baccalaureate degree should be minimal preparation for “professional” nursing practice and the NLN “supported all education programs in nursing, in response,...to the social reality.”⁴⁵ Both organizations still support all education programs in nursing today.

Differentiated Practice in the 1990's

Numerous studies noted in the literature between 1990 and 1999 concerned differentiation of entry-level RN practice. All the studies reported positive and beneficial outcomes such as increased patient satisfaction, efficient and effective utilization of scarce nursing resources, empowered decision making, and preparation of graduates for a more specified role.⁴⁶ No studies reported negative consequences to the differentiation of entry-level RN practice. Only two studies in the 1990's reported barriers to the implementation of differentiated practice, including: lack of appreciation and value for the “other” educationally-prepared nurses, ignorance, lack of current differentiated compensation, insufficient supply of BSN nurses, and a decrease in

applicants to nursing programs.⁴⁷ While beneficial evidence supporting differentiated practice existed in the literature, implementation of differentiated practice between entry-level RNs remained minimal. Barriers rather than negative consequences to differentiated entry-level RN practice may explain the hesitance to implement such practice.

“BSN in 10”

The “BSN in 10” legislative proposals submitted by both the New York and New Jersey State Nurses Associations represent a current resurfacing of the historical debate.⁴⁸ The proposals mandate advancement of diploma and ADN-prepared nurses’ education to the BSN undergraduate level within ten years of obtaining initial RN licensure. Again, the decision to adopt a “BSN in 10” may present a resolution to the historical debate identified in this research study or conversely, adoption may turn out to be the fourth event or pathway development adding further disorder to the historical debate and division of nursing labor. Regardless of how the “BSN in 10” legislative proposals contribute to the historical debate, the preliminary research suggests that the legislative proposals serve as a historical event in American nursing. Historical research allows for the decisions surrounding the new event to be viewed within the historical context rather than within a vacuum of the present time.

Summary

This literature review provides evidence of the preliminary work done to assess the feasibility of this historical research study—*Reframing Disorder*. The data within the literature review illustrated the historical debate and disorder within the nursing profession and drove the research questions of this research study. Three developments in nursing education surfaced as significant events of the century-long historical debate and disorder, demonstrating a feasible timeline with the use of case study design. Interestingly, reflecting back, the literature review

hints to the divisions of gender and class that the analysis reveals. *CHAPTER 4 – Diploma Pathway, CHAPTER 5 – BSN Pathway, and CHAPTER 6 – ADN Pathway* provide an in-depth analysis to clearly illustrate the divisions of gender and class that serve as the root of the debate and division of labor disorder.

Notes

¹ Martha M. Libster and Sister Betty Ann McNeil, *Enlightened Charity: The Holistic Nursing Care, Education, and ADVICES CONCERNING THE SICK of Sister Matilda Coskery, 1799-1870* (Farmville, NC: Golden Apple Publications, 2009), xv-xxii. Personal Copy.

² *Ibid.*, 35-82.

³ 1873–1923, Fiftieth Anniversary: Bellevue Training School for Nurses (1923), Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Bellevue Hospital Papers, Sub-Series 1: Edamay Bialko Papers 1948, Box 4: Books.

⁴ Abby Howland Woosley, *A Century of Nursing* (New York: G. P. Putnam's Sons, 1950), 110. Microfiche, East Carolina University, William E. Laupus Health Sciences Library.

⁵ *Ibid.*, 146.

⁶ Sandra Beth Lewenson, *Taking Charge: Nursing, Suffrage, & Feminism in America, 1873 – 1920* (New York: NLN Press, 1996), 1. East Carolina University, William E. Laupus Health Sciences Library.

⁷ Louisa Lee Schuyler, *First Training Schools for Nurses in the United States. Correspondence — Dr. Mary Forrester Hobart, Member Committee on Training School, Member Board of Directors, New England Hospital for Women and Children, Boston and Louisa Lee Schuyler, Honorary Member Bellevue Training School for Nurses, Vice President State Charities Aid Association, New York: Ten letters — July 7, 1915, to July 14, 1917. (1918).* Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19 Series 1: People, Box 2: Non-alumnae, Folder #35; Dorothy Giles, *A Candle in Her Hand: A Story of Nursing Schools of Bellevue Hospital* (New York: G. P. Putnam's Sons, 1949), 108 and 131. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19 Bellevue Alumnae Association, Series 5: Books, Box 1; Alumnae Association of the Bellevue School of Nursing, *Bellevue School of Nursing, 1889-1989.* (Topeka, KS: Jostens Printing and Publishing, 1989). Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19 Bellevue Hospital Papers, Sub-series 1: Edamay Bialko Papers 1948, Box 4: Books.

⁸ 1873–1923, Fiftieth Anniversary: Bellevue Training School for Nurses. - The success of the graduates in practice resulted in an influx of applications and requests from all over the country for Bellevue graduates to start other training schools. Bellevue was given the name “mother of all American Training Schools” and from Bellevue graduated “trained women to minister to the sick, assist the doctors, and develop their own profession.”

⁹ Lewenson, ix; Schuyler, “Introduction,” 4.

¹⁰ Schuyler, Letter #1, 1.

¹¹ Florence Nightingale, Letter to Dr. Wylie. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Bellevue Alumnae Association, Artifact Box 4.

¹² Barbara J. Harris, *Beyond Her Sphere: Women and the Professions in American History* (Westport, CT: Greenwood Press, 1978), 95-126. East Carolina University, J. Y. Joyner Library.

¹³ Department of Nursing Education “Preliminary Report on University Schools of Nursing,” *The American Journal of Nursing* 21, no. 9 (June 1921): 620-629. Electronic Database, JSTOR accessed through East Carolina University, William E. Laupus Health Sciences Library.

¹⁴ *Ibid.*, 621.

¹⁵ Ibid., 622.

¹⁶ Ibid.

¹⁷ Ibid.; Jean Brim Cahall, *Pictorial History*, College of Nursing & Health, 1889-1989, University of Cincinnati (Cincinnati: College of Nursing & Health Alumni Association, 1989), 27. East Carolina University, William E. Laupus Health Sciences Library.

¹⁸ J. Goldmark, *Nursing and Nursing Education in the United States* (New York: MacMillan Company, 1923). Microfiche, East Carolina University, William E. Laupus Health Sciences Library.

¹⁹ Committee on the Grading of Nursing Schools, *Nursing Schools Today and Tomorrow: Final Report of the Committee on the Grading of Nursing Schools*. (New York: National League for Nursing Education, 1934), 119-149, 215. East Carolina University, William E. Laupus Health Sciences Library.

²⁰ Ibid., 228.

²¹ Ibid., 233.

²² Shirley K. Comer, "Nursing Licensure,"

http://aam.govst.edu/projects/scomer/student_page1.html - "Permissive" nursing licensure was an option available to nurses permitting the nurse to legally use the "registered nurse" title yet was not required to practice nursing. "Mandatory" nursing licensure was required licensure to practice nursing; Barbara Melosh, "The Physician's Hand:" *Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982), 40. East Carolina University, William E. Laupus Health Sciences Library.

²³ Louie Croft Boyd, *State Registration of Nurses* (Philadelphia: W. B. Saunders Company, 1915), 12. Retrieved from Google Books.

²⁴ Melosh, 40.

²⁵ Esther Lucille Brown, *Nursing for the Future: A Report Prepared for the National Nursing Council* (New York: Russell Sage Foundation, 1948). East Carolina University, William E. Laupus Health Sciences Library.

²⁶ Ibid., 73.

²⁷ Patricia T. Haase, *The Origins and Rise of Associate Degree Nursing Education* (Durham, NC: Duke University Press, 1990), 1. Personal Copy; Mildred L. Montag, *The Education of Nursing Technicians* (New York: G. P. Putnam's Sons, 1951), 12-40. Personal Copy.

²⁸ Montag, 3.

²⁹ As cited in Haase, 22.

³⁰ Montag, 3-8.

³¹ Ibid., 4, 6.

³² Ibid., 4-8.

³³ Ibid., 8.

³⁴ Carol M. Boston, "Introduction" in *Current Issues and Perspectives on Differentiated Practice*, ed. Carol M. Boston, (Chicago: American Organization of Nurse Executives, 1990), 1. East Carolina University, William E. Laupus Health Sciences Library.

³⁵ Haase, 39-40.

³⁶ Haase, 126-154; Rose M. Channing, *Associate Degree Nursing-Problem or Solution?* (New York: National League for Nursing, 1979). East Carolina University, William E. Laupus Health Sciences Library; Mildred O. Hogstel, "Associate and Baccalaureate Graduates: Do They Function Differently?" *The American Journal of Nursing* 77, no. 10 (October 1977): 1598-1600.

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³⁷ Ibid.

³⁸ June M. Harrington, *American Nursing and the Failed Dream: A Critical Assessment of Nursing Education in America* (2009), 125. Personal Copy.

³⁹ Martha E. Rogers, *Educational Revolution in Nursing* (New York: The MacMillan Company, 1961), 4. University of North Carolina Wilmington, William Madison Randall Library.

⁴⁰ Ibid.

⁴¹ Ibid.

⁴² As cited in Haase, 92-96.

⁴³ Ibid., 122.

⁴⁴ Ibid., 123.

⁴⁵ Ibid., 124.

⁴⁶ Kathleen M. Malloch, Doris A. Milton, and Margaret O. Jobes, "A Model for Differentiated Nursing Practice," *Journal of Nursing Administration* 20, no. 2 (February 1990): 20-26. Electronic Database, CINAHL accessed through East Carolina University, William E. Laupus Health Sciences Library; JoEllen Koerner, "Differentiated Practice: The Evolution of Professional Nursing," *Journal of Professional Nursing* 8, no. 6 (November-December 1992): 335-341. Electronic Database, CINAHL accessed through East Carolina University, William E. Laupus Health Sciences Library; Catherine Vena & Syble Oldaker, "Differentiated Practice Paradigm Using a Theoretical Approach," *Nursing Administration Quarterly* 19, no. 1 (1994): 66-73. Electronic Database, CINAHL accessed through East Carolina University, William E. Laupus Health Sciences Library; Janis P. Bellack and Renatta S. Loquist, "Employer Responses to Differentiated Nursing Education," *Journal of Nursing Administration* 29, no. 9 (September 1999): 4-8, 32. Electronic Database, CINAHL accessed through East Carolina University, William E. Laupus Health Sciences Library.

⁴⁷ Pam Pitts-Willhelm, Christine S. Nicolai, and JoEllen Koerner, "Differentiating Nursing Practice to Improve Service Outcomes," *Nursing Management* 22, no. 12 (December 1991): 12-25. Electronic Database, CINAHL accessed through East Carolina University, William E. Laupus Health Sciences Library; Bellack and Loquist.

⁴⁸ State of New York Assembly. 2009-2010 Legislative Session (January 23, 2009) S01074; State of New Jersey Assembly. 213th Legislature pre-filed for Introduction in the 2008 Session (updated as of October 10, 2008) S620/A3768.

CHAPTER 3

Methodology

This chapter discusses the rationale for the selection of historical research methodology and case study design for this research study. The chapter also details the identification of archives and other sources of primary and secondary documents used in this research, the strategies for archival retrieval, and other plans for historical data collection. Strategies used for data analysis, synthesis, and exposition are commented on briefly.

Methodology and Design

Historical case study design served as the research method and design for this study. The historical events defined as the educational pathway developments and the historical debate, and their connection to the “BSN in 10,” a contemporary event, create an overlapping of historical methodology and case study design. The form of research questions, the focus on a contemporary event, and the lack of control of behavioral events serve as the criteria for choosing historical methodology and case study design.¹

Research questions 1 and 2 guided the archival retrieval of data related to the historical debate and educational pathway developments:

1. What is the history of the resurfacing debate regarding the role and functions, the educational pathway, and the professional identity of the entry-level RN in 1873, 1916, and 1952?
2. What is the history of the decisions to develop the diploma, BSN, and ADN educational pathways in 1873, 1916, and 1952?

Research questions 3 and 4 guided the analysis of the data as it relates to Montag's Nursing Functions Continuum Practice Model and the "BSN in 10" legislative proposals:

3. Does the historical study of the entry-level RN educational pathway developments and their relationship to the historical debate reframe Montag's Nursing Functions Continuum Practice Model and, if so, how?
4. What impact might evidence from this historical study have on the decision regarding the present "BSN in 10" legislative proposals?

The presence of explanatory questions suggests the use of case study design along with historical method.²

Triangulated Case Study Design

This research study focused on past decisions to develop the three educational pathways to RN practice and their relationship to the historical debate regarding the role and functions, educational pathway, and professional identity of the entry-level RN. Historical research on all three pathway developments elicits a pattern of events. Focusing the research on only one pathway development merely results in a biographical history of that pathway. The use of only two pathway developments in the historical analysis allows for comparing and contrasting yet without the dimension that the inclusion of the third pathway allows. Researching the historical developments of the three pathways allows for a multidimensional design that elicits multidimensional representations and patterns of the past. A greater number of perspectives or dimensions captured add to the rigor of this historical research study.

Case Studies

The three decision points in history, when individuals decided to develop the diploma, BSN, and ADN educational pathways, served as the three case studies for this historical research

study. Research began with these initial schools/programs of the above developments, accordingly: Bellevue Training School for Nurses in New York, 1873; University of Cincinnati School for Nursing and Health in Ohio, 1916; and Orange County Community College nursing program in Middletown, New York, 1952. Study of the initial programs of each pathway supplies a greater understanding of the professional and socio-cultural-political context: the influences on the decision to create a new and different educational pathway to RN practice, the intended defining differences of the pathway and the graduates in practice, and the subsequent debate resurfaced by each decision to develop a new educational pathway.

As previously noted in *CHAPTER 1 – Introduction*, the historical timeline of the study begins in 1873, the year America’s nurse training schools introduced and adopted the Nightingale model for training nurses. The historical timeline of this research study extends from 1873 to 1952. This historical case study research captured evidence from the three significant events along the timeline—diploma pathway development in 1873, BSN pathway development in 1916, and ADN pathway development in 1952. The practical or vocational nurse and alternate-entry or accelerated BSN, RN to BSN, and alternate-entry MSN educational pathways do not present as separate case studies. Nursing practice provided some of the context that related to the decisions to develop educational pathways and to the historical debate.

Access to Data

The written history, built using a range of sources, exposed the researcher to multiple angles of the events under study.³ The use of both primary and secondary sources for this historical research study helped build the scientific rigor of the research and historical representation of the past that ultimately led to a more thorough analysis of the historical data.

Primary sources—original documents containing first-hand information of a person’s experience or an event—specifically enhance the rigor of historical study. A sample of the primary sources used in this study includes personal letters, position papers, and meeting minutes. The following list of archives by case study illustrates the location of the primary source documents used from the data collection for this research study:

Diploma Pathway

- Archives of the Foundation of the New York State Nurses Association, Bellevue Alumnae Center for Nursing History in Guilderland, New York.

BSN Pathway

- Archive and Rare Books Library/Blegen Library, University of Cincinnati in Cincinnati, Ohio;
- Henry Winkler Center/College of Medicine, University of Cincinnati in Cincinnati, Ohio;
- Wedbush Centre/College of Nursing, University of Cincinnati in Cincinnati, Ohio; and
- Genealogy and Local History, Cincinnati Public Library in Cincinnati, Ohio.

ADN Pathway

- Gottesman Libraries Archives at Teachers College, Columbia University in New York, New York.

Secondary sources served as equally important to complete the representation of the broader historical context and served as a resource to locate primary sources. Sources of secondary nature or second-hand accounts of historical events or experiences selected for use in

this research study include research studies, reports on nursing, books, journal and newspaper articles, and dissertations. The location of secondary sources included the following resources:

- William E. Laupus Health Sciences Library at East Carolina University;
- J. Y. Joyner Library at East Carolina University;
- William Madison Randall Library at University of North Carolina Wilmington;
- Electronic databases such as CINAHL and JSTOR; and
- Personal libraries.

Control and Collection of Data

Control over the creation, storage, and preservation of the data rests with the agencies that store the data. These agencies have control over what the researcher may view, when it may be viewed, how long it may be viewed, and how data may be collected within the archive. The researcher contacted the archivists and obtained permission to view archival data prior to data collection. The documents stored at the Bellevue Hospital and at the Gottesman Libraries Archives serve as an excellent example of limits to a study due to archival control of data. The Bellevue Hospital denied the researcher access to primary source documents known to be stored within its possession. Cross-comparison and analysis of other primary and secondary source documents replaced the preferred reading and visualization of the Bellevue Hospital documents. Gottesman Libraries also denied in-house archival retrieval. The lack of a comprehensive finding aid for the selected collections further challenged the researcher. Citations within secondary sources facilitated the researcher's discovery of known documents within the Gottesman Libraries Archives. A comprehensive list of needed documents sent to the archivist librarian resulted in most documents scanned onto a flash drive and mailed to the researcher.

The researcher maintained complete control over the process of determining significant data to this study, or which data to include or exclude from the study. Being the sole data collector and analyzer of the data, the researcher collected the data over the course of one year.⁴ Data collection began immediately after obtaining East Carolina University Institutional Review Board approval through the expedited review process (See APPENDIX A). The research plan included time for determining and documenting the genuineness and authenticity of the data throughout data collection.

Genuineness

Determining the genuineness of the data or knowing the document is real versus forged occurred while visiting the archives.⁵ Genuineness is also referred to as determining the validity or authenticity of the document.⁶ The researcher used external criticism—the process of questioning the genuineness of data—throughout the study using the principles of diplomacy and tact. Genuineness was determined through careful reading of documents, paying attention to authorship and assessing evidence of dates on documents, and by careful examination of the document's paper, ink, handwriting, and general condition. Through careful inspection and analysis, assurance that the document is what it is claimed to be ensured genuineness.

Authenticity

The authenticity of the data or the truthful reporting of the document was also determined. This is sometimes referred to as determining the reliability of the content.⁷ The researcher used internal criticism—the process of questioning the truth of the data—throughout the study. Assurance of authenticity was accomplished through questioning the following: timing of the written account in relationship to the events; credentials of the author of the written account; and

the rationale provided if suppression of data occurred. In order to support authenticity of the content, the researcher performed the following three steps:

1. Check for corroborating evidence;
2. Look for another independent primary source that supports data; and
3. Identify any disagreements between sources.⁸

The researcher served as the instrument for data collection for this historical research study. The researcher “relie[d] strictly on data created by someone other than the researcher” and served as a “human filter through which all information passe[d].”⁹ The researcher held accountability for determining not only significance but also the authenticity and genuineness of all data collected. Data collection and analysis of data occurred simultaneously as the researcher deemed the data significant, true, and genuine.

Data Analysis

Analysis of the data began during data collection as the data was organized into themes framed according to the research questions. Microsoft Word® was used for creating documents. The purpose of the study served to direct the data analysis. The researcher performed two tasks of data collection, balancing conflict and controlling bias.

Balancing Conflict

When the presence of a conflict occurred between sources of data, the researcher balanced the conflict. Supporting evidence was gathered to support either side of the argument when a conflict arose.

Controlling Bias

Researcher bias was controlled through self-awareness and disclosure. The researcher kept a journal of thoughts and feelings encountered throughout the study and repeatedly reviewed the

research questions throughout data collection and analysis to maintain self-awareness. Disclosure of thoughts and feelings occurred through discussions with the dissertation chair and committee members.

Controlling bias required immediate disclosure; holding true to feminist approach, the researcher believes that bias is not only inherently present but that it is natural. This study relates closely to the professional life of the researcher, who held the position as an ADN educator for ten years and now holds a position as an RN to BS educator. The connection with ADN education stimulated this research inquiry. Although intimately connected professionally, the researcher embraced an open mind and prepared for any possible analysis. Bracketing previous knowledge and intimate connections assisted the researcher to maintain an open mind. Bracketing was achieved to the extent possible through reflective journaling. The researcher's ability to perceive the possibility of healing for the profession through historical understanding of the resurfacing debate and sustained disorder related to multiple pathways to entry-level RN practice also permitted open-mindedness. Feminist method emphasizes trust, empathy, and nonexploitative relationships to allow healing rather than any type of deception or manipulation.¹⁰

Feminist method also embraces the notion that research is strengthened through relationships; understanding and disclosure of the relationships between the case studies and the historical debate as well as understanding and disclosure of the relationship between the researcher and the research will add to genuineness of this research study.

In addition to personal bias, source bias was considered. An example of source bias is the purposeful or unintentional exclusion of documents available to the researcher in the archive collections at the Bellevue Hospital and Gottesman Libraries. Finding aids were used when

available to locate documents. When direct access was denied to the documents or when the finding aid did not exhaustively exist, the potential of source bias by way of the archivist influenced this study regardless of intentionality. Sharing the purpose of the research with the archivist and ensuring ethical use of the documents helped alleviate purposeful source bias by way of the Gottesman Libraries archivist.

In historical research, data analysis occurs as an ongoing process as data collection proceeds. Balancing conflict and controlling bias were accomplished in this research study through diligent journaling, disclosure, and careful consideration. Analysis of data was facilitated through emergence of themes and continuous reorganization of data into a synthesized narrative of the history.

Synthesis and Exposition

As data collection and analysis occurred, the researcher displayed the synthesis of the data through the creation of a narrative account of both the descriptive and interpretative elements of the research study. Appropriate use of data and ethical considerations occurred with creation of the narrative. This included refraining from the use of data that may result in exploitative or embarrassing details because the purpose of the study is to understand the socio-cultural-political context surrounding the decisions to develop educational pathways and the historical debate, not of a particular individual, institution, or organization. Utilizing a feminist approach as outlined in *CHAPTER 1 – Theoretical Framework* and as previously noted above in *Controlling Bias*, healing rather than instigating conflict through examination of relationships also served as the purpose of this research study. Through the use of genuine data, the historical relationships between the developments and the debate facilitate a better understanding and thus allow informed dialogue within the profession of nursing. The case study chapters, *CHAPTER 4 –*

Diploma Pathway, CHAPTER 5 – BSN Pathway, and CHAPTER 6 – ADN Pathway, address the first two research questions focused on the history of the decisions to develop the educational pathways and the history of the resurfacing debate. The narrative concludes with *CHAPTER 7 – Conclusion*, focused on the second two research questions—the application of the enhanced understanding of past events and debate to reframe Montag’s Nursing Functions Continuum Practice Model and to guide decisions regarding the current “BSN in 10” legislative proposals. The narrative account is referenced using *The Chicago Manual of Style 15A* with endnotes to allow readers to check on the accuracy of the quotations, citations, and assertions.

Summary

Historical case study research enhances the nursing profession’s understanding of the socio-cultural-political context surrounding the following: the decisions to develop the diploma, BSN, and ADN educational pathways; the historical debate concerning the role and functions, educational pathway, and professional identity of the entry-level RN; and the relationship between the educational pathway developments and the historical debate. Historical case study research provides a new lens to reframe historical events by which nurses may view the future and guide decisions that may need to be made today. This historical research study provides an original perspective of the past in which to reframe Montag’s model and to guide decisions concerning contemporary events, specifically the current “BSN in 10” legislative proposals.

The use of primary and secondary sources enhanced the rigor of this historical study. Through careful collection and inspection of the data, significance of the data was determined. Bias was controlled with journaling, disclosure, and frequent review of the research questions and purpose. Narrative interpretation serves as an avenue to share the data with others. Through the collective professional history of nursing, a sense of unity and identity may be discovered.

Notes

¹ Robert K. Yin, *Case Study Research: Design and Methods*, 4th ed. (Los Angeles: Sage Publications, Inc., 2009), 8-14. Personal Copy.

² Ibid., 9-10.

³ Christine Hallett, "The Truth About the Past?" The Art of Working With Archival Materials," in *Capturing Nursing History: A Guide to Historical Methods in Research*, eds. Sandra B. Lewenson and Eleanor Krohn Herrmann, (New York: Springer Publishing Company, LLC, 2008): 154. Personal Copy.

⁴ L. K. Glass, "Historical Research," in *Advanced Design in Nursing Research*, 2nd ed., eds. P.J. Brink and M. J. Wood, (Thousand Oaks, CA: Sage Publications, Inc., 1998): 356-374. Personal Copy.

⁵ Sandra B. Lewenson, "Historical Research Method," in *Qualitative Research in Nursing: Advancing the Humanistic Perspective*, 3rd ed., eds. Helen. J. Streubert-Speziale and Dona R. Carpenter, (Philadelphia: Lippincott Williams & Wilkins, 2003): 207-224. Personal Copy.

⁶ Glass.

⁷ Ibid.

⁸ Lewenson.

⁹ Ibid.; Glass.

¹⁰ Denise F. Polit and Cheryl Tatano Beck, eds., *Nursing Research: Principles and Methods*, 7th ed. (Philadelphia: Lippincott Williams & Wilkins, 2004), 265. Personal Copy.

CHAPTER 4

Diploma Pathway

In 1873, the first American training school for nurses following the Nightingale model opened at the Bellevue Hospital in New York. The Bellevue Training School for Nurses became the model for the diploma educational pathway in America. Why a revolutionary new training school for nurses developed in America, how the development transpired, why Florence Nightingale's training school model was chosen, and why the graduates of this training school were considered different from the graduates of the already existing American schools for nurses will be explained in this chapter. The key influencers in the school's development will be highlighted and include Louisa Schuyler and Florence Nightingale. The historical debate within American nursing began with the development of the Nightingale model training school. How the debate was created will also be described.

The changing role of women within the public sphere directly correlated with the changing role of the nurse. Traditionally, the woman—because of her acknowledged natural and instinctual nurturing characteristics—held the position of nurse whether as the expert nurse within her rural community or the lay nurse within her family. Development of the Bellevue Training School for Nurses opened a new recognized profession for American middle-class women. Professionalization of nursing began to occur as a result of initiating a specific educational pathway, the Nightingale model, and establishment of a unique gender-specific partner role with associated functions for the trained nurse alongside the physician. Adoption of the Nightingale model introduced divisions of gender and class into American secularized nursing and initiated a division of nursing labor. Opportunities to create the public-recognized

profession of nursing presented through the demands and needs of both the war and the ever-growing cities and their hospitals. The social, political, and cultural context of the nineteenth century shaped the development of the Bellevue Training School for Nurses and the subsequent attempts to professionalize American nursing for middle-class women.

Historical Context

Traditional Role and Education of the Nurse Prior to 1873

The American housewife through the eighteenth and nineteenth centuries lived under the expectation to be the nurse as well as the cook, cleaner, and gardener for her family.¹ The word “nursing” referred to the caregiving practices of women, thus “women’s work” gained inclusion of nursing and medicine within the family.² The expectation that women assume the role of nurse focused on the woman’s instinctual nature to care and nurture; but, also, the role of nurse served as a practical necessity for survival of the family. A woman supported her family’s health through her nursing and medical knowledge of healing the sick.³ The task performed often determined use of the title “nurse,” yet some women, considered expert nurses by the community, held advanced knowledge and skill of nursing because of the “breadth and depth of their commitment.”⁴ The expert nurses were called upon when the domestic medicine and nursing known to the woman of the household proved unsuccessful and the care required moved beyond her knowledge and skill. Martha Ballard (1735-1812), a midwife at the turn of the eighteenth century, demonstrates the role of the expert nurse within a community. The historian, Laurel Thatcher Ulrich, brilliantly illustrates Ballard’s daily routines as an expert nurse within the community in her book, *A Midwife’s Tale: The Life of Martha Ballard Based on Her Diary, 1785-1812*.⁵

Women acquired the necessary knowledge and skill through “shared knowledge” and mere exposure and experience.⁶ Shared knowledge consisted of oral sharing and receipt books. Medicinal and culinary recipes often shared the pages of one receipt book.⁷ Few women of this time could write but most could read, thus the receipt books served beneficial to most.⁸ Women gained knowledge of caregiving through personal experiences with family and neighbors. Nursing and watching at the bedside of the sick developed from the care of children and often, just like childcare, adolescent daughters assumed the task of watching.⁹ Knowledge and skill of nursing passed from one generation of women to another through shared knowledge and mere experience.

Determined to bring the mission of the French Daughters of Charity (DOC) to America, Elizabeth Ann Bayley Seton (1774-1821) established the American Sisters of Charity (SOC) in 1809.¹⁰ The DOC served as a community of “lay women vowed to apostolic service of the poor.”¹¹ Theoretical and practical preparation of the DOC nurses included oral tradition, mentoring, and instruction through lecture, demonstration, and practice.¹² The American SOC nurses carried the same strong oral tradition and a novice sister worked under a mentor for an extended period of time.¹³ Much like the ordinary housewife, the SOC nurse learned nursing practice from another SOC nurse yet the SOC nurse, called to nursing service by God, provided nursing care in the public sphere rather than her own domestic sphere. The SOC nurses chose the hospitals in which they would work based on the ability to carry out their mission.¹⁴ A small supply of SOC nurses compared to the large demand and need for nursing care within the developing cities of the nineteenth century created an issue. The unbalanced supply and demand, coupled with the SOC nurses’ autonomy of care and choice of where to provide nursing care, left many hospitals without knowledgeable and skilled nurses to provide proper nursing care. The

hired “nurses” within the public sphere often included lower-class women and, at times, men needing to work for pay. Often the hired nurses lacked training and therefore knowledge and skill: “Though varied in motive and gender, what all these “nurses” [untrained nurses within the public sphere] shared (besides class) was ignorance as to any method or reasoned way to do their tasks.”¹⁵

It is historically important to point out that the success of the DOC nurses’ care of the sick received recognition from the Protestant pastor Theodore Fliedner (1800-1864) and led to his initiation of the German lay order of deaconesses of Kaiserwerth.¹⁶ Florence Nightingale, often referred to as the “Mother of Modern Nursing,” received her nurse training at Kaiserwerth. Nightingale envisioned an educated or trained role of the nurse within the public sphere. She believed the role of nurse belonged to women because of the nurturing qualities of the woman and that the nurse must possess a calling to care for the sick. Nightingale also believed in the revolutionary idea that the role of the nurse belonged to intelligent, middle-class women capable of learning the scientific theories underlying the rationale of nursing practice. The horrors of the Crimean War provided Nightingale an opportunity to live and prove the effectiveness of her vision.

Florence Nightingale was born in Florence, Italy, on May 12, 1820, to a prominent family. Her father believed in discipline and ensured that she received the finest education known to that day. Nightingale was thoroughly trained in mathematics, Greek, Latin, French, German, and Italian.¹⁷ In addition to her excellent academic education, Nightingale was raised to be a proper woman capable of caring for her household, family, and community. Nightingale was highly educated and brilliantly accomplished, and very early she exhibited an intense devotion to the alleviation of suffering.¹⁸ Although Nightingale received only three months of

nurse training at Kaiserwerth in 1851, her upbringing and life experiences prepared her to become a nurse. Rationalization of her short duration of formal nurse training transpires in this way:

In these days when at least three years are deemed necessary for a nurse's training, the question arises how could so short a course have been considered enough by one [Nightingale] who so fully understood the necessity of thorough preparation. The answer is that before she went to Kaiserwerth she was already a model housekeeper; she knew how to modify the home for the comfort of the sick and suffering; she had acquired sufficient knowledge of anatomy and physiology and hygiene; she knew the history of the art of nursing; and she had intently observed the actual practice of the art in her visits to the famous hospitals of Europe. She knew her lack of technical training and that is what she went there [Kaiserwerth] for.¹⁹

In October 1854, the English government pleaded for devoted women to help their soldiers in the hospitals of Scutari who were wounded and diseased because of the Crimean War. Sydney Herbert (1810-1861), England's Secretary of War, wrote a letter to Nightingale requesting that she lead a band of nurses to the Crimea to care and nurse these soldiers away from death. Remarkably, without knowledge of Herbert's letter, Nightingale also wrote a letter to him volunteering her services to organize an adequate nursing department within the army's hospitals. Nightingale, with her thirty-eight nurses, headed to the Crimea and found "thousands and thousands of sick and wounded men who had been brought from the seat of war, without nurses, without suitable food, without a laundry, without the possibility of a change of clothes, without a kitchen for preparation of proper food, with no possible conveniences or appliances for the care of the sick and the wounded."²⁰ With Nightingale's leadership, knowledge, and organizational skills, the nurses improved the sanitation and hygiene so that in just a few months, the death rate was reduced from 60 to 1 percent.²¹ The hospitals of the Crimean War under the supervision of Nightingale became models of neatness and order.

Nightingale earned the respect of the War Department of England for herself and her group of women nurses.²² She emerged from the Crimean War demonstrating two great principles: “first, that the physician or surgeon cannot work unaided, he needs an ally; second, that the ally best fitted by temperament and nature is the trained woman nurse.”²³ Teamwork between the doctor and trained nurse was necessary in nursing the sick.²⁴ Nightingale's theory concerning the environment—to include the cleanliness of air, water, and food and its influence on the health and healing of the patient—was also clearly demonstrated in the Crimean War. She grounded her theory in practice for the profession of nursing:

Nursing the sick and wounded was no longer a theory. She had proved through experience that nursing could be done successfully; the work she loved had a place; that it was a profession on a par with medical practice. The trained nurse had come into her own. A great profession was born.²⁵

In the spring of 1855, Nightingale contracted the Crimean fever. Months later when she was well enough to travel, she refused to leave the army and remained until every patient was removed from her field hospitals in 1856. The English people donated thousands of pounds to honor Nightingale and her work in the Crimean War. Nightingale refused the money for herself but put the money into a fund to establish a training school for nurses, “the first of its kind to be conducted on high and broad and pure methods and principles.”²⁶ The resultant school opened June 24, 1860, and incurred the name, the Nightingale Training School for Nurses at St. Thomas’ Hospital in England. The Nightingale Training School for Nurses proved that student nurses provide the best nursing service in the hospital when the school's main purpose remains education of the student and not gain of the hospital by taking advantage of the student.²⁷ Nightingale’s training school, the first secularized, non-ordered training school for nurses allowing middle-class women of any religious denomination a place to train to become nurses, affords her the titles of Mother of Modern Nursing and the Creator of Nursing as Trained

Profession. Nightingale provided a “new and high calling for woman, [sic] in opening for them a new profession, a new sphere of usefulness.”²⁸ The new profession of nursing was “at first almost the only pathway by which ambitious young women could win their independence.”²⁹ Harriet Martineau (1802-1876), an English social theorist, prepared Nightingale’s obituary in the summer of 1856 for she believed Nightingale’s death imminent due to Crimean fever. Within the obituary, Martineau acknowledged Nightingale’s contribution to patient care and the professionalization of nursing:

It is no small distinction to our time that it produced a woman who effected two great things;—a mighty reform in the care of the sick, and an opening for her sex into the region of serious business in proportion to their ability to maintain a place in it.³⁰

Nightingale did not die in 1856 at the age of 36 but continued to contribute to nursing through oral and written consultation until her death on August 13, 1910, at 90 years and 3 months. Nightingale’s nursing care during the Crimean War proved instrumental in the development of the International Red Cross and the women’s branch of the U.S. Sanitary Commission, the New York Women’s Central Association of Relief (WCAR) for Civil War wounded soldiers.³¹ Women who worked within the New York WCAR developed the Bellevue Training School for Nurses.

Nightingale combined the calling to serve, womanly attributes, and theoretically based rationale of techniques to introduce a new concept, the trained nurse. Nightingale depended on the socially acceptable beliefs regarding division of gender to create the public role of the trained nurse for middle-class women. Her desire for intelligent, middle-class women to assume the trained nurse role created a division of class between the trained and untrained nurses and an informal division of labor within nursing. Nightingale’s model for training nurses and her vision

of the role and functions of the trained nurse served as the philosophy and mission of the Bellevue Training School for Nurses.

Changing Role of Nineteenth Century Women

The American Industrial Revolution and the resultant development of urban cities shifted the role of women in American culture. The shift from hand and home production to machine and factory production moved women's role from one strictly within the domestic sphere to one involving the public sphere. Middle- and upper-class women of the early nineteenth century focused on benevolence and moral reform of American society.³² Movement into the political arena proved inevitable as women used their superior morality to effect change on broader social and political issues. The Civil War provided middle- and upper-class women an opportunity to move the corporate-like organization of reform and relief "to new heights of organizational fervor in the work of supplying the army, training and sending nurses and agents to the front, and establishing local and regional centers for the systemization of their work."³³ Civil War benevolent workers established the Sanitary Commission, "the first centralized, quasi-public organization for relief of Northern soldiers."³⁴ The men and women who worked for the Sanitary Commission have been criticized for the perceived motive of their efforts. One historian refers to the men and women of the Sanitary Commission as the "Sanitary Elite" motivated to guide "the nation through its period of greatest stress to assert their own class, ideological, and regional prerogatives in the postwar society."³⁵ Louisa Lee Schuyler (1837-1926), one of the "urban elite" and great-granddaughter of Alexander Hamilton, served as a chairman of the New York Women's Central Association of Relief (WCAR) for Civil War wounded soldiers, the largest branch of the U.S. Sanitary Commission.³⁶ The first objective of the New York WCAR concerned "organization of a committee composed of women and doctors to select candidates to

nurse Union soldiers in Army hospitals.”³⁷ The committee referred to Nightingale’s experience during the Crimean War to select and prepare the women sent to nurse the Union soldiers.³⁸ Interestingly, the Bellevue Hospital and the New York Hospital served as the training sites for the selected women “to receive a month’s practical training in their wards.”³⁹ Schuyler’s work with the New York WCAR, specifically in relation to providing nurses to the Union Army, holds a direct link to her work to develop the Bellevue Training School for Nurses.

Medicine Becomes a Learned Profession

During the eighteenth century, America developed a closer relationship with England, providing men greater access to medical knowledge than women.⁴⁰ American society welcomed the new medical knowledge not only because society viewed education as a greater utility but also the new medical knowledge appeared to promise greater efficacy in treating the sick.⁴¹ The American Medical Association, formed in 1847, worked quickly to create a code of ethics and focus on medical education reform.⁴² The 1850’s served as “a decade of professional consolidation [for medicine] marked by the struggle of members of the lower ranks to disassociate themselves from trade by claiming a place within a recognized, organized profession.”⁴³ Medicine transformed from a learned specialty to a full time profession.⁴⁴ As medicine defined its scope of practice, “medicine claimed the right to set the limits of nurses’ work.”⁴⁵

Medical men carried an aura of learning compared to the expert nurses and midwives who claimed authority of experience.⁴⁶ With physicians’ new professional status, members of most communities now possessed a choice. When illness or injury arrived, families chose between their traditional healing practices of the woman nurse in the family, the expert woman nurse of their community, or the learned male physician. The patients within the public hospitals

lacked choices; the medical students and learned male physicians accompanied by untrained, lower-class nurses provided the care in most public hospitals.

Women in College

Women gained admission into college as well during the late nineteenth century yet the instruction received varied greatly from that which men received. The philosophy of instruction for women focused on the “virtuous, True Womanhood, but within its framework extended woman’s sphere beyond the familial roles.”⁴⁷ The college preparation was “not intended to fit woman for any particular sphere or profession but to develop by the most carefully devised means all her intellectual capacities, so that she may be a more perfect woman in any position.”⁴⁸ Medicine resisted the inclusion of women into the developing profession for no medical school admitted women, yet a “few hardy females...recognized the need for women physicians to concentrate on the health of women and children” and broke the barrier by finding “sympathetic doctors” to train them through apprenticeships.⁴⁹ Elizabeth Blackwell (1821-1910) finally gained admission to Geneva College Medical School because of the evidence of her success as a medical practitioner. Blackwell later instituted a separate medical training for women within her New York Infirmary for Women and Children. Medicine’s experience with the “strong-minded women” who forced entry into medicine tainted medicine’s reaction to the future development of nursing because of the medical women and nurses’ shared gender.⁵⁰

The Development of the Diploma Pathway

New York State Charities Aid Association

After the Civil War and working for the New York Women’s Central Association of Relief (WCAR) for Civil War wounded soldiers, Schuyler recognized her potential as an administrator and leader and turned her attention to the poor and sick of New York State.⁵¹

Schuyler founded the New York State Charities Aid Association, the “most influential and notable of its kind in the country” in 1872.⁵² The association developed a system of visitation to state-aided charitable institutions by volunteer committees of citizens. The association was formed on the “principle that every citizen has an obligation to see that the public institutions are well and humanely administered.”⁵³ Upon invitation by General James Bowen (1801-1886), the president of the Board of New York City’s Commission of Charities, Schuyler, Bowen, and Mrs. David Lane visited Bellevue with the idea that the work of the association might be extended to the hospital. After just one exposure to the deplorable conditions at the Bellevue Hospital, Schuyler and Lane determined the only solution would be to supply trained nurses for the care of the sick through the establishment of a training school for nurses for “no permanent improvement in the condition of the hospital could be made until the nursing service was radically changed.”⁵⁴ Schuyler and Lane, through their previous participation with the New York WCAR, gained knowledge of Florence Nightingale’s success in the Crimean War and witnessed success of the nurses trained and sent to nurse the soldiers of the Civil War. Their exposure and experience with middle-class “trained nurses” most certainly influenced their desire to add trained nurses rather than increase the medical staff with male or even female physicians. Schuyler apparently adopted Nightingale’s vision of middle-class, trained nurses holding a needed and valuable as well as distinct yet complimentary gender-specific role to the physician in the care of the patients.

The establishment of a training school at the Bellevue Hospital became the mission of the New York State Charities Aid Association, yet more evidence was needed to produce a proposal with the strength to convince the appropriate authorities of the hospital and city, all of whom were men and many of whom were physicians. The association then formed a subcommittee on

January 26, 1872, to thoroughly investigate the conditions of the Bellevue Hospital.⁵⁵ The subcommittee was composed of fifty-three “public spirited women” chaired by Mrs. Joseph Hobson (1831-1912), and known as the Local Visiting Association of Bellevue Hospital.⁵⁶ The women visited the hospital “regularly and systematically” to observe the conditions of all the wards, and visits began immediately the next day on January 27, 1872.⁵⁷ Each woman received direction to record her observations with great detail. The detailed reports were intended to provide enough evidence to generate the reform to improve the physical, mental, and moral treatment of the patients through the establishment of a training school for nurses at the Bellevue Hospital.⁵⁸

Conditions at the Bellevue Hospital

The Local Visiting Association of Bellevue Hospital visited the hospital for several months beginning January 27, 1872, resulting in a comprehensive record of the quality of care provided to the patients. The actual reports are not presently accessible, yet numerous publications throughout the century provide similar accounts of the observations of the Local Visiting Association of Bellevue Hospital volunteer members.

The condition of the hospital was desperate and the lack of equipment and supplies immediately noticed. The hospital was infested with rats that scurried about among the patients during the night.⁵⁹ There was only one lone man responsible for the laundry of the entire hospital. In addition to the lack of assistance for his enormous task, he was found to be without laundry soap for the past six weeks.⁶⁰ In the kitchen, there was only one cook for the entire hospital and one cauldron was found to be used for the soup, tea, and coffee alike.⁶¹ The arrangement of the kitchen plumbing was awkward, leaving the floor soaked with dirty water slowly making its way to the central drain.⁶² It was noted that the eating utensils were piled on

the floor above the drain and merely rinsed off between the patients' use.⁶³ The food was transported to the hospital across a 100-foot courtyard by hand regardless of the weather.⁶⁴ The trek across the courtyard and the long wait before the patient received the food often resulted in cold food served to the patients.⁶⁵ During one visit, the volunteer witnessed the food being placed directly on the boards of the table because the hospital lacked an adequate number of clean plates on which the food could be served.⁶⁶ The feeding of patients was noted to be "spasmodic and cannot be relied on."⁶⁷ The volunteers soon recognized the dangerous behavior of the doctors and surgeons using the same sea sponges to clean the wounds of multiple patients one after another without disinfection.⁶⁸ Although the hospital lacked adequate supplies and personnel, it was the care of the patients, or lack of care, by the existing personnel that provided the strongest evidence that trained nurses were needed. Over the course of the visits made by the members of the Local Visiting Association of Bellevue Hospital, physical conditions within the hospital did slowly improve. The number of personnel and cleanliness of the supplies and hospital itself made steady improvements yet the care of the patients still remained undesirable.

The visiting volunteer members discovered that "Bellevue was a hospital where patients were neither nursed, fed, nor clothed as humanity demanded."⁶⁹ Patients were left unattended or attended by individuals without proper knowledge of nursing the sick. Many of the attendants, referred to as "nurses," were illiterate women hired at a very low wage. The untrained and uneducated women were assisted by prisoners serving their time through hospital service or by convalescent patients who were glad to find a home in the hospital.⁷⁰ In 1824, a law was passed in New York stating that each county possess at least one poorhouse.⁷¹ Within this law, individuals convicted as disorderly persons might also be committed to a poorhouse to serve out their sentence. Within the confines of New York City, the court could commit to the Bellevue

Hospital “habitual drunkards, prostitutes, petty thieves, drug addicts, sex perverts, and charlatans.”⁷² The lack of emphasis placed on securing adequately educated and experienced nurses is evident in the care provided and the behaviors of those charged with caring for the sick at the Bellevue Hospital.

At the start of the visits, only three night watchmen attended to more than 600 to 800 patients throughout the night.⁷³ It was noted that these men drugged the patients that they assumed would require their attention. The night watchmen also drank the patients’ stimulants themselves rather than administer the stimulants to the patients. Throughout the day and night, medicines were casually given to the patients. One of the volunteer members, Mrs. Griffin, wrote in the account of her May 11, 1872 visit:

Found Annie Shay crying for opium...The night nurse, who had been employed to watch her after the operation, had given her large doses at her own discretion to keep her quiet and had then helped herself to Annie’s brandy for her own gratification. Proofs of the pernicious nursing in the Hospital that an ignorant woman has the power to dose a patient with opium, and that the brandy should be left by the bedside to be taken by whoever may choose.⁷⁴

Another night nurse who had spent time in an insane asylum after the shock of her husband dying within the hospital from a throat tumor “drove her crazy” was charged with the care of three wards when “she does not look fit to take charge of one ward.”⁷⁵ Attendants and nurses were “supposed to visit each ward every half hour, to attend to the dying and to lay them out” during the night.⁷⁶ The nurses expressed to the members of the Local Visiting Association that the amount of work assigned to them was much more than they could accomplish, leaving some of the nurses with feelings of remorse when work was left undone. Despite the near excellent medical and surgical care provided by the physicians and surgeons, patients were dying after simple operations and minor acute illnesses and injuries because of the lack of adequate nursing care. Although conditions of private hospitals were “superior to” or “much better than” the

public institutions like Bellevue, the idea that nurses should be educated or trained was still considered “revolutionary.”⁷⁷ By the end of the summer of 1872, the association felt that it “had effected all reforms it can hope for *until the nursing system is changed.*”⁷⁸ It was time to propose the training school to the appropriate authorities. Both the Commissioners of Charities and the Medical Board of the Bellevue Hospital would need to consent to opening a training school for nurses. Schuyler decided to first “broach the subject” with General Bowen, the president of the City Commissioners of Charities, a “friend” to the Local Visiting Association of Bellevue Hospital.⁷⁹ After months of collecting evidence, Schuyler approached General Bowen with the proposal to open a training school for nurses following Florence Nightingale’s model. General Bowen had never heard of such a school and Schuyler assured him that “this is not surprising, for there are none in this country.”⁸⁰ Despite his ignorance, General Bowen was willing to learn more about the revolutionary concept, the middle-class trained nurse. Schuyler introduced General Bowen to Nightingale’s philosophy of the trained nurse’s role and the model for training nurses.

Gaining the Authorities’ Consent

A week after their initial meeting, General Bowen returned to Schuyler’s home and consented to the proposal yet with a condition—a condition that no money would need to be spent by the city or the hospital. Although General Bowen promised to advocate the training school proposal with his colleagues of the City of Commissioners of Charities and the Bellevue Hospital Medical Board, “he frankly said he could not undertake to get an appropriation for the School.”⁸¹ Bowen assured Schuyler that the hospital would pay the Visiting Committee what it cost the hospital to run the wards but any additional expense would be the responsibility of the school.⁸² The new training school would need to be financially separate from the hospital.

When the Visiting Committee introduced the proposal to the other commissioners of the City Commissioners of Charities and the members of the Bellevue Hospital Medical Board, they received much opposition. Most of the physicians opposed educating women to become nurses. These physicians believed an educated nurse “would probably be independent and assertive...not amenable to discipline.”⁸³ The physicians held concerns that the trained nurse would challenge their orders and plan of care. The physicians wanted women “who will do as they are told.”⁸⁴ Not every physician held this conservative viewpoint. Actually in England, decades prior, the medical men urged the development of a “supply of good nurses” through the creation of “a calling...almost said a profession—by which an intelligent and worthy female may, at an early age, gain an honourable [sic] independence.”⁸⁵ Nightingale strategically molded a subordinate, gender-specific role of the trained nurse within a separate sphere of sanitation and hygiene to meet the needs of patients under the care of the medical men without raising the physicians’ perceptions of competition within the medical or surgical sphere. Medicine failed to develop and train male attendants to carry out the proposed role of the trained nurse again because of fear that the male attendants would infiltrate the medical hierarchy.⁸⁶ Nightingale’s “representation of nursing as subordinate to, but also wholly different from, medical practice” facilitated medicine’s acceptance of the trained nurse role.⁸⁷ Nightingale’s use of the socially acceptable division of gender facilitated the creation of the trained nurse role, yet served to challenge professionalization efforts through education for American nursing.

Interestingly, in 1868, just five years prior, the president of the American Medical Association (AMA), Dr. Samuel D. Gross (1805-1884), commented in his opening address at the AMA annual meeting:

I am not aware that the education of nurses has received any attention from this body—a circumstance the more surprising when we consider the great importance of the subject. 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 principal towns and cities in the Union, institutions for the education of persons whose duty is to take care of the sick.⁸⁸

Possibly, Dr. Gross, aware of England's view of nursing and Nightingale's success in the Crimean War, embraced the principles and role of the middle-class, trained nurse and therefore accepted the gender-specific nature of the role. Fortunately, a few other physicians at the Bellevue Hospital held Dr. Gross's perspective, and they supported the idea of the establishment of the training school. One particular doctor, Dr. Walker Gill Wylie (1848-1923), served instrumental in the Local Visiting Association's entire process to open the school. Dr. Wylie assisted the association visitors with their observations within the hospital during the previous several months.⁸⁹ He guided the visitors to ensure they would observe the problem areas of the hospital. Now, as the commissioners and board members considered the proposal, the association prepared a plan for the organization of the school. Dr. Wylie agreed to travel to Europe to study the Nightingale model for training nurses and "get the practical information" needed at his own expense.⁹⁰ Dr. Wylie traveled to St. Thomas' Hospital and witnessed the Nightingale model in action. He held hopes to interview with Nightingale but such an interview never occurred; however, Nightingale addressed Dr. Wylie in a letter, outlining "the fundamental principles of the management of a training school."⁹¹ Nightingale's letter served as the sole document that outlined the standards of a Nightingale model training school and guided the formation and continued operation of the school for many years to come. The association members regarded Nightingale's letter as the "Constitution of our School."⁹²

After Dr. Wylie's visit to Europe, the plan for organization of the school reached completion in September 1872. The association provided the plan to the Hospital Board, which in turn passed it to the commissioners, and the proposal to develop the training school received

acceptance. The Bellevue Hospital Medical Board and, reluctantly, the City of Commissioners for Charities accepted the proposal and plan awarding the Local Visiting Association six wards of the Bellevue Hospital for the training of nurses but with the strict condition of no additional cost to the hospital.⁹³ Perhaps the medical board and commissioners thought the school might never open without comprehensive financial support from the hospital. Although the city and hospital refused to financially support the training school, the hospital and city ultimately held control of the success of the school through the power to grant or deny access to the hospital wards and patients, thus paternalistic control of nurse training began.

Funding the School

Once the Local Visiting Association received acceptance of the proposal and plan, the group quickly advertised the new development and appealed to the public for funds to establish the school. Surprisingly to all, funds in the amount of \$23,000 were collected within six weeks. Astonishingly, in January of 1873, the physicians publicly supported the development of the training school and requested funds from the community. The leaflet, signed by “eminent physicians and surgeons,” read:

Having long felt the great necessity for trained, intelligent nurses, we hail with pleasure the project of establishing a Training School for Nurses in this country. The plans prepared meet our hearty approval, and we trust the public will contribute promptly and liberally to a cause which will benefit all classes in the community.⁹⁴

Quite possibly, the Local Visiting Association’s plan with inclusion of Nightingale’s letter and Dr. Wylie’s report of his visit to St. Thomas’ Hospital prompted additional research by the physicians or dampened the fear of competition for Nightingale stressed the gender-specific, subordinate role of the nurse to the physician. With increased knowledge of the revolutionary concept of a middle-class trained nurse as a gender-restricted partner in caring for the sick, the

physicians and surgeons decided to publicly support the establishment so they could witness firsthand the results of this experiment.

Search for Students and a Superintendent

Immediately, the Local Visiting Association began advertising for qualified applicants to become the first cohort of students. Many applications came in, but few met the strict requirements provided by Nightingale. The role of the trained nurse not only fought against medicine's opposition of gender but now the battle of class had to be won in America. The image of the paid nurse role in hospitals belonging to lower-class women had to be dissolved. Ultimately, six students were accepted to begin their training at the Bellevue Hospital Training School for Nurses. The association found a house near the hospital to serve as the nurses' home. The house would provide comfortable quarters for the student nurses while off-duty. Despite all provisions that were now in place, in April 1873, the school still lacked a qualified and experienced superintendent.

Finding a superintendent of nurses became the most difficult task for the Local Visiting Association. The association had advertised, searched, and researched for someone capable to be the superintendent of nurses for a Nightingale model training school but without success. Because the position for a superintendent of nurses remained unfilled, the association feared delay of the opening of the school planned for May 1873, or worse, the school might never open. Less than one month before the school was scheduled to open, Mrs. Hobson received an unexpected visitor at her home—a qualified nurse willing to fill the position of the superintendent of nurses for the Bellevue Hospital Training School for Nurses. Sister Helen Bowdin (1827-1896) of the All Saints' Sisterhood was on a leave of absence from the University College Hospital in London. Sister Helen had completed the establishment of a Sisterhood in

Baltimore and therefore would remain in America for a while longer. She offered her services to the association to assist in the establishment of the Bellevue Hospital Training School for Nurses.

The Constitution of the School: Nightingale's Letter

Three major fundamental principles outlined in Nightingale's letter to Dr. Wylie served as the founding principles for the establishment and continued operation of the Bellevue Training School for Nurses. The principles focused on divisions of gender and class or, more specifically, the nurses' role in relation to the physician, the uniqueness of training of the nurse, and the supervision and discipline of the nurses.

Due to the immediate opposition to the establishment of the school centered on the anticipated interference of the nurse in the medical plan of care, Dr. Wylie asked Nightingale to address "the instructions, the duties, and position of the nurses in distinction from those of medical men."⁹⁵ Nightingale firmly declared:

Nurses are not "medical men." On the contrary, the nurses are there, solely there, *to carry out the orders of the medical and surgical staff*, including, of course, the whole practice of cleanliness, fresh air, diet, etc. The whole organization of discipline to which the nurses must be subjected is for the sole purpose of enabling the nurses to carry out, intelligently and faithfully, such orders and such duties as constitute the whole practice of nursing.⁹⁶

Nightingale also stressed the need for the training to include "*the reason* why this is to be done *this* way and not *that* way."⁹⁷ Understanding the rationale behind the techniques elevated the nurse's knowledge to that of a trained nurse rather than a woman with trial and error experience and expertise in caring for the sick. Teaching the rationale eventually transformed the curriculum to include instruction in the sciences such as biology, anatomy, physiology, and so on. The ability to understand and grasp the rationale of nursing techniques required a higher class of women to enter nursing in comparison to the uneducated, lower-class citizens that currently

held the “nurse” positions within the Bellevue Hospital. Nightingale’s model illustrated the role of the trained nurse as an assistant to the physician that provided an intelligent and skilled extension of the physicians’ hands functioning to manipulate the patient and his environment to allow natural healing following medical and surgical care.

Due to the distinct gender-specific, role difference between nurses and medical men, Nightingale insisted that the nurses “*must* be, for discipline and internal management, entirely under a woman, a *trained* superintendent, whose whole business is to see that the nursing duties are performed according to this standard.”⁹⁸ Since nursing is uniquely and inherently different than medicine, only a trained nurse can supervise and discipline the nurse and her performance of nursing tasks. Nightingale’s principle supports autonomy of the profession of nursing. She further supports a system or hierarchy of women that care for the sick and have a distinct superior to whom to report and from whom to accept orders and discipline. Such a system is orderly and provides a means to enforce accountability of the care one provides.

Forward Aims of the Training School

A report of the Hospitals Committee of the State Charities Aid Association, dated December 23, 1872, outlined the forward aims of the development of the training school at Bellevue.⁹⁹

Although the nursing of only six wards would be controlled by the school upon its opening, over time the association proposed to “benefit not only Bellevue, but all public hospitals, and also to train nurses for the sick in private houses and for the work among the poor.”¹⁰⁰ This statement reflects the broader influence that the trained nurse would have on the community as a whole and also reflects Nightingale’s philosophy. Nightingale envisioned the nurse’s territory for sanitation and hygiene reform to expand from the patient’s body to the

patient's room and eventually to "the alleyways of crowded slums, the narrow streets where sewage runs, entire neighborhoods and urban districts."¹⁰¹ The school would serve beyond the walls of the Bellevue Hospital through the transformation of the nurse into a middle-class, trained nurse whose expertise and knowledge would promote the health and welfare of the greater community. The trained nurse "becomes a public agent of moral reform" as she monitors the home environment of the poor.¹⁰² The founders of the Bellevue Training School for Nurses essentially identified three possible practice roles for the Bellevue trained nurse graduate: skilled hospital nursing, private duty nursing, and community health or public health nursing.

The association members envisioned a greater educational resource for nurses in the future. They hoped to establish a "college for the training of nurses, which will receive a charter from the State, and become a recognised [sic] institution of the country."¹⁰³ They also envisioned the students would receive a diploma or certificate after completion of their training that would be renewable at fixed periods. The diploma or certificate would "protect the public from imposition."¹⁰⁴ Such desires would clearly delineate and define a division of labor in nursing between the trained and untrained nurses. The association's forward vision of the education and regulation of the trained nurse proved accurate and, eventually, partially realized as will be discussed in later chapters; however, immediately Bellevue graduates offered an educational resource, a pool of trained nurses capable to serve as superintendents of nurses. The Bellevue Training School for Nurses opened its doors to not only train nurses to care for the sick but also teach future nursing students and supervise schools for nurses.¹⁰⁵ This role of teacher as well as nurse was supported by Nightingale.¹⁰⁶ Graduates of Bellevue, a Nightingale model training school, were considered different because of the training they received. Graduates of the Nightingale model training schools became the trained nurses, thus beginning the differentiation

and division of nursing labor between the middle-class trained nurses and those not trained in the Nightingale model and other lay caregivers.

The Historical Debate Begins

If a nurse was trained or untrained depended on whether the training school she attended followed Nightingale's model for training nurses. Analyzing a debate regarding which school should receive the title as the first training school in America best illustrates Nightingale's fundamental principles that compose her model.

On July 7, 1915, Dr. Mary Forrester Hobart (1851-ca. 1930), a member of the Committee of the Training School and member of the Board of Directors of New England Hospital for Women and Children in Boston, Massachusetts, initiated a ten-letter, two-year correspondence with Louisa Schuyler, at that time, an honorary Member of the Bellevue Training School for Nurses and Vice President of the State Charities Aid Association in New York. The purpose of Hobart's initial letter included a request for Schuyler to privately correct newspaper statements naming Bellevue Hospital Training School for Nurses the first training school for nurses in America and thus giving the New England Hospital for Women and Children said title.

Schuyler initially responded with a declaration that Bellevue's school opened May 1, 1873 and "was the first school of its kind attached to a general hospital in this country, and modelled [sic] upon Miss Nightingale's Training School at St. Thomas' Hospital, London"¹⁰⁷ Beyond the fact that the Bellevue training school followed the Nightingale model, Schuyler emphasized the broader student experiences of Bellevue student nurses to that of New England's specialty hospital. Dr. Hobart counter argued that New England offered medical, surgical, and obstetrical experiences to its students from its inception whereas Bellevue did not offer obstetrical cases until three years after its development.¹⁰⁸ Schuyler agreed but reemphasized the

vast number of various cases available to the students within the Bellevue Hospital due to its mere size and number of beds occupied by men, women, and children alike; “during the first year, it [Bellevue Training School] covered five wards only...these representing about twice the number of beds of the New England Hospital for Women and Children.”¹⁰⁹ The issue argued by Dr. Hobart and Schuyler centers on the comprehensive nature of the training to adequately prepare the student to become a trained nurse. The varied experiences of just these two schools demonstrate the lack of standardization or sameness among the many training schools in America.

Dr. Hobart also declared that the New England training school provided better instruction than Bellevue within the first year of each training school. She based this declaration upon the opinion of Linda Richards (1841-1930), known to be the “first trained nurse in America” and who graduated from the New England Hospital School for Women and Children in 1873.¹¹⁰ Richards began her work at the Bellevue Hospital in the fall of the same year as a night superintendent, “where she so proves her capacity and organizing power, and so completely masters the Nightingale system under Sister Helen.”¹¹¹ Schuyler essentially credits Richards’s time working at Bellevue as completing her training to become a trained nurse. Dr. Hobart quotes Richards in one of her letters:

We must give due credit to Bellevue, of which I am very fond. Bellevue did fulfil [sic] the requirements in regard to Nurses' Home and Superintendent of the school; Sister Helen was a splendid disciplinarian and an excellent organizer, but I think her knowledge of nursing was limited. The New England Hospital training school had better and more systematic instruction to nurses, during the first year, than did Bellevue.¹¹²

It is important to note that New England’s training for nurses was only one year in length whereas Bellevue’s training lasted two years initially after it opened in 1873.¹¹³ Schuyler resolved the issue of Richards’s known title as the first trained nurse through rationalizing

Bellevue's contribution to her limited training after graduation from New England's school. Schuyler did not directly address Richards's opinion of instruction at Bellevue or of Sister Helen's expertise; she allowed her description of Sister Helen within a previous letter to be sufficient argument against such claims:

She was "Sister Helen" of the Protestant order of All Saints, a former Superintendent of London University College Hospital, where the Nightingale System had been adopted. For three years Sister Helen was the capable and devoted superintendent of the Bellevue School, after which she returned to England. A strict disciplinarian, she commanded both the respect and affection of her pupils; and under her were trained many a nurse to whom we are indebted for the organisation [sic] of our schools in this country.¹¹⁴

Schuyler did, however, change the focus of the disagreement to the principles or standards of a Nightingale modeled school.

The standards or principles that were discussed between Dr. Hobart and Schuyler included: the availability of a nurses' home apart from the hospital, the credentials of the superintendent of nurses, and the organization of the school as a separate and distinct part of the hospital.

The discussion of the nurses' home served to define "apart from the hospital." The women concluded that the nurses' home must provide a place in which the student can get away from the wards and hospital work to allow for relaxation and rest but not necessarily within a separate building. Nightingale illustrates the purpose and structure of the nurses' home as a means of "providing a real home, within reach of their work, for the nurses to live in...a home where any good mother, of whatever class, would be willing to let her daughter, however attractive or highly educated, live."¹¹⁵ Bellevue's nurses' home was housed in a separate building thus meeting Nightingale's requirements. Dr. Hobart and Schuyler disagreed as to whether the separate rooms situated between the wards provided to the students at New England met Nightingale's requirements.

Nightingale insists that the superintendent for nurses, who internally manages and disciplines the students, must be “a woman, a *trained* superintendent, whose whole business is to see that the nursing duties are performed according to this standard.”¹¹⁶ Nightingale further defines the training of the superintendent of nurses at the World’s Fair in Chicago in 1893, as a “trained nurse.”¹¹⁷ The New England Hospital utilized a woman doctor to carry the dual role of resident physician and superintendent of nurses because as Dr. Hobart explains, with “the smaller number of patients in those early days, together with a limited number of pupils, it would have been extreme to have appointed a separate Superintendent of Nurses, when one thoroughly competent woman physician could so ably combine the duties.”¹¹⁸ Obviously, New England focused on the gender of the superintendent rather than the training or expertise of the superintendent; a similar problem noted with the utilization of the untrained nurse within nursing’s informal division of labor. In 1872, Dr. Susan Dimock (1847-1875) reorganized the New England training school after “she had visited Miss Nightingale and made herself thoroughly acquainted with her methods of teaching.”¹¹⁹ Despite Dr. Dimock’s acquaintance with Nightingale, the New England training school “did not conform to the exact letter of the Nightingale System” but “it did embody the spirit of that system most adequately,” according to Dr. Hobart.¹²⁰ Bellevue’s training school did secure a Nightingale trained superintendent of nurses, Sister Helen Bowdin as previously noted, and Schuyler showcased the difficulty Bellevue faced in securing a qualified superintendent:

Apparently there was not a woman in the country who had been trained in a Nightingale School, not one who knew how to introduce the new system....an English woman appeared, most unexpectedly, and offered her services. She was “Sister Helen” of the Protestant order of All Saints, a former Superintendent of London University College Hospital, where the Nightingale System had been adopted.¹²¹

The definitive characteristics of the superintendent of nurses who must internally manage and discipline the students according to Nightingale included the gender of woman and the expertise of a trained nurse. Bellevue secured such a superintendent and New England did not. The very nature of the dual role of resident physician and superintendent of nurses carried by a woman at New England challenged the third principle of the Nightingale model—that the school must be organized as a separate and distinct part of the hospital. Schuyler recognized this as a challenge for New England Hospital because of the use of a woman physician within the described dual role and argued: “This would make the organization of the school, as a separate and distinct part of the Hospital, an impossibility.”¹²²

Schuyler indicated that the organization of the school, according to Nightingale, must be a separate and distinct part of the hospital by having “its own managers or committee, who, with the Superintendent, are to plan and provide for its curriculum and instructors.”¹²³ These exact words are not found within Nightingale’s 1872 letter to Dr. Wylie, yet Nightingale outlines, in an 1867 paper, the needed relationship between nursing and the hospital authority for efficient nursing. She explains the need for autonomy of the nursing system within the hospital by nursing maintaining control over nursing and keeping control away from the medical staff. The nursing establishment would answer and report to the hospital board or committee that had governing authority over the hospital, not necessarily the medical staff. Nightingale essentially suggested the same as what Schuyler described. Nightingale required an autonomous, although not uncontrolled, nursing establishment within the hospital. Such a structure would allow nurses to supervise and discipline nurses and make decisions regarding nursing care. The Bellevue Hospital Training School for Nurses did secure an autonomous structure through a separate board or committee that governed the school. New England Hospital for Women and Children,

as pointed out by Schuyler, did not have a separate board or committee that governed the school. Dr. Hobart argued that “no friction between our Hospital and our Training School [existed]; each was necessary to the other, and the School was upheld and encouraged by the Board of Directors and the Medical Staff.”¹²⁴ Woman physicians, not nurses, developed and governed the school, in addition to the instruction of the students within the school of the New England hospital—this violates autonomy of nursing as suggested by Nightingale.

Fundamental differences in beliefs of division of gender existed between the individuals of the Bellevue Training School for Nurses and the New England Hospital School for Women and Children. The predominantly female gender of New England authorities softened their interpretation of Nightingale’s principles and training school model. Conversely, Bellevue fully adopted Nightingale’s division of gender principles and held tighter to Nightingale’s principles and model to maintain the accepted gender-specific role of the middle-class trained nurse. Whether New England or Bellevue should hold the title as the first training school—and thus the graduates earn the title of trained nurse—depends on the gender philosophy held by the evaluator. Lack of uniform standards and principles of the numerous training schools for nurses during this time period moves the argument to be indeterminable. Divisions of labor, class, and gender challenge the resolution of this disagreement and will continue to challenge the professionalization of American nurses for years to come.

Summary

Changing Role of Women Parallels the Changing Role of Nurses

As the role of women moved beyond the domestic sphere into the public, the role of nurse also moved into the public sphere. The advancement of medicine and medical education along with the development of public hospitals called for a new role of the nurse within the

public sphere. Despite medicine's advancing techniques, a need for a trained attendant or assistant role to partner in the care of the sick proved critical. Medical men's insecurity and fear of competition and mutiny resisted the development and use of intelligent partners in care regardless of gender. Florence Nightingale successfully molded the role of the middle-class trained nurse to encompass womanly attributes and intelligence into a subordinate and distinct, gender-specific role from that of the physician. She further challenged the issue of class by calling for middle-class rather than the traditional lower-class women to fulfill the paid trained nurse role. Nightingale utilized division of gender and class to create the trained nurse role and thus created a division of labor within nursing. Nightingale's success in healing the sick and injured soldiers during the Crimean War gained worldwide attention and her philosophy of the trained nurse and the model of her training school served to design the American trained nurse. The American training schools rapidly developed "from three in 1873 to approximately 1,600 by World War I."¹²⁵

Resolution to the Debate: Quest for Standardization

As illustrated within one isolated debate between two individuals, standardization or sameness among the American training schools for nurses did not exist and thus created a disordered division of labor within nursing by educational preparation. Interpretation of Nightingale's principles varied, creating distinct differences in the training of nurses. Such differences resulted in a disordered identity of the trained nurse and disordered division of nursing labor. As the development of training schools proliferated in America, superintendents of nurses began to communicate with one another. Eventually, the first American national nursing organization developed in 1893—the American Society of Superintendents of Training Schools for Nurses.¹²⁶ Upon the proposal and approval for the establishment of the organization, the

organization's object was "to advance and perfect the practice of nursing and to elevate the profession."¹²⁷ The major focus of the organization centered on development of uniform educational standards in nursing; "unification was identified as a key to the development of a respected profession."¹²⁸

The inception of the Nightingale model for training nurses into America beginning with the Bellevue Hospital Training School for Nurses initiated standardization efforts and the development of a recognized profession for nursing in America through a division of nursing labor based on training. The historical debate, rooted with divisions of gender and class, began in America with creation of the trained nurse; the role, educational pathway, and identity of the nurse was yet to be fully determined as the American Society of Superintendents of Training Schools for Nurses began its work. Continued divisions of gender and class created by the adoption of the Nightingale model challenged the work of the organization.

Notes

¹ R. Baxandall and L. Gordon (Eds.), *America's Working Women: A Documentary History 1600 to Present* (New York: W.W. Norton and Company, 1995), 12. Retrieved from Google Books.

² Martha M. Libster, *Herbal Diplomats: The Contribution of Early American Nurses (1830-1860) to Nineteenth-Century Health Care Reform and the Botanical Movement*. (West LaFayette, IN: Golden Apple Publication, 2004), 86. Personal Copy; R. J. Tannenbaum, *The Healer's Calling: Women and Medicine in Early New England* (Ithaca, NY: Cornell University, 2002), 31. Personal Copy.

³ Tannenbaum, 22-44.

⁴ Libster, 96.

⁵ Laurel Thatcher Ulrich, *A Midwife's Tale: The Life of Martha Ballard Based on Her Diary, 1785-1812*. (New York: Vintage Books, 1991). Personal Copy. Martha Ballard attended births and provided care to sick mothers and babies throughout her community. Often her nursing responsibilities to the community held precedence over the domestic duties and responsibilities of her own household. The community members, many local physicians, and even the court, considered her nursing knowledge and skill as expert. Martha Ballard exchanged her nursing services for money, goods, and domestic services to help provide for her family. For a detailed description of Martha Ballard's authentic daily experiences, read Ulrich's historical analysis of Ballard's personal diary.

⁶ Tannenbaum, 17.

⁷ Libster, 87.

⁸ Tannenbaum, 19.

⁹ *Ibid.*, 29.

¹⁰ As cited in Libster, 199-200.

¹¹ *Ibid.*, 192.

¹² Libster, 194-7.

¹³ *Ibid.*, 207.

¹⁴ *Ibid.*, 217-20. The SOC were obedient to God first to carry out their mission before obedient to hospital authorities. When the hospital authorities did not allow the SOC nurses enough autonomy to "run the daily activities of the hospital in the way they needed to fulfill their spiritual mission," the SOC nurses would leave the hospital.

¹⁵ Ellen D. Baer, "Nurses," in *Women Health and Medicine in America: A Historical Handbook*, ed. Rima D. Apple (New York: Garland Publishing, Inc., 1990), 461. East Carolina University, J. Y. Joyner Library.

¹⁶ As cited in Libster, 194.

¹⁷ Joseph H. Choate, "What Florence Nightingale Did for Mankind," *The American Journal of Nursing* 11, no. 5 (February 1911): 348. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Series 1: People, Box 2: Non-Alumnae, Folder 26, Florence Nightingale.

¹⁸ John VanR. Hoff, "The Soldier Nurse," *The American Journal of Nursing*, 11, no. 5 (February 1911): 343.

¹⁹ Alfred Worcester, "Florence Nightingale May 12, 1820-1920," noted from *The Boston and Medical Surgical*, 183, (August 1920): 4. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Series 1: People, Box 2: Non-Alumnae, Folder 27.

²⁰ Choate, 352-3.

²¹ J. A. D., "Editorial Comment," *The American Journal of Nursing*, 11, no. 5 (February 1911): 335. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Series 1: People, Box 2: Non-Alumnae, Folder 26, Florence Nightingale.

²² C. V. Mosby, *A Little Journey to the home of Florence Nightingale* (St. Louis: The CV Mosby Company, 1940), 20. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Series 1: People, Box 2 Non-Alumnae, Folder 27.

²³ Henry Fairfield Osborn, "Florence Nightingale," *The American Journal of Nursing*, 11, no. 5 (February 1911): 339. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Series 1: People, Box 2: Non-Alumnae, Folder 26, Florence Nightingale.

²⁴ Mosby, 23.

²⁵ *Ibid.*, 20

²⁶ Choate, 355.

²⁷ Worcester, 8.

²⁸ *Ibid.*, 7.

²⁹ *Ibid.*, 11.

³⁰ As cited in Mary Poovey, *Uneven Developments: The Ideological Work of Gender in Mid-Victorian England*, (Chicago: The University of Chicago Press, 1988), 164. East Carolina University, J. Y. Joyner Library.

³¹ Choate, 356; Hoff, 345.

³² Lori D. Ginzberg, *Women and the Work of Benevolence: Morality, Politics, and Class in the Nineteenth-Century United States* (New Haven: Yale University Press, 1990), 1 and 99. Personal Copy.

³³ *Ibid.*, 134-135.

³⁴ *Ibid.*, 134; The South did not have a centralized organization such as the U.S. Sanitary Commission. For a look at how the South supplied nursing and medical care to Confederate soldiers, read Marie E. Pokorny, "An Historical Perspective of Confederate Nursing During the Civil War, 1861-1865," *Nursing Research*, 41, no. 1 (January/February 1992): 28-32. Electronic Database, CINAHL accessed through East Carolina University, William E. Laupus Health Sciences Library.

³⁵ *Ibid.*, Ginzberg referring to George Fredrickson's *The Inner Civil War: Northern Intellectuals and the Crisis of the Union*, Chapter 7, p. 108.

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- ³⁶ Lousia Lee Schuyler Death Announcement. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Series 1: People, Box 2: Non-Alumnae, Folder 34; Jane E. Mottus, *New York Nightingales: The Emergence of the Nursing Profession at Bellevue and New York Hospital, 1850-1920* (Ann Arbor, MI: UMI Research Press, 1981), 32. Personal Copy; Ginzberg, 134 - "urban elite" quote.
- ³⁷ Mottus, 23.
- ³⁸ Ibid., 25
- ³⁹ Ibid.
- ⁴⁰ Tannenbaum, 135.
- ⁴¹ Robert. P. Hudson, "Abraham Flexner in Perspective: American Medical Education, 1865-1910," in *Sickness & Health in America: Readings in the History of Medicine and Public Health*, 3rd ed., eds. Judith Walzer Leavitt and Ronald L. Numbers (Madison, WI: The University of Wisconsin Press, 1997), 200. Personal Copy; Tannenbaum, 135-8.
- ⁴² Ronald L. Numbers, "The Fall and Rise of the American Medical Profession," in *Sickness & Health in America: Readings in the History of Medicine and Public Health*, 3rd ed., eds. Judith Walzer Leavitt and Ronald L. Numbers (Madison, WI: The University of Wisconsin Press, 1997), 228-229. Personal Copy.
- ⁴³ Poovey, 173.
- ⁴⁴ As cited by Laurel Thatcher Ulrich, "Martha Moore Ballard and the Medical Challenge of Midwifery," in *Sickness & Health in America: Readings in the History of Medicine and Public Health*, 3rd ed., eds. Judith Walzer Leavitt and Ronald L. Numbers (Madison, WI: The University of Wisconsin Press, 1997), 81. Personal Copy.
- ⁴⁵ As cited in Libster, 105.
- ⁴⁶ As cited by Ulrich in Leavitt and Numbers, 76.
- ⁴⁷ Barbara Miller Solomon, *In the Company of Educated Women: A History of Women and Higher Education in America* (New Haven: Yale University Press, 1985), 49. East Carolina University, J. Y. Joyner Library.
- ⁴⁸ Ibid.
- ⁴⁹ Ibid., 34-35.
- ⁵⁰ Poovey, 173 - quote.
- ⁵¹ Mottus, 32.
- ⁵² Unpublished document. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Series 1: People, Box 2: Non-Alumnae, Folder 34, Louisa Lee Schuyler.
- ⁵³ Ibid.
- ⁵⁴ Letter to Mrs. Hobson from Schuyler (40 years after visit to Bellevue) as cited in Dorothy Giles, *A Candle in Her Hand: A Story of the Nursing Schools of Bellevue Hospital* (New York: G.P. Putnam's Sons, 1949), 67. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Series 5: Books, Box 1.

⁵⁵ *Bellevue: A Short History of Bellevue Hospital and of the Training Schools* (New York: Bellevue Alumnae Association of Bellevue, December 1915). Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, MC 19, Bellevue Alumnae Association, Bellevue Hospital Papers, Sub-series 1: Edamay Bialko Papers 1948, Box 4: Books.

⁵⁶ M. Adelaide Nutting and Lavinia L. Dock, *A History of Nursing: The Evolution of Nursing Systems from the Earliest Times to the Foundation of the First English and American Training Schools for Nurses Vol. II* (New York: G.P. Putnam's Sons, 1935), 376 - number of members. Microfiche at the East Carolina University, William E. Laupus Health Sciences Library; *1873–1923, Fiftieth Anniversary: Bellevue Training School for Nurses* (1923) – quote. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Bellevue Hospital Papers, Sub-Series 1: Edamay Bialko Papers 1948, Box 4: Books and Microfiche at East Carolina University Laupus Library; Dorothy Giles, *A Candle in Her Hand: A Story of the Nursing Schools of Bellevue Hospital* (New York: G. P. Putnam's Sons, 1949), 72 - Hobson as chairman. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, MC 19, Series 5: Books, Box 1 – A letter found within the book in the archives reads: “prepared by Miss William Church Osborn before her death and Completed by Dorothy Giles.”

⁵⁷ *1873-1923 Fiftieth Anniversary Bellevue Training School for Nurses*.

⁵⁸ *Ibid.*

⁵⁹ Giles, 73; Elizabeth Christophers Hobson, *Recollections of a Happy Life* (New York: G. P. Putnam's Sons, 1916), 84. Personal Copy.

⁶⁰ Hobson, 83; Nutting and Dock, 378; Giles cites Osborn's notes dated February 23, 1872, “clothes being steamed in large vats; no indication of soap being used,” 74.

⁶¹ Hobson, 83; Nutting and Dock, p. 379; Giles cites Osborn's notes dated February 5, 12, and 19, 1872, “There is one cook for all the patients,” 74.

⁶² Giles, 80. Cites Griffin's notes dated April 11, 1872, “The floor [of the kitchen] was still foul with water as the only drain is near the door and the water and steam must flow to it with the food that is spilled.”

⁶³ *Ibid.*, 74. Cites Osborn's notes dated April 11, 1872, “They [utensils] are all put together in a heap and the water poured over them near the drain.”

⁶⁴ *Ibid.* Cites Osborn's notes dated February 5, 12, and 19, 1872, “We visited the kitchen which is across the open court at least one hundred feet from the door of the Hospital; all food must be brought by hand this distance in all weather to every part of the Hospital.”

⁶⁵ *Ibid.*, 75. Cites Osborn's notes dated March 11, 1872, “[Dinner] stood in these [tin] pails at least half an hour before being served.”

⁶⁶ Nutting and Dock, 377.

⁶⁷ Giles, 75. Cites Osborn's notes dated March 18, 1872.

⁶⁸ *Ibid.*, 83.

⁶⁹ *1873-1923 Fiftieth Anniversary Bellevue Training School for Nurses*. Cites from the Local Visiting Association of Bellevue Hospital March meeting minutes.

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- ⁷⁰ Ibid.
- ⁷¹ As cited in Giles, 54.
- ⁷² Giles, 54.
- ⁷³ Ibid., 73; Hobson, 84; Nutting and Dock, 381.
- ⁷⁴ As cited in Giles, 77.
- ⁷⁵ Ibid., 78
- ⁷⁶ Ibid., 79. Cites Mrs. Griffin's notes.
- ⁷⁷ Giles, 83; John Starr, *Hospital City: The Story of the Men and Women of Bellevue* (New York: Crown Publishers, Inc., 1959), 114. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, MC 19, Bellevue Alumnae Association, Series 5: Books, Box 1.
- ⁷⁸ As cited in Giles, 78.
- ⁷⁹ Letter of "Dearest C" from Louisa Schuyler dated May 19, 1912. Addressed to Mrs. Joseph Hobson, Washington D.C. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, MC 19, Bellevue Alumnae Association, Series 1: People, Box 2: Non-Alumnae, Folder 34: Louisa Lee Schuyler; also cited in Giles, 81.
- ⁸⁰ Ibid.
- ⁸¹ Hobson, 93.
- ⁸² Ibid.
- ⁸³ Giles, 82.
- ⁸⁴ Ibid.
- ⁸⁵ As cited in Poovey, 176.
- ⁸⁶ Poovey, 174-5.
- ⁸⁷ Ibid., 175
- ⁸⁸ As cited in *A Century of Nursing with Hints Toward the Organization of a Training School* (New York: G. P. Putnam's Sons, 1950), 107. Microfiche at the East Carolina University, William E. Laupus Health Sciences Library.
- ⁸⁹ Giles, 72
- ⁹⁰ Ibid., 83; Hobson, 94 – quote.
- ⁹¹ Hobson, 94.
- ⁹² Ibid.
- ⁹³ Nutting and Dock, 383.
- ⁹⁴ As cited in Hobson, 97.
- ⁹⁵ Florence Nightingale, Letter to Dr. Wylie, 3. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Bellevue Alumnae Association, Artifact Box 4.
- ⁹⁶ Ibid.
- ⁹⁷ Ibid., 5.
- ⁹⁸ Ibid.
- ⁹⁹ As cited in Nutting and Dock, 383.

¹⁰⁰ Nutting and Dock, 384.

¹⁰¹ Poovey, 191.

¹⁰² Ibid.

¹⁰³ Nutting and Dock, 384.

¹⁰⁴ Ibid.

¹⁰⁵ Giles, 108 and 131; The Alumnae Association of Bellevue School of Nursing, *Bellevue School of Nursing, 1889-1989* (Topeka, KS: Jostens Printing, 1989). Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, MC 19, Bellevue Alumnae Association, Bellevue Hospital Papers, Sub-Series 1: Edamay Biaklo Papers 1948, Box 4: Books.

¹⁰⁶ J. A. D., 334.

¹⁰⁷ Louisa Lee Schuyler, *First Training Schools for Nurses in the United States. Correspondence — Dr. Mary Forrester Hobart, Member Committee on Training School, Member Board of Directors, New England Hospital for Women and Children, Boston and Louisa Lee Schuyler, Honorary Member Bellevue Training School for Nurses, Vice President State Charities Aid Association, New York: Ten letters — July 7, 1915, to July 14, 1917.* (1918). Letter #2, 2. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19 Series 1: People, Box 2: Non-alumnae, Folder #35

¹⁰⁸ Ibid., Letter #7, 1-2; Letter #8, 2 - explained why obstetrical training was not offered to the students: “Obstetrical training was suspended almost as soon as commenced, owing to an outbreak of puerperal fever which caused great mortality. To save the lives of women (an object happily attained) the maternity service was removed from the hospital at the earnest request of the managers of the school. It was not resumed until several years later in a separate building of the hospital.”

¹⁰⁹ Ibid., Letter #8, 2.

¹¹⁰ Ibid., Letter #3, 3 noted Richards’s graduation date from New England Hospital for Women and Children as October 1, 1873 whereas Letter #5, 3 noted Richards’s graduation date from New England Hospital for Women and Children as September 1, 1873. The month and date of graduation conflict between the two letters written by Dr. Hobart yet the year remained 1873.

¹¹¹ Ibid., Letter #8, 3.

¹¹² Ibid., Letter #5, 5.

¹¹³ Ibid., Letter #3, 2; Photograph of “First Graduating Class, 1875” within *The Crane 75th Anniversary, 1873-1948* (New York: Bellevue Schools of Nursing, New York University, College of Medicine, 1948), 17 - First nursing class began in October 1873 and the students graduated in 1875, therefore length of training was approximately two years. Archives of the Foundation of the NYSNA, Bellevue Alumnae Center for Nursing History, Guilderland, NY. MC 19, Sub-series1: Edamay Bialko Papers 1948, Box 4: Books.

¹¹⁴ Ibid., Letter #4, 10.

¹¹⁵ As cited in Poovey, 190. Nightingale ideal of a “real home” included “what real family homes are supposed to give—materially a bedroom for each, dining and sitting-rooms in common, all

meals prepared and eaten in the home; morally, direction, support, sympathy in a common work; further training and instruction in it; proper rest and recreation; and a head of the home, who is also and pre-eminently trained and skilled head of nursing.”

¹¹⁶ Nightingale, Letter to Dr. W. Gill Wylie, 5.

¹¹⁷ As cited in Schuyler, Letter #6, 12.

¹¹⁸ Schuyler, Letter #5, 2.

¹¹⁹ Ibid.

¹²⁰ Ibid., Letter #7, 4.

¹²¹ Ibid., Letter #4, 9-10.

¹²² Ibid., Letter #6, 7.

¹²³ Ibid., Letter #4, 6.

¹²⁴ Ibid., Letter #5, 5.

¹²⁵ As cited by Baer, 462.

¹²⁶ Nettie Birnbach and Sandra Lewenson, eds. *Legacy of Leadership* (New York: National League for Nursing Press, 1993), xiii. East Carolina University, William E. Laupus Health Sciences Library.

¹²⁷ As cited by Anna Alston, “Address of President Anna Alston, First Convention of the Superintendents’ Society, 1894, New York, New York,” in *Legacy of Leadership*, 15.

¹²⁸ Birnbach and Lewenson, xv.

CHAPTER 5

BSN Pathway

In 1916, the University of Cincinnati (UC) became one of the first universities to offer a new educational pathway to enter nursing practice leading to both a Bachelor of Science (BS) degree and diploma of nursing. This dual BS/diploma program resulted when the School for Nursing and Health of the Cincinnati General Hospital moved to a department within the College of Medicine at the University of Cincinnati. The University of Cincinnati School for Nursing and Health dual BS/diploma program with the inclusion of liberal studies became the model for the BSN educational pathway in America. A brief history of the origin of the hospital training school will be provided to demonstrate the school's development and its similarity to the development of Bellevue Hospital Training School. Why the hospital school moved to the university, how the transfer transpired, why the dual BS/diploma program was chosen, and why the graduates of this program were considered different from the sole diploma graduates will be explained in this chapter. The key players in the school's development will be highlighted and include Laura Logan and John R. Holmes. The historical debate within American nursing education continued with the development of the dual BS/diploma program. How the new educational pathway contributed to the debate through the twentieth century will also be described.

The changing role and education of the nurse paralleled the continued changing role of women within the public sphere, specifically the movement toward equal rights and value with men thus challenged Nightingale's and the American trained nurses' foundational division of gender. The development of the dual BS/diploma program served two major purposes: one, to disband some of the division of gender ideology and two, to further delineate the division of

labor in nursing, thus creating further divisions of class. Movement of the nursing school to the university and creation of the dual BS/diploma program could have assisted nursing to gain equal recognized professional status through inclusion of liberal studies and reacquisition of autonomy of both nursing education and practice from paternalistic control. Additionally, the program would prepare students for the autonomous public health nurse role within nursing's division of labor immediately post graduation. Inclusion of the public health nurse role as an entry-level practice role further divided entry-level nurses by class within the division of nursing labor based on education preparation. The development of the BSN educational pathway attempted to dissolve division of gender, yet created deeper divisions of class within nursing's division of nursing labor and thus sustained the historical debate and disorder within American nursing.

Historical Context

State of Training Schools Since 1873

After the inception of the Nightingale model for training nurses in America at the Bellevue Hospital, the students of training schools proved valuable as commodities to staff the wards and provide the nursing care within the hospital. The hospitals quickly recognized the value of the student's labor: "Nursing students provided a relatively inexpensive, stable, and disciplined workforce."¹ Hospital administrators swiftly sought to control the schools of nursing that used the hospitals for training. The male hospital administrators and physicians easily gained paternalistic control of the nurses and the schools because they held greater financial resources and power. The hospital administrators and physicians could grant or deny access to the wards and the patients of the hospital. In addition, the "womanly duty, submission, and practical labor" stressed by modern nursing founders to include Nightingale provided "hospitals ideological justification for what quickly became outright exploitation."² The nurses were viewed as the

submissive wives of the hospital family while the doctors and administrators served as the father authority and the patients, the children.³ The nurses, in the physicians' absence, served as the physicians' eyes and hands for the care of the patients just as the woman of the house carried the male responsibilities only when the male was gone.⁴ As the hospital administrators and physicians realized their dependence on nurses for the success of patient care, the physicians feared nurses would gain equal status and thus they intensified their desire to control nursing.⁵ The physicians' fear grew from economic roots: "The nursing profession was clearly perceived as a group of women with the *potential* to engage in economic competition with men."⁶ Ashley further explains the rationale for the physicians' fear and desire to control nursing:

At the inception of organized nursing, nurses in many ways were equals of physicians in their professional training and their contributions to the health care of society. However, they were not their equals in the political and economic spheres of human activity, or in influence on the public, and it was the lack of equality that would shape their development far more than their professional ideals.⁷

The physician's fear of competition with the nurse fueled the original resistance to accept training schools and trained nurses into American culture. The same fear of competition heightened with the recognized dependence on the nurse and resulted in exploitation and paternalistic control of the training schools, student nurses, and trained nurses.

The superintendents of the training schools quickly lost autonomy of nursing practice and education, which Nightingale adamantly insisted the schools maintain in order to preserve the educational priority of the school and the autonomous female role of the nurse in the hospital.⁸ The power and money available to the hospital administrators and physicians left the training schools vulnerable and the superintendents of nurses in awkward positions. The superintendents attempted to regain professional autonomy through friendly and submissive collaboration with the male hospital administrators, yet this approach had its limitations. The training schools

offered several effective functions; “they were functional to the women becoming nurses, functional to the hospitals, functional to society in providing skilled workers for home and hospital in a context consistent with the society’s cultural assumptions.”⁹ The effective functions of the current system of the training schools served as opposing forces for the nurse leaders of professional organizations pushing to gain recognized professional status of nursing through repossession of autonomy.

As the male hospital authorities and physicians gained paternalistic control, “nursing education and nursing service became synonymous terms in American hospitals.”¹⁰ By combining two distinct purposes, education and training, into one “quasi-educational aim,” service to the hospital became viewed as an educational opportunity for the student although insufficient.¹¹ Paternalistic control and “discipline shaped every aspect of the student’s day” and “the need for ward work superseded every other pedagogic goal.”¹² Students gained information and skills largely through “hard physical labor” on the ward and an apprenticeship style of learning.¹³ Because the training schools now clearly existed under the paternalistic control of the hospital, the curricula of each school differed greatly, varying according to the diverse demands of the various institutions and their authorities.¹⁴ The theoretical instruction provided to students was sporadic and, often, experienced students assumed the role of teacher for the new students.¹⁵ Service to the hospital held priority over training, thus training involved more work than learning.¹⁶ The training school’s inability to maintain economic independence and a position of influence with hospital administrators, priority of hospital service over student learning, and use of students as teachers violated Nightingale’s model for training nurses.¹⁷ The Nightingale model, which provided the foundation for American modern nursing, began to disintegrate yet, the division of gender remained.

The desire to achieve autonomy of nursing education and practice from the paternalistic control of the hospital served as a major momentum for the development of the new educational pathway within the university. The development of the new educational pathway of the dual BS/diploma program within the university allowed the student nurse to be just that, a student rather than a worker within the hospital during her training. Education would serve as first priority over hospital service when the student nurse became a university student.

Woman Suffrage Movement and Nursing

Many middle- and upper-class women of the progressive era actively joined women's organizations for social reform and experienced public life for the first time.¹⁸ Eventually, the woman suffrage movement evolved as the women's concerns moved to the political arena and focused on legal rights. The essence of the woman suffrage movement involved acquisition of the right to vote, thus an equal right with men in the public sphere. Despite the common goal to obtain the right to vote, "no official ideology" existed; "although they [women] agree that women should have the right to vote, they disagreed on why they ought to have the right."¹⁹ Some leaders of the woman suffrage movement gained recognition as radical feminists—militant in the approach to cease patriarchy. The rise of organized nursing coincided with "domestic feminism"—women expanding their lives from the "private to public forum without destroying the existing gender system."²⁰ A paradox existed between nursing and the woman suffrage movement; both failed to collectively recognize the value and benefits of supporting the other.

Despite the large pool of women within nursing, few nurses and nurse leaders actively engaged in efforts of the woman suffrage movement; "nurses saw themselves as social reformers and not as radical feminists."²¹ Leaders of woman suffrage failed to show an interest in nursing as an expanding role for women because of the lack of autonomy of nurses' work and nursing's

link to a traditional woman's role; the traditional nurse role of the family left nursing outside the attention of feminists who were concerned with only expanding roles for women.²² Eventually, nurse leaders collectively supported the woman suffrage movement to acquire the right to vote for professional gain; yet, nursing remained ignored by feminists for years to come.²³ Although the efforts of nurse leaders and the leaders of the woman suffrage movement lacked coordination, the two groups held resemblance in organization efforts and in the goal to acquire legally recognized, equal status with men.²⁴

In 1893 at the Chicago World's Fair, superintendents of nurses joined together to discuss the critical issues of nurse training.²⁵ The nurse leaders paid the greatest attention to these issues: rapid expansion of training schools, lack of educational standards of many of the schools, and loss of autonomy over nursing practice.²⁶ Formation of the American Society of Superintendents of Training Schools for Nurses with a major purpose to "establish and maintain a universal standard of training" was a result of this 1893 meeting.²⁷ The American Society of Superintendents for Training Schools for Nurses will be referred to as the Superintendents' Society throughout this research study. Nurse leaders organized within the Superintendents' Society just as the women leaders of the woman suffrage movement organized to gain a collective force for efforts. The Superintendents' Society attempted to achieve professional status recognition for nurses through efforts to gain control of nurse training and practice. Nurse leaders' narrow perspective of their professionalization goal resulted in lack of collective support for the woman suffrage movement publicly. Some nurse leaders feared association with the radical feminists would destroy the friendly, collaborative relationships with the male hospital administrators and physicians, and provoke resistance.²⁸ As nurse leaders sought registration for nurses in order to control standardization of education and practice, they realized legislative

action called for them to “be able to speak and write in their own defense, to learn how legislators work and to help in preventing bad and promoting good legislation.”²⁹ The “compelling need to politically control the nursing profession” through legislative action led nurse leaders of the Superintendents’ Society to collectively support the woman suffrage movement.³⁰ Interestingly, nurses maintained a delicate boundary of support for the woman suffrage movement for reason of “concern the nursing legislation [registration] might be adversely affected politically if nursing took too strong a position in favor of suffrage.”³¹ The strength of the paternalistic control—the very force from which nurse leaders fought to gain release—strangled the efforts and resources of the nurse leaders.

The disconnection between women leaders in the suffrage movement and nurse leaders engaged in professionalization efforts remains unfortunate. Nurse leaders collectively failed to identify the nurse training and practice issues as a “women’s problem” and failed to recognize the role of nursing as “the epitome of women’s role in American society.”³² Nurse leaders’ desire to dissolve the division of gender and professionalize nursing pushed nursing away from the collective equal rights efforts of women in the suffrage movement. Suffrage leaders collectively failed to recognize the importance and power of liberating nurses from paternalistic control of hospital administrators and physicians for the greater cause of equal rights for women. Nursing’s strong traditional, gender-specific role did not attract the suffrage leaders’ attention. The combined failure resulted in a long, and continued struggle for clear identifiable professional status for nurses.

The Trained Nurse

Institution of the Nightingale model for training nurses within America, although inconsistent in its use and weakened by paternalistic control of hospitals, provided a foundation

for standardization of nurse training and led to the identified role or title—trained nurse. Since the student nurses provided cheap labor to nurse the patients within the hospitals, the hospitals did not hire the trained nurse graduates to staff the hospitals. The graduates predominantly entered private-duty nursing within the community if they did not accept positions as superintendents of training schools. The trained nurse graduates encountered competition for private-duty cases with untrained nurses, often referred to as professed or practical nurses.³³ The untrained, professed or practical nurse “remained a fixed member of the nursing work force” and thus sustained an informal and disordered division of labor for nursing.³⁴ Some hospitals sent student nurses out of the hospital for private-duty cases as a source of income for the hospital, further decreasing the number of cases available to the graduates of their own training schools.³⁵ Hospital administrators rationalized the decision to use student nurses for private-duty cases; “private duty nursing seemed an appropriate part of the nurse training when it was assumed that the vast majority of Americans would never see the inside of a hospital.”³⁶ Trained nurses competed with untrained and student nurses to earn a livelihood within the disordered division of nursing labor.

Interestingly, the hospital and physicians still controlled the practice of the trained nurse graduates. The trained nurses cared for a physician’s patient and the physician decided the nurse’s role within each private-duty case.³⁷ A nurse’s rapport with physicians could determine the amount of cases she received. Despite physicians working alongside student nurses within the hospital training schools, some physicians did not fully comprehend or appreciate the difference between the trained and untrained nurse. Some physicians and patients remained uncertain why the trained nurse’s services cost more. The lower cost of services provided by the untrained nurses heightened the competition with the trained nurses. Many “health care officials

in and outside of hospitals were arguing that all women, regardless of educational preparation, should be allowed to practice nursing.”³⁸ With the continued use and support of the untrained nurse by health care authorities, and physicians’ lack of value placed on the training of nurses within the hospitals, the public would remain uncertain of nursing’s division of labor and the differentiation between the trained and untrained nurse. Even those who accepted the role of the trained nurse in the care of the sick did not fully comprehend or support the professionalization efforts of nurse leaders. Reverby summarizes this truth:

By 1900 trained nursing *was* becoming more accepted as a necessary part of the medical world. But acceptance of nursing’s importance did not translate into cultural and political willingness to support nursing in its professional efforts. The public remained indifferent and physicians and hospital administrators, hostile.³⁹

Reverby concluded the indifference and hostility stemmed from “ignorance and uncertainty about the trained nurse.”⁴⁰ The traditional gender-specific role of nursing challenged the collective acceptance of professionalization of nurses.

Development of a nursing program within a university with the graduates receiving a university conferred degree would hopefully elevate the public’s value and recognition of the education and training of the nurse. With an education comparable to other professions, the public may identify the trained nurse as a professional and thus soften the divisions of gender.

Liberal Studies Education

As education for all the recognized professions evolved and included liberal studies, nursing as a developing profession also needed an expanded liberal studies education. Interestingly during this time, women attended college yet not always with the aspiration to become a professional.

Education for women “evoked opposition because it gave women an identity outside the family,” thus challenging traditional divisions of gender.⁴¹ Educating women created anxiety, for

women and men alike, over the possibility women would abandon traditional female roles.⁴² Physicians opposed a broader education for nurses for this reason: the possibility that the nurse's role within the hospital family would alter or the nurse would abandon the dependent role altogether. Many physicians were "uneasy [with] the prospect of working with a knowledgeable and opinionated trained nurse."⁴³ "A nurse may be overeducated," Rosenberg cites one physician, but "she can never be over-trained."⁴⁴ Dominant themes of physicians' opposition of higher education for nurses were related to the loss of the nurses' dependent role. Higher education proved "dangerous" as nurses' elevated confidence encouraged nurses to question a doctor's plan of treatment for a patient; higher education decreased a nurse's willingness to perform "menial tasks associated with patient care;" and higher education introduced a "mercenary element" in nurses and thus destroyed the altruistic calling of the nurse.⁴⁵ Liberal education and its connection with changing roles for women frightened the paternalistic controllers of hospital training schools for nurses.

Education for the woman created a personal dilemma and nurses would struggle with this dilemma of how to carry out the promise of her education yet at the same time fulfill her gender-specific, female role.⁴⁶ Woman's usefulness rather than professional status served as the measure of a good woman. Female college students, unlike the male students, found themselves torn "between the attraction of using their education in professional ways and keeping in mind that a woman's usefulness was not equated with professionalism."⁴⁷ Rosenberg further illustrates this personal conflict through examining the paradoxical position of nursing because of its gender-specific role; "the feminization of nursing, the very ideology that originally justified the creation of this new profession...constrain the options available to nurses."⁴⁸ Social conceptions regarding the nature of woman influenced nursing and "'womanly' qualities on part of the nurse

were valued more than knowledge.”⁴⁹ In addition, most physicians felt “disciplined subordination” captured the essence of professionalism for the nurse.⁵⁰ Despite the challenges noted, the role of the trained nurse required a certain level of education and the training schools did not provide the level of education needed.

Acknowledgment of the rapidly changing environment of nurses’ work along with the push for recognized professional status led nurse leaders of the professional organizations to propose higher education for nurses. In 1901, Mrs. Bedford Fenwick (1857-1947), the president of the International Council of Nurses, proposed four reasons for higher education of nurses:

The advanced level of many of the activities they [nurses] perform; the development of intelligence and vitality necessary for keeping abreast of advances in science and in hospital economics; the cultivation of the individual personality; and finally, the evolution of a strong sense of civic responsibility.⁵¹

Rapid growth of “reliable knowledge in the physical and the social sciences” required education “beyond the bounds of technical knowledge or expertness.”⁵² Education of professionals extended beyond competence of skill to broader competence of thinking and reasoning. Critical thinking, as it is commonly referred to today, or “competence in using diverse forms of reasoning” could be gained only through exposure and “experience with intellectual processes other than those conventionally employed in his [her] major academic field.”⁵³ Advances in medical sciences demanded “more knowledge and more independent judgment on the part of the nurse.”⁵⁴ Russell explains the connection between liberal studies and recognized professional status of the nurse:

The liberal ingredient brings knowledge to its humane level, and therefore forms an essential element in the performance of professional service. If nurses are to carry out their appointed tasks in such a way as to command public recognition as a profession in the fullest sense, they must not only be educated, but educated in the liberal manner.⁵⁵

Nurse leaders did not propose liberal studies and higher education merely because other professions required the same; the work and environment of the nurse demanded a broader education.

Two articles published in the *American Journal of Nursing* between 1902 and 1903 illustrated the reasons for a liberal studies education for nurses to include: advances in medical science requiring a “higher level of reasoning on the part of the nurse;” new roles for nurses; and the “narrowness of educational opportunities” of the training school system of that time.⁵⁶ The role of the nurse within the hospital and private-duty required an expanded education of the nurse. Nurses gained responsibility of advanced skills once performed by the physicians and physicians relied more on the nurse’s assessment of physiological signs and symptoms.⁵⁷ A broader education served necessary to enhance the nurse’s ability to reason, think critically, and adapt for no two patient situations proved the same.⁵⁸ Attainment of knowledge rather than mere competent, robotic skill developed critical thinking and refuted the opposition’s position that any and all women could practice nursing. In addition to the expanding traditional role of the trained nurse within the hospital and private-duty cases, a new role—the public health nurse—emerged. Unlike the patients of the hospital and private-duty cases, the public health nurse’s patients did not belong to the physician—the patients belonged to the nurse. This resulted in the most autonomous role for the trained nurse. The current training school system did not, however, prepare the trained nurse adequately for this role. The new public health nurse role provided the strongest argument for nurses to acquire a liberal studies education.

Evolution of liberal studies for professional education, the changing environment of traditional trained nurse roles, and the emergence of the public health nurse role fueled the push for liberal studies education for trained nurses. Recognized professional status would hopefully

result. The nontraditional, autonomous public health nurse role, free from the paternalistic control of the hospital and physicians, provided nursing the greatest promise for liberal studies education and professional status.

The Public Health Nurse

The patients of the hospitals now represented a more diverse sample from the community population, yet nursing care within the community held an important role for promotion of the entire public's health. After 1900, concern for the public's health heightened with the government's overall concern for health because of the increase in immigration, urbanization, and industrialization.⁵⁹ During the progressive era, reformers held an interest in improving public health. Women often held active leadership roles, thus the nurse, predominantly female, gained professional responsibility within public health. Yet, the nurse, found to be one of the most valuable workers for the public health movement, lacked in her educational preparation.⁶⁰ Agencies hiring public health nurses received an abundant supply of applications yet many applicants lacked qualifications. More than half of the rejected applicants lacked an academic background with course work specific to public health.⁶¹ The success of the public health nurse largely depended on the nurse's educational foundation and her ability to continue to learn and grow from the foundation provided to her in training. In 1901, the superintendent of the Visiting Nurse Association of Chicago explained this concept of the rich educational foundation required for growth and success of the public health nurse in this way:

The success of district nursing depends, more than in hospital and private practice, upon the character of the nurse; and the character of the nurse depends much more upon the nature of her training and the continuance of those helps, physical and moral, which that training has supplied her.⁶²

The public health nurse role provided autonomy and allowed the nurse opportunities to make independent decisions because the nurse did not have a head nurse or physician to advise

her like available in the hospital or private-duty case.⁶³ To earn the patients' trust and respect required a specific demeanor and personality of the public health nurse. The public health nurse regularly provided lessons in appropriate middle-class health behaviors to lower- and working-class patients.⁶⁴ Success of the lessons rested largely on the patient's trust and understanding of the middle-class nurse as well as the nurse's ability to teach. Knowledge of sociology, psychology, and economics in addition to history, art, and literature would provide the public health nurse a large resource from which she could draw information to best relate with her patients and families. Expectations to fully understand and study civic problems and community resources in order to effectively organize, teach, and work with individuals and groups existed for the public health nurse.⁶⁵ The public health nurse needed to possess an empathy rooted in cultural competence and knowledge of both medical and social causes of illness.⁶⁶ The role of the public health nurse proudly expanded beyond the care of the sick; "the nurse who tends the sick only, and teaches nothing, and prevents nothing, is abortive in her work."⁶⁷ The public health nurse assumed several roles in relation to the patient, including nurse, teacher, counselor, and friend, and thus required an expanded education.⁶⁸

In 1912 at the American Nurses' Association (ANA) convention, sixty-nine nurses gathered and established the National Organization for Public Health Nursing (NOPHN).⁶⁹ The establishment of the NOPHN created the foundation for a collective identity for public health nurses—an identity connected to laypersons and professionals for a greater purpose and not merely a nursing organization.

At the founding meeting, [the NOPHN organizers] emphasized that the NOPHN was to be an organization for public health *nursing*—a cooperative effort of professionals and laypersons committed to the [public health] movement, not an organization designed to represent nurses' specific professional interests.⁷⁰

The NOPHN members recognized the public health nurse's contribution to the larger and important public health movement, thus the public health nurse held a "sense of belonging to something bigger than herself, of having an important part in a great undertaking."⁷¹ The NOPHN founding members "claimed an autonomous role within preventative care and implicitly declar[ed] their legitimate right to direct and organize the nursing activities related to public health."⁷² The opportunities and prestige of the public health movement offered the public health nurse an elite reputation within nursing.⁷³ The reputation was supported by the level of education needed for the public health nurse.

NOPHN leaders immediately attempted to differentiate the public health nurse from the trained nurse in 1912 by creating a post-graduate specialty education requirement for the public health nurse.⁷⁴ Although surveys of the NOPHN repeatedly documented a gap between the educational requirements advocated and the nurses' actual qualifications, most public health nurses held more credentials than nurses in supervisory and administrative positions in the hospitals.⁷⁵ The NOPHN recognized experience as an equivalent credential to an academic background with public health courses for the public health nurses who did not hold an administrative-type position in public health.⁷⁶ The reality of the emerging public health role for nurses and the inadequacy of the hospital training schools preparation of the graduates to fulfill the public health role were addressed three times between 1912 and 1916 in the presidential addresses at the annual conventions of the Superintendents' Society and National League for Nursing Education.⁷⁷ The training schools did not offer the type of education, focusing on prevention and education, needed for the public health nurse role.⁷⁸ Despite the lack of educational preparation of the candidates for public health nurse positions, the NOPHN rejected attempts to integrate training for public health into the hospital school curriculum.⁷⁹ The hospital

administrators agreed. Hospital administrators relinquished the hospital training schools from the task of preparing nurses for the public health nurse role.⁸⁰ Hospital administrators viewed the public health nurse role as a specialty that should require additional specialty training beyond the hospital training.⁸¹ A few colleges did accept *graduate* nurses into liberal studies courses to better prepare the nurse for the public health nurse, educator, or administrator role. Since the hospitals showed no interest in expanding curricula to include preparation for the public health nurse role and the NOPHN resisted attempts to incorporate public health nurse preparation into the hospital curricula, an opportunity arose to look at educational institutions to support the needed education for the *student* nurse rather than the *graduate*, trained nurse. Liberal studies courses within a university would provide the expanded educational needs of the public health nurse.

Although a relatively small practice field within nursing, public health nursing provided an autonomous role for the educated nurse. Because the role of the public health nurse entailed independence from the hospital and physicians and required teaching to lower-class community members, public health nurses were perceived to be the elite nurses.⁸² The public health nurse rose as an emerging autonomous role within nursing and mirrored the community and public reform efforts of the high-society women. The liberal studies education coupled with the autonomous reform efforts of the public health role elevated the class status and, possibly, professionalization, of the public health nurse regardless of the NOPHN's lack of professionalization efforts.

Opportunities to provide nursing *students* an expanded education with liberal studies courses presented through the expansion of universities and their partnerships with developing medical centers. Movement of the School for Nursing and Health of the Cincinnati General

Hospital to a department within the College of Medicine at the University of Cincinnati and creation of the dual BS/diploma program demonstrate the realization of such an opportunity. The social, political, and cultural context of the early twentieth century shaped the development of the University of Cincinnati School of Nursing and Health dual BS/diploma program and the subsequent development of an adequately prepared public health nurse immediately post graduation. Divisions of gender and class shifted as the division of nursing labor changed with the new BSN educational pathway development.

Development of the BSN Pathway

The Origin of the School

The Cincinnati Training School for Nurses was established January 1, 1889, sixteen years after the opening of the Bellevue Training School for Nurses. The establishment of the Cincinnati Training School for Nurses mirrored the establishment of the Bellevue Training School for Nurses. A group of “public-minded women” formed the Society for the Training School to meet the great need that existed in Cincinnati for trained nurses and a training school to produce such nurses.⁸³ Concerned about the high morbidity and mortality rates within Cincinnati and the deplorable conditions that existed in the hospitals of Cincinnati, the Society for the Training School proposed that the Cincinnati Hospital house and financially support the development of a two-year course for women “desirous of becoming professional nurses.”⁸⁴ Initially, the Cincinnati Hospital Trustees rejected the proposal on the condition that “funds of the Hospital could be used only for the direct expenses of the Hospital and could in no way be diverted for an educational project.”⁸⁵ The Society for the Training School, following the example of Bellevue and unknowingly following the guidelines of the Nightingale model, responded with a request to use one ward to begin an independent training school for nurses,

operated and financially supported by the Society for the Training School. The Trustees of the Cincinnati Hospital approved this request, granting the Society for the Training School full charge of the female medical ward. Within five months, the trustees granted the Society for the Training School access to five wards and twenty-one months after the establishment of the Cincinnati Training School for Nurses, the Society for the Training School gained permission to train the student nurses in every ward of the hospital. Full access to all of the hospital wards was granted due to the exceptional care and comfort provided to the patients by the student nurses and, most likely, due to the fact that the students provided unpaid labor. The work of the students and the Society for the Training School was noted to be a “valuable assistance to the hospital staff, and eminently satisfactory to [the Cincinnati Hospital Trustees] Board.”⁸⁶

Within four years of the establishment of the independent Cincinnati Training School for Nurses, the Society for the Training School successfully met the three objectives of its formation. Judge William Howard Taft (1857-1930), the husband of one of the Society for the Training School members, summarized the successes in his speech at the January 1893 Report of the Society:

First you wished to give the people of Cincinnati and vicinity a privilege enjoyed for years by other cities—that of a calling to their aid, in case of sickness, skilled practitioners in a profession which is quite as important in relief of suffering and preservation of life as the medical profession itself. Second, you wished to extend to young women of intelligence, refinement and education, an opportunity to break the conventional bonds that so often tie them down to idleness and spheres of restricted usefulness, and to pursue an ennobling life of enthusiasm in the cause of humanity. Third, you wished to offer to the poor patients of the great Cincinnati Hospital the much desired boon of decent, cleanly, and scientific nursing. For four years you have worked to these ends.⁸⁷

The hospital hoped to gain even more from the success of the Society for the Training School. The Society for the Training School, through the development of an exceptional training school with excellent student nurses, had created a cheap labor force in the eyes of the hospital trustees.

As an independent school, the hospital was forced to confer with the Society for the Training School Board of Managers “whose first duty and interest was to look after the quality of nursing, the training and welfare of the nurses, and the professional and educational responsibilities involved.”⁸⁸ Again, the structure and organization of the Cincinnati Training School for Nurses followed Nightingale’s guidelines and ensured the quality of the training received by the student nurses and the quality of the care provided to the patients. In an effort to gain control of the training school, the Cincinnati Hospital inserted a clause in the contract with the Society for the Training School, that the hospital trustees would obtain “absolute discretion to discharge [the] superintendent, [the school’s] highest executive officer.”⁸⁹ In 1893, the Society for the Training School, unable to negotiate an acceptable contract maintaining an independent training school, withdrew from affiliation with the Cincinnati Hospital. Despite the lack of changes to the hospital’s charter from the time when the school first developed, the Cincinnati Hospital trustees established a training school for nurses under its auspices called the Cincinnati Hospital Training School for Nurses. The Cincinnati Hospital Training School for Nurses continued under this name until 1914.

As noted previously, hospitals assuming full responsibility for financing and operating the hospital training schools proved common practice once hospital authorities recognized the value of the student’s labor to the hospital.⁹⁰ As noted in *CHAPTER 4 – Diploma Pathway* and earlier in this chapter, hospital control of the school violated the Nightingale model.

Unfortunately, many training schools struggled to acquire the needed funds for its operation, thus masking the hospital’s offer as a financial opportunity, yet at the expense of nursing’s autonomy. Paternalistic control of hospital nursing continued for many decades while hospital-based diploma programs remained the major source of educating nurses.

In 1914, a new hospital was built and named the Cincinnati General Hospital. The new, immaculate, 850-bed, modern hospital provided a glimpse of the dream of a great Cincinnati medical center. Along with the new hospital, changes to the nursing school occurred as well. The new physical building and additions to the curriculum not only changed the name of the school to the School of Nursing and Health of the Cincinnati General Hospital but also marked the beginning of an active relationship between the university and the hospital training school.

A Proposed Cooperation

The new hospital provided a visual representation of the vision and concerns of the medical community and public officials of Cincinnati. The health and welfare of Cincinnati's citizens urged the development of a modern hospital facility. Reorganization of the school seemed advisable to meet the changes of the hospital and realization of the vision of a great medical center.

At the University of Cincinnati Board of Trustees meeting on June 2, 1914, John R. Holmes (1856-1920), the Director of Public Safety, proposed a secure cooperation between the hospital's nursing school and the University of Cincinnati "in the interest of efficiency and economy."⁹¹ The cooperation included shared division of expenses, employment of persons, and use of facilities and instruction between the hospital's nursing school and the College of Medicine, School of Household Arts, and other colleges of the University of Cincinnati. The proposal requested all degrees and diplomas granted to graduates of the hospital's nursing school be conferred by the University of Cincinnati. The matter of the proposal was given to the University of Cincinnati president, Charles William Dabney (1855-1945). President Dabney promptly traveled to the University of Indiana and the University of Minnesota to "investigate some of the training schools for nurses connected with university medical colleges."⁹² Less than

two months later, on July 20, 1914, President Dabney reported back to the Board of Trustees. He agreed to the cooperation proposal on all grounds making the hospital's nursing school a department within the College of Medicine yet with the following conditions:

First: That the Hospital shall pay the entire expenses of the [hospital's nursing] school, including those for all the instruction, except such as may be provided by the existing Colleges of the University.

Second: That this Board approves the plan of instruction submitted for the School of Nursing and Health at this time..., but reserves the right to withdraw from this connection, if at any time the plan is changed in a way to render it undesirable for the University to grant the said degrees and diplomas.

Third: That the Director of Public Safety also reserves the right to withdraw from this connection, if at any time he becomes dissatisfied with its operation.⁹³

Holmes, the Director of Public Safety, responded with a resolution detailing the cooperation further. He explained that both the university and hospital existed as departments of the city government; the university can provide the scientific instruction essential to the study and practice of nursing; the hospital provides, without charge, ample facilities for practical training of many university students; and the student nurses provide services to the hospital through the care of patients in return for their instruction and maintenance without further compensation. Therefore, Holmes again resolved that the "Board of Trustees of the University and the Hospital authorities of the City of Cincinnati, unite for mutual economic and professional advantage, thus making the School of Nursing a School under the auspices of the University of Cincinnati; but controlled by the Department of Safety of the City of Cincinnati."⁹⁴ The matter of the proposal was then given to a select committee for consideration and report to the board.

No further reports were noted in the Board of Trustees minutes until February 2, 1915, when it was reported that the select committee, titled the "Special Committee on the School of Nursing and Health," was discontinued.⁹⁵ Supporting papers filed with these minutes include: July 20, 1914 report to the Board of Trustees from President Dabney; the Director of Public

Safety Holmes's resolution to President Dabney's report; handwritten note dated June 20, 1914 from Dr. David Wolfstein, the chairman of the Committee of Professional Schools of UC, approving the union of the training school and UC with the condition that "the union would be piloted next fall [1915] and would not incur any expense to the University;" and a preliminary drafted announcement of the School of Nursing and Health of the Cincinnati General Hospital 1914-1915. Interestingly, although not addressed in any of the Board of Trustees minutes, the preliminary announcement included a curriculum plan of study for a dual Bachelor of Science degree and diploma of nursing. It is quite possible that this proposed plan of study created the dissolve of the cooperation agreement. The documentation within the Board of Trustees minutes did not address or suggest such a drastic change to the curriculum of the School of Nursing requiring this level of commitment from the University of Cincinnati. At the time of this dissolve, neither the University of Minnesota nor the University of Indiana, the two schools investigated to serve as models for the cooperation between UC and the hospital's nursing school, offered a dual BS/diploma curriculum plan of study.

On June 29, 1916, the level of cooperation originally proposed in 1914 and the dual BS/diploma curriculum received approval. This final approval began on June 6, 1916. The Chairman of the UC Board of Trustees reported to the board that the mayor of Cincinnati, George Puchta (1860-1937), and the superintendent of the hospital's nursing school, Laura R. Logan (1879-1974), requested that the question of UC "taking over teaching in the City Hospital" be revisited.⁹⁶ Dr. Griess, a board member, voted in the negative and another board member, Mr. Renner, motioned to refer this question to the Committee on Professional Schools for consideration. Interestingly, twenty- three days later on June 29, 1916, Dr. Griess was confined to the hospital by illness and Mr. Renner was "out of the city" and therefore both were

absent from the Board of Trustees meeting.⁹⁷ At this meeting “the special matter for consideration was the questions of making the Nurses Training School of the City Hospital [School for Nursing and Health of the Cincinnati General Hospital] a part of the Medical College of the University.”⁹⁸ After discussion, a resolution was presented, motioned, and voted affirmatively “to begin the work of the school [School for Nursing and Health of the Cincinnati General Hospital] in the fall of 1916 as a department of the University.”⁹⁹ The resolution provides insight to the rationale for the decision to make the hospital’s nursing school a part of the Medical College, which in turn consisted of a new curriculum of study to include a BS degree.¹⁰⁰ Key points of rationale within the resolution include:

- Both UC and the hospital are departments of the city government;
- The UC colleges can provide the scientific instruction in fundamental knowledge essential to the study and practice of nursing;
- The nursing profession within Cincinnati feels it lacks the preparation to adequately meet the demands of nurses within the city;
- Unusual opportunities for the training of nurses will be offered to the student nurses because of the University recognition of the nursing school;
- The inclusion of the nursing school within the UC Medical College is not without precedent because Columbia University and the Universities of Indiana and Minnesota also have schools of nursing as departments within the university; and
- The UC Medical College “realizes its obligation to co-operate in making the highest use of all educational functions of the hospital in the interests of the health and education of the community it serves.”¹⁰¹

Before these rationales are examined within the context of nursing during 1916, a historical detour to what occurred within the hospital's nursing school just prior to June 2, 1914, the date of the original proposed cooperation, through June 29, 1916, when the cooperation was approved, deserves attention.

The School Between 1913 and 1916

In 1913, the superintendent of the hospital, Dr. Arthur C. Bachmeyer (1886-1953), reported that the nursing staff was “doing good work” under the supervision of Miss Marguerite Fagen, although the number of nurses was less than half the number needed to properly care for the number of patients admitted.¹⁰² The average number of nurses on duty daily to include the night shift nurses was 45 and the average number of patients per day was approximately 442.¹⁰³ With the anticipation of the new hospital and the current shortage of nursing staff, efforts to recruit more pupil nurses were reported. In 1913 there were only 19 graduates. Graduates were reported to enter into public health as well as private-duty nursing, therefore maintaining a hospital shortage. The curriculum of the hospital training school was reported to include seven months of daily lectures received in addition to practical work on the wards. A proposed extension of up to three months of preliminary classroom work prior to entering the ward was also reported.¹⁰⁴

The year of 1914 brought many changes. In addition to the obvious external change of the new hospital building, the training school incurred many internal changes as well. As the city officials and University of Cincinnati Board of Trustees discussed and managed the details of a proposed cooperation agreement between the hospital training school and UC, the training school moved forward with a new vision for the education of nurses. It is not certain who originated the vision but it is certain that Laura Logan embraced the vision. Logan officially

replaced Fagen as the superintendent of the school of nursing on September 1, 1914, after Fagen's resignation, yet this is not the first time her name appears in connection with the cooperation proposal.¹⁰⁵ Although not officially employed by the hospital or university in July 1914, Logan was noted to provide statements regarding the proposed cooperation between the hospital's training school and UC at the Board of Trustees meeting.¹⁰⁶ Unfortunately, the nature of her remarks was not documented but her actions after employment by the hospital illustrate her position on the proposed cooperation. Logan was hired with the assurance that the hospital's school of nursing would become a part of the university.¹⁰⁷ Logan did not sit back and wait for this level of cooperation between UC and the hospital's nursing school to be officially accepted; she pressed forward with the vision.

The 1914 Annual Report of the Hospital portrayed a positive message of growth directly linked to the new hospital. The growth portrayed positively included that of per capita cost, personnel and student numbers, and educational excellence. The 1914 Annual Report of the Hospital notes an "attempt to secure the highest degree of efficiency possible, and at the same time practice a true economy."¹⁰⁸ In this report, the hospital superintendent prepared city officials for the changes on the horizon. Although the number of nurses desired to care for the number of patients admitted to the hospital lacked in quantity, the report illustrated hope for an increase in nursing staff and student nurses as well as "improvement in the personnel of the nursing staff of the new hospital."¹⁰⁹ The hospital's nursing school under the supervision of Logan was reported to have "an organization equal to that of the best schools in the country, and should take its place at the head of nurse training and instruction" and "should soon be one of [the] most efficient [branches of hospital service at the Cincinnati General Hospital]."¹¹⁰ Logan held a new philosophy for the hospital's nursing school—that of cooperative education defined

as “an exercise in integration, the synthesis of theory with experience, of personal development with intellectual growth.”¹¹¹ Logan borrowed the philosophy of cooperative education from the UC College of Engineering professor, Herman Schneider (1872-1939), who initiated such a program in 1906 for the engineering students.¹¹² The cooperative education system was based on a “major idea...that of balanced training” alternating theory in the classroom and practice in the laboratory or workplace.¹¹³ Many changes took place between 1914 and 1916 to embrace the cooperative education philosophy within the nursing school.

The care and maintenance of students changed. The school admitted students three times a year without an allowance but with textbooks and uniforms provided to them.¹¹⁴ Students received one month vacation and the hospital assumed care of the student during illness.¹¹⁵ The probation period of the students increased to four months, the duration of one semester.¹¹⁶ Along with such privileges, Logan expected professional accountability and responsibility of the graduate and student nurses. In December 1915, seriousness of these expectations gained publicity in the local newspapers. Logan dismissed two nurses for patient abandonment because they left the ward with patients unattended, and reduced two senior students to the level of probationers for arriving late to duty and transporting to duty in a hospital ambulance.¹¹⁷ Logan determined the consequences of the nurses’ behaviors and the hospital superintendent, Dr. Bachmeyer, and the Director of Public Safety, Holmes, supported her decisions, thus illustrating a shared vision and partnership between the city, the hospital, and Logan.

The curriculum plan of study also changed significantly. Students earned credit hours for classroom and practice courses. Fifteen hours of practice work per week per semester or one month of nursing of at least eight hours per day was equivalent to one credit hour of practice work.¹¹⁸ Instruction occurred in two parts: courses in the school of nursing consisting of forty-

three credit hours and practice courses in the wards, diet kitchen, and operating rooms consisting of twenty-nine credit hours.¹¹⁹ As early as November 1914, Logan secured agreements from the UC Medical College professors, also responsible for the medical services in the hospital, to assist in the lectures and demonstrations in anatomy, physiology, bacteriology, pathology, pharmacology, and therapeutics.¹²⁰ Additionally, Logan added a course in elementary sociology taught by a UC professor of the College of Liberal Arts on the university grounds.¹²¹ Lectures added to the nursing courses included Hygiene and Sanitation, Psychology, Hospital and Household Economy, and History of Nursing. Furthermore, electives available to the student nurses by 1915 included instruction and practice in Hospital Social Service, Modern Philanthropy, and Public Health Nursing.¹²² In 1914, Logan gained supervision of the nursing department within the Tuberculosis (TB) Sanatorium of the Cincinnati General Hospital with a forward intention to develop an optional course in TB nursing for the nursing school.¹²³ Logan believed that “such a course will be influential in improving the personnel of the nursing staff here [at the Cincinnati General Hospital] and will provide more properly trained women for the large field that is being developed in tuberculosis nursing in the country.”¹²⁴ Logan expanded the curriculum of the training school to better coincide with a university, liberal studies curriculum and to better prepare the trained nurse graduates for the expanding roles of nurses within the community.

In the effort to provide excellence in the education of nurses and succeed in “improvement in the personnel of the nursing staff of the new hospital,” standardization and perfection of nursing procedures served as a major focus.¹²⁵ To obtain the goal of standardization of nursing procedures by all nursing staff and students, Logan scheduled demonstrations twice a week for four months in the surgical amphitheatre and required the attendance of all graduate

and student nurses.¹²⁶ In addition, the City of Cincinnati purchased a “life-sized doll” or manikin in 1915 for \$150 to assist student nurses in perfecting nursing skills and techniques.¹²⁷ Logan proved serious in her efforts to accomplish standardization of nursing procedures and the city and hospital supported her efforts.

Logan’s support of making the school of nursing a part of the UC Medical College and her adoption of the cooperative education philosophy that resulted in changes to the nursing curriculum held deeper roots within Logan’s commitment to public health. Logan viewed the role of institutions that educate and train nurses to be “subservient [sic] not merely the immediate need of a hospital, but responsible for preparation of professional members of society, concerned...with the health and welfare of a community.”¹²⁸ Logan’s desire to prepare graduates for a broader role beyond hospital nursing and for the role of public health nurse grew evident in her curriculum decisions and became outwardly publicized. The General Statement found within the 1915-1916 Announcement of the School of Nursing and Health of the Cincinnati General Hospital supports this position:

The School of Nursing and Health was established on January 1, 1889, as the Cincinnati Training School for Nurses. In 1896 it was re-organized as the Cincinnati Hospital Training School for Nurses, and in November, 1914, it was again re-organized as the School of Nursing and Health of the Cincinnati General Hospital. It is primarily a professional school conducted in close co-operation with the Cincinnati General Hospital. The hospital serves not only as laboratory, but also as a means of providing co-operative assistance to the student nurse in obtaining her training. It aims to give scientific instruction in the fundamental principles and practices of nursing, and to prepare women adequately for entering the nursing profession as private, institutional, or public health nurses. The courses offered are fundamental to teaching and administration in the field of nursing and health, and are open to all students who are qualified to pursue them with profit.¹²⁹

Logan’s goal to prepare nurses for the emerging public health nurse role guided her leadership efforts to broaden the education of the student nurses and cooperate with the University of Cincinnati.

Rationale for Approval of the Cooperation Agreement

An original resistance in 1914 to the cooperation agreement between UC and the Cincinnati General Hospital regarded the decision of which entity would provide financial support of the training school. The resistance may have stemmed from UC President Dabney's visit to the University of Minnesota. The University of Minnesota School of Nursing budget beginning in 1909 and remaining for decades was part of the hospital budget.¹³⁰ The June 29, 1916 resolution clearly diminished such resistance because both the university and hospital were departments of the city.¹³¹ Movement of the training school to UC would securely ensure efficiency and economy of the city's financial resources; however, the move was proposed for reasons greater than, although related to, finances. In order to prepare nurses for the needed role within the city, cooperation between the training school and UC was necessary. As cited from the 1913 Annual Reports of the Hospital, graduates were entering public health, private, and institutional nursing roles.¹³²

The public health nurse role epitomized the responsibility and accountability of the nurse for the overall health and welfare of the community. The City of Cincinnati and Logan recognized the need to adjust the school's curriculum from one that trained the nurse to one that educated the nurse to include content to prepare the nurse for her role in public health. Clara D. Noyes (1869-1936), president of the National League for Nursing Education from 1914 to 1916, stated it simply in 1916, "It has taken many of us a long time to learn the difference between training and education, but we are learning."¹³³ Logan understood the changes required to switch from training to education. Logan's own education and experiences grounded her understanding.

Logan, born in Amherst, Nova Scotia, Canada, received her first college degree, a Bachelor of Arts (BA) in English, from Acadia University, Wolfville, Nova Scotia in 1901. She

received a Diploma in Nursing from Mount Sinai Hospital School of Nursing in New York and Bachelor of Science in Nursing and a Diploma in Education and Hospital Economics from Columbia University Teachers College in New York by 1908. The Columbia University Teachers College (TC), home of the premiere Department of Nursing and Health, prepared graduate nurses for public health, administration, and teaching roles. Logan embraced her teaching from TC and pushed to include similar teaching at the undergraduate level in order to encompass the expanded role of the public health nurse, thus preparing nurses for the needed role within Cincinnati.

Logan recognized her limitations within the hospital nursing school to prepare the students for the new role. An example, noted previously, demonstrates her acknowledgment of such limitations—the use of UC professors as guest lecturers for the student nurses. The cooperative agreement with UC would allow for a diverse faculty that held expertise in their specialty to instruct the student nurses in specific areas related to the study and practice of nursing. University affiliation of the nursing school would also open all doors within the hospital to the student nurse for learning opportunities because the student nurse now gained recognition as a university student of the UC Medical College. More experiences equate to enhanced education of the student nurse. The hospital now provided the fullest services for the health and education of its community through the cooperative partnership with UC to adequately prepare graduates for the public health nurse role.

As noted previously, nursing schools were affiliated with universities in other states. The three universities documented to be known by the decision makers in Cincinnati included: Columbia University Teachers College, University of Minnesota, and the University of Indiana.

The Department of Nursing and Health at Columbia University Teachers College (TC) provided advanced education to the *graduate* nurse. Students of TC received diplomas from other training schools. TC granted special professional diplomas and/or bachelor degrees to those who completed the education that filled the gaps of the basic diploma nursing training to prepare graduate nurses for the roles of public health, administration, and teaching.

The training schools of the Universities of Minnesota and Indiana were under the university auspices for the students' full three years of nurse training; however, the curriculum of the training did not result in a bachelor's degree because the curricula lacked a full liberal studies curriculum. For example, the nurse graduate of the University of Minnesota received a "Degree of Graduate in Nursing" following the three years of training, not a BS degree.¹³⁴ In 1919, three years after the University of Cincinnati School for Nursing and Health, the University of Minnesota followed the example of UC and offered for the first time a combined course in the College of Science, Literature, and the Arts and the School of Nursing, which resulted in a Bachelor of Science degree for the graduate.¹³⁵

The mere movement of the training school to the university did not elevate the education of the student nurse. Movement of hospital training schools to universities without an educational change created an illusion of higher education for nurses. This practice continued for decades and, in 1954, one nurse leader exposed the illusion:

Instead of developing entirely new programs of nursing education and building them along the lines of other university programs, we seem to be moving our old hospital programs to the university without changing the philosophy, the objectives, the organization of learning experiences, the methods of teaching or the time of the plan.¹³⁶

Inclusion of a full liberal studies curriculum resulting in a BS degree changed the philosophy and mission of the University of Cincinnati School for Nursing and Health.

Recognition and acceptance of the role change for the professional nurse in the City of Cincinnati, Ohio, resulted in a major organization and curriculum change in the educational pathway for the new professional, public health nurse role. As a result of the concern for the overall health and welfare of Cincinnatians, the city urged the move of the School of Nursing and Health of the Cincinnati General Hospital to a department within the University of Cincinnati Medical College. Along with this organization structural change, a major curriculum revision emerged. Implementation of the extensive curriculum change to include liberal studies courses occurred due to the recognition and acceptance that the city needed a new role for the trained nurse. The new role required education beyond what the hospital training/diploma curriculum provided, thus the dual BS/diploma program for the professional, public health nurse began.

Debate and Division Within Nursing

The combination of the public health movement and forward thinking of Cincinnati officials resulted in a liberal studies undergraduate nursing education program for the public health nurse role. Although the public health nurse role provided an opportunity to encourage higher education for nurses and thus professional recognition, nurse leaders did not primarily focus on this argument. The Superintendents' Society focused efforts on registration of nurses to gain autonomous control of nursing education and practice. Differentiation of nurses through registration created debate and division within nursing.

Benefits of Registration

The Superintendents' Society's major purpose served "to establish and maintain a universal standard of training" for nurses.¹³⁷ Legal registration of nurses based on set educational

principles would provide maintenance of a universal standard for training nurses and an identifiable professional role for the adequately prepared trained nurse.

Nurse leaders, aware the “country [had] been flooded with a very nondescript class of women, all bearing the title of trained nurse, the term standing for all grades of training and all grades of women,” realized the need to differentiate the various nurses in practice and thus legally define a division of nursing labor.¹³⁸ The registration of trained nurses from the schools that met the set training standards served to differentiate and identify the adequately prepared trained nurse from those prepared by the lower grade schools and those who lacked formal training. The connection of registration of nurses with the standardization of nursing school curricula served as a means to differentiate the division of nursing labor by educational preparation and publicly identify the properly trained nurse.¹³⁹

The public would not understand the necessity to professionalize nursing as long as the public remained uncertain of the difference between the trained and untrained nurse.¹⁴⁰ Establishing a distinct identity from the untrained, professed or practical nurses and the trained nurses from lower grade training schools through state registration posed the possibility of gaining a recognized professional status based on the quality of the nurse’s education.

Nursing, because of the nature and traditions of nurses’ work, ideologically remained within the domestic sphere’s parameters. Nurse leaders hoped that “state legitimation [sic] of high standards, set by nurses, would free nursing...from the ideological constriction.”¹⁴¹ Nurse leaders believed that legislation holding the power of the state would transform nursing; the nurse leaders’ views proved similar to other progressives and the leaders of the woman suffrage movement.

Stewart frankly revealed the challenges of professionalization efforts as she reflected on the presentations by nurse leaders at the Chicago World's Fair in 1893; "the evils of shoddy training, student exploitation, and lack of standards...were ascribed chiefly to the selfishness of hospitals, the complacency of nurses, and the apathy of the public."¹⁴² Nurse leaders hoped that registration of nurses based on their set standards for education and practice would dissolve the "evils" and disband the attributing factors and thus lead to professional status for the registered nurse.

Quest for Registration Meets Opposition

The Superintendents' Society's registration efforts stimulated opposition from the male hospital administrators and physicians but, ironically, also from practicing nurses. The internal opposition created division of class and weakened organized nursing's defense against external opposition.

Male hospital administrators and physicians opposed registration for two major reasons: loss of the dependent role of nurse and loss of a "cheap, reliable, and orderly labor supply."¹⁴³ Registration based on the nurse leaders' set educational standards posed to threaten the hospitals' control of the school. Educational reform challenged the continuance of smaller hospitals: "Reform threatened to demoralize small hospitals; many conceded that they would not be able to continue without training schools."¹⁴⁴ Some male authorities within medicine believed the registration of nurses equated to professional status and thus "licensed [the nurse] to contradict the physician."¹⁴⁵ Registration of trained nurses demanded educational reform for training schools and resulted in recognized professionalization of the nurse; both educational reform and professionalization intimidated the paternalistic control of the hospital because it threatened the foundational division of gender for nursing.

As the Superintendents' Society focused on state registration laws and educational reforms in the training schools, the nurse leaders became isolated from the majority of working nurses, who held different concerns.¹⁴⁶ The quest for registration of adequately prepared trained nurses created a class division within nursing between educational leaders and the nurses in practice, the “worker-nurse” of private-duty nursing.¹⁴⁷ Many worker-nurses—those untrained or trained in the smaller, lower-grade training schools—opposed the registration efforts of the nurse leaders within the Superintendents' Society.¹⁴⁸ Opposition originated from concerns of losing work and thus their livelihood, without acquisition of registration.¹⁴⁹ Several worker-nurses wrestled with the involvement of the superintendents in the practice of nurses post graduation and expressed their frustration in a letter to the editor: “Women with pride and self-respect will not submit to being governed by and dictated to by those who have no authority beyond the training school...They are not capable of judging the needs of the graduate in private practice.”¹⁵⁰ The division of class within nursing, just like the disconnection with the woman suffrage movement, destroyed the possibility of a powerful united force against division of gender and paternalistic control.

Interestingly, the superintendents of the Superintendents' Society comprised a minority of women within nursing from “better social backgrounds.”¹⁵¹ Many of these “women of refinement” were “daughters of professionals and businessmen, some boasting a solid secondary education as well as the appropriate social style.”¹⁵² Identification of the “elite” occurred in the first days of nurse training and, as graduates, they were selected into positions as superintendents. The difference between the superintendents and worker-nurses created a class division within nursing. The formation of the Superintendents' Society purposefully divided class further through exclusion of lower-grade training school superintendents; “high standards

for admission [into the Superintendents' Society] were set that excluded superintendents of small hospitals or specialty institution schools."¹⁵³ The number of members of the Superintendents' Society included few when compared with the many nurses. Despite the unbalanced number and opposition from the majority, the nurses who resisted and criticized professionalization remained unable to organize against it.¹⁵⁴ The nurse leaders' "educational concerns and professional goals were rejected or ignored by the majority of working nurses who remained unorganized and increasingly under- or un-employed."¹⁵⁵ The dilemma regarding the professional identity and adequate educational preparation for the trained, now registered, nurse continued during the early twentieth century. The traditional dependent role of women and nurses fueled the external opposition. Internal opposition enforced by conflicts between class positions created division between the educational leaders and the working nurses.

Summary

Movement of the School for Nursing and Health of the Cincinnati General Hospital to a department within the College of Medicine at the University of Cincinnati and its development of the new dual BS/diploma program served as a small, unrecognized victory for organized nursing. The move to the university and inclusion of the liberal studies curriculum succeeded to step nursing away from division of gender and paternalistic control of the hospital and toward professional status recognition. Unfortunately, the culture of Cincinnati proved rare, and the level of partnership between university and training school to include a liberal studies curriculum occurred minimally and in isolated cases.

Nurse leaders focused efforts on professionalization and autonomy through legal state registration. In 1903, North Carolina passed a nurse registration law and "before 1913, over 20 states had enacted laws governing the practice of nursing and the education of nurses."¹⁵⁶ The

extent of educational reform demanded through registration did not reach the level of liberal studies curricula implemented in Cincinnati nor did the dual BS/diploma graduates receive differentiation from the trained nurses by means of a different level of registration. Despite the successes of the nurse leaders achieving state registration for some nurses and Cincinnati's implementation of a liberal studies curriculum for even fewer nurses, the professional identity and division of labor by educational preparation for the entry-level nurse remained disordered. Freedom from hospitals' paternalistic control remained questionable. Hospital training schools remained the majority norm and even the few university-based programs existed within medical colleges. Use of the practical nurse continued despite their lack of registration and thus further disordered division of nursing labor and served to challenge the professionalization efforts of nurse leaders.

Development of the dual BS/diploma program, although a success for the education of some nurses, added a new ingredient to the disorder between nursing education and practice. State registration efforts of the Superintendents' Society nurse leaders mirrored the legislative efforts of the woman suffrage leaders but created a new class division between nurse leaders in education and working nurses. The "elite" status of the public health nurse coupled with her liberal studies education also contributed to the class division between higher education and practicing nurses. Nurse leaders of the Superintendents' Society began to question whether the hospital training "school could ever hope to achieve its essential [educational] purposes" as they experienced "dissatisfaction...with their lack of autonomy" and "frustration with balancing the educational needs of the student with service needs of the hospital."¹⁵⁷ Paired with the influence of the nurse leaders' desire for professional status recognition, the leaders initiated a stronger argument for the move of nursing education to universities and colleges—institutions whose

primary mission focused on education.¹⁵⁸ Now lacking a united force of organized nursing created by the class division of nursing over registration, educational reform at this grand level presented as a colossal challenge. The educational pathway development at the University of Cincinnati School for Nursing and Health remained unrecognized and devalued as a success by the majority of nursing. Sustained divisions of gender and paternalistic control, and new divisions of class within nursing, continued the disordered division of nursing labor and challenged upcoming educational reform efforts for professionalization.

Notes

¹ Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: The Johns Hopkins University Press, 1987), 220. East Carolina University, William E. Laupus Health Sciences Library.

² Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (New York: Cambridge University Press, 1987), 3. Personal Copy.

³ Jo Ann Ashley, *Hospitals, Paternalism, and the Role of the Nurse* (New York: Teachers College Press, 1976), 17. East Carolina University, William E. Laupus Health Sciences Library.

⁴ *Ibid.*

⁵ *Ibid.*, 19, 78, 83.

⁶ *Ibid.*, 93.

⁷ *Ibid.*, 100.

⁸ Kathleen Shirley Hanson, *A Historical Analysis of the Liberal Education Theme in Nursing Education: 1893-1952* (Ann Arbor, MI: University Microfilms International, 1989), 45-6. East Carolina University, William E. Laupus Health Sciences Library; Rosenberg, 218. "Nightingale movement" justified an autonomous female role in the hospital. Despite the nurse superintendents' struggles within most secular American hospitals, the Catholic nurses gained administrative control and held voting power in the American Catholic hospitals. Several Catholic hospitals during the early twentieth century were primarily managed by Catholic Sister Nurses. The Catholic nurses' level of autonomy and responsibility served as an anomaly to the practices within the secular hospitals. Although the Catholic nurses shared the same gender of the American secular nurses, Catholic nurses were held in high esteem. The many decades of an accepted expanded, public sphere of the Catholic nurses may have contributed to the difference between the Catholic and secular nurses within hospital management. For a more thorough analysis, read Barbara Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace, 1865-1925* (Columbus, OH: The Ohio University Press, 2005). Personal Copy. and Martha M. Libster and Sister Betty Ann McNeil, *Enlightened Charity: The Holistic Nursing Care, Education, and ADVICES CONCERNING THE SICK of Sister Matilda Coskery, 1799-1870* (Farmville, NC: Golden Apple Publications, 2009). Personal Copy.

⁹ Rosenberg, 220.

¹⁰ Ashley, 24.

¹¹ Hanson, 49.

¹² Rosenberg, 226.

¹³ Hanson, 46. - quote; Rosenberg, 226 – apprenticeship.

¹⁴ As cited in Isabel Maitland Stewart, *The Education of Nurses: Historical Foundations and Modern Trends* (New York: MacMillan Company, 1950), 136. East Carolina University, William E. Laupus Health Sciences Library. Stewart cites Isabel Hampton Robb from the Chicago World's Fair in 1893.

¹⁵ Hanson, 47.

¹⁶ Reverby, 3.

¹⁷ Hanson, 47.

¹⁸ "The Progressive Era, 1890-1920," in *Volume II: Since 1865, A Narrative History of the American Republic, Nation of Nations*, 5th eds. James West Davidson, William E. Gienapp,

Christine Leigh Heyrman, Mark H. Lytle, and Michael B. Stoff (New York: McGraw Hill, 2005), 718. Personal Copy.

¹⁹ Aileen S. Kraditor, *The Ideas of Woman Suffrage Movement, 1890-1920* (New York: W. W. Norton & Company, Inc., 1981), xi. Personal Copy.

²⁰ Sandra Beth Lewenson, *Taking Charge: Nursing, Suffrage, and Feminism in America, 1873-1920* (New York: National League for Nursing (NLN) Press, 1996), 23. East Carolina University, William E. Laupus Health Sciences Library.

²¹ Ashley, 99; Lavinia Dock, a nurse and radical feminist serves as the best example of a nurse leader who was consistently and aggressively involved and instrumental in the woman suffrage movement. For a brief synopsis of her contributions to nursing and the woman suffrage movement, visit the American Association for the History of Nursing (AAHN), under Nursing History, Gravesites of Prominent Nurses, "Lavinia Lloyd Dock, 1858-1956," <http://www.aahn.org/gravesites/dock.html>.

²² Reverby, 130.

²³ Lewenson, 138-9 - professional gain; As cited in Ellen D. Baer, "Nurses," in *Women Health and Medicine in America: A Historical Handbook*, ed. Rima D. Apple (New York: Garland Publishing, Inc., 1990), 459. East Carolina University, J. Y. Joyner Library - "The irony pervades the study of nursing and its history is that, as primarily women's work, it is ignored equally by traditional historians who focus more on men's work and by feminist historians who choose more usually to celebrate women who have entered occupations previously considered men's province."

²⁴ Ashley, 116.

²⁵ Hanson, 49-50 - Organizers of the International Congress of Charities, Correction, and Philanthropy devoted a section of the conference at the Chicago World's Fair to the topics of Hospitals, Dispensaries, and Nursing. Papers were read by superintendents of nurses.

²⁶ *Ibid.*, 50.

²⁷ *Ibid.*; Stewart, 150 - quote; National League for Nursing webpage at <http://dev.nln.org/aboutnln/info-history.htm> - The American Society of Superintendents for Training Schools for Nurses become the National League for Nursing Education in 1912 and National League for Nursing in 1952.

²⁸ Ashley, 115 - "Legal recognition of nurses was associated in the minds of many with issue of woman's suffrage, and incurred heated resistance."

²⁹ Stewart, 141.

³⁰ Lewenson, 141.

³¹ *Ibid.*, 144.

³² Ashley, 121, 125.

³³ Reverby, 21.

³⁴ *Ibid.*

³⁵ Rosenberg, 222.

³⁶ *Ibid.*

³⁷ Reverby, 96.

³⁸ Ashley, 67.

³⁹ Reverby, 128.

⁴⁰ *Ibid.*, 129.

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- ⁴¹ Barbara Miller Solomon, *In the Company of Educated Women*, (New Haven: Yale University Press, 1985), xviii. East Carolina University, J. Y. Joyner Library.
- ⁴² *Ibid.*
- ⁴³ Rosenberg, 231.
- ⁴⁴ *Ibid.*, 233.
- ⁴⁵ Hanson, 61.
- ⁴⁶ Solomon, xix.
- ⁴⁷ *Ibid.*, 83.
- ⁴⁸ Rosenberg, 236.
- ⁴⁹ Ashley, 75-6.
- ⁵⁰ Rosenberg, 231.
- ⁵¹ Charles H. Russell, *Liberal Education and Nursing* (New York: Institute of Higher Education, 1959), 24. East Carolina University, William E. Laupus Health Sciences Library.
- ⁵² *Ibid.*, 7.
- ⁵³ *Ibid.*, 9.
- ⁵⁴ Hanson, 51.
- ⁵⁵ Russell, 20.
- ⁵⁶ As cited in Hanson, 61.
- ⁵⁷ Hanson, 52.
- ⁵⁸ *Ibid.*, 65
- ⁵⁹ Reverby, 109; Hanson, 52.
- ⁶⁰ Stewart, 148.
- ⁶¹ As cited in Reverby, 110.
- ⁶² Reverby, 110
- ⁶³ *Ibid.*
- ⁶⁴ *Ibid.*
- ⁶⁵ Stewart, 152.
- ⁶⁶ Hanson, 54.
- ⁶⁷ As cited in Barbara Melosh, "*The Physician's Hand: Work Culture and Conflict in American Nursing*," (Philadelphia: Temple University Press, 1982), 125. East Carolina University, William E. Laupus Health Sciences Library.
- ⁶⁸ Melosh, 141.
- ⁶⁹ *Ibid.*, 120.
- ⁷⁰ *Ibid.*, 122.
- ⁷¹ *Ibid.*, 121.
- ⁷² *Ibid.*, 122.
- ⁷³ *Ibid.*
- ⁷⁴ *Ibid.*, 122-3.
- ⁷⁵ *Ibid.*, 123.
- ⁷⁶ *Ibid.*
- ⁷⁷ As cited in Nettie Birnbach and Sandra Lewenson, eds., *Legacy of Leadership* (New York: National League for Nursing Press, 1993) - Address of Mary C. Wheeler, 18th Annual convention of the Superintendent's Society, 1912 Chicago, Illinois, 93; Address of Clara D. Noyes, 20th Annual Convention of the NLNE, 1914, St. Louis, Missouri, 115; Address of Clara D. Noyes, 22nd Annual Convention of the NLNE, 1916, New Orleans, Louisiana, 125. East

Carolina University, William E. Laupus Health Sciences Library. The Superintendents' Society became the National League for Nursing Education in 1912.

⁷⁸ Hanson, 53 - "Prevention and education became the keystone for [public health] programs."

⁷⁹ Melosh, 123.

⁸⁰ Stewart, 148-9.

⁸¹ Ibid.

⁸² Reverby, 110.

⁸³ Unpublished document. "The Cincinnati Training School for Nurses, Organized in 1888 – Corporation dissolved in 1911. Fund set aside for a Dietetics Laboratory Equipment in The School of Household Arts, Women's Building, University of Cincinnati. Equipment installed July 26, 1918." Archives of the University of Cincinnati, Henry Winkler Center, Cincinnati, OH. Folder: Cincinnati Training School for Nurses.

⁸⁴ Ibid.; Framed Display at the Level 2 entrance of the University of Cincinnati College of Nursing in Cincinnati, OH on June 24, 2010; Brochure, "University of Cincinnati College of Nursing and Health, Dedication of William Cooper Proctor Hall, October 10, 1968 2:00 O'clock," Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library, File: College of Nursing and Health.

⁸⁵ Unpublished document. "The Cincinnati Training School for Nurses, Organized in 1888 – Corporation dissolved in 1911."

⁸⁶ As cited in Laura Logan, "Nursing in Cincinnati, 1820-1920," in *University of Cincinnati Medical Bulletin*, November 1920, 6. Archives of the University of Cincinnati, Wedbush Centre, Cincinnati, OH. Folder: Laura Logan.

⁸⁷ Ibid.

⁸⁸ Unpublished document. "The Cincinnati Training School for Nurses, Organized in 1888 – Corporation dissolved in 1911."

⁸⁹ Logan, "Nursing in Cincinnati, 1820-1920," 6.

⁹⁰ Unpublished document. Walter Eugene Sindlinger, *Experimentation in Education for Nursing at Orange County Community College: A Report of a Type A Report*, (New York: May 1956), 9. Archives of Columbia University, Teachers College, Gottesman Libraries, PDF b11642002 accessible through <http://pocketknowledge.tc.columbia.edu>.

⁹¹ University of Cincinnati Board of Trustees Minutes, dated June 2, 1914, 96-7. Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library, Book No. 9, Record of Minutes: Jan 1914 to Dec 1918.

⁹² University of Cincinnati Board of Trustees Minutes, dated August 17, 1914; Supporting Papers Letter from President Dabney to Board of Directors, dated June 27, 1914. Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library, Box: Board of Trustees Supporting Papers, File: August 17, 1914.

⁹³ University of Cincinnati Board of Trustees Minutes, dated July 20, 1914, 106. Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library, Book No. 9, Record of Minutes: Jan 1914 to Dec 1918.

⁹⁴ Ibid.

⁹⁵ University of Cincinnati Board of Trustees Minutes, dated February 2, 1915, 205. Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library, Book No. 9, Record of Minutes: Jan 1914 to Dec 1918.

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- ⁹⁶ University of Cincinnati Board of Trustees Minutes, dated Jun 6, 1916, 379. Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library, Book No. 9, Record of Minutes: Jan 1914 to Dec 1918.
- ⁹⁷ University of Cincinnati Board of Trustees Minutes, dated Jun 29, 1916, 385. Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library, Book No. 9, Record of Minutes: Jan 1914 to Dec 1918.
- ⁹⁸ Ibid.
- ⁹⁹ Ibid.
- ¹⁰⁰ University of Cincinnati Record 1916-1917, 13, Ser. 1. Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library.
- ¹⁰¹ University of Cincinnati Board of Trustees Minutes, dated Jun 29, 1916, 385.
- ¹⁰² Annual Reports of Officers, Boards and Departments of City of Cincinnati for 1913, 389. Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library.
- ¹⁰³ Ibid.
- ¹⁰⁴ Ibid., 396-7.
- ¹⁰⁵ Annual Reports of Officers, Boards and Departments of City of Cincinnati for 1914, 391. Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library.
- ¹⁰⁶ University of Cincinnati Board of Trustees Minutes, dated July 20, 1914, 106.
- ¹⁰⁷ Laura Rosnagle, "Nursing School Aids Fight on Disease," in Civic Section of Cincinnati Times Star Centennial 100th Anniversary Issue (Vol. 101, No. 100, April 25, 1940), 4. Archives of the University of Cincinnati, Wedbush Centre, Cincinnati, OH; Folder: Laura Rosnagle; "General Hospital Nurses' Home, Cincinnati, Hamilton Co., Ohio." Archives of the University of Cincinnati, Wedbush Centre, Cincinnati, OH; Logan, 9.
- ¹⁰⁸ Annual Reports of Officers, Boards and Departments of City of Cincinnati for 1914, 392.
- ¹⁰⁹ Ibid.
- ¹¹⁰ Ibid.
- ¹¹¹ Laura Logan, "The Place of the University in the Nursing Profession," Speech given at 1941 University of Cincinnati School of Nursing and Health graduation, 14. Archives of the University of Cincinnati, Wedbush Centre, Cincinnati, OH. Folder: Laura Logan.
- ¹¹² M. B. Reilly, *The Ivory Tower and the Smokestack: 100 years of Cooperative Education at the University of Cincinnati*, (Cincinnati, OH: Emmis Books, 2006). Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library; Unpublished document. Laura Rosnagle and Mable I. Darrington, "History of the College of Nursing and Health," January 5, 1950, 16. Archives of the University of Cincinnati, Wedbush Centre, Cincinnati, OH. Folder: Laura Rosnagle.
- ¹¹³ "Four Decades of the Cooperative System, A Distinct Epoch in the History of Higher Education, 1906-1946," 40th Anniversary Program dated October 16, 1946, (Cincinnati, OH: The University of Cincinnati, 1947), 10-11. Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library.
- ¹¹⁴ As cited in Rosnagle and Darrington, 17; Laura Logan, "Report of the School of Nursing and Health and the Nursing Department of the Cincinnati General Hospital, From Jan 1st, 1915 to Dec. 31st, 1919," 1. Archives of the University of Cincinnati, Wedbush Centre, Cincinnati, OH. Folder: Laura Logan.

¹¹⁵ Rosnagle and Darrington, 17; Logan, “Report of the School of Nursing and Health and the Nursing Department of the Cincinnati General Hospital, From Jan 1st, 1915 to Dec. 31st, 1919,” 2.

¹¹⁶ Rosnagle and Darrington, 17.

¹¹⁷ “Nurses are Dismissed, Claim they Quit Ward,” Times Star, December 31, 1914. Archives of the Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library. Holmes scrapbook, 9/22/1914 – 5/17/1917, M10.5; “Two Nurses Dropped: And Two Others at City Hospital Reduced to Probationers,” Enquirer, January 1, 1915. Archives of the Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library. Holmes scrapbook, 9/22/1914 – 5/17/1917, M10.5.

¹¹⁸ As cited in Rosnagle and Darrington, 17.

¹¹⁹ Ibid.

¹²⁰ Ibid., 17-18; Annual Reports of Officers, Boards and Departments of City of Cincinnati for 1914, 402.

¹²¹ As cited in Rosnagle and Darrington, 17-18; Logan, “The Place of the University in the Nursing Profession,” 3.

¹²² As cited in Rosnagle and Darrington, 18.

¹²³ Annual Reports of Officers, Boards and Departments of City of Cincinnati for 1914, 458.

¹²⁴ Ibid.

¹²⁵ Ibid., 392.

¹²⁶ Logan, “Report of the School of Nursing and Health and the Nursing Department of the Cincinnati General Hospital, From Jan 1st, 1915 to Dec. 31st, 1919,” 2.

¹²⁷ “60 Nurses Practice on Woman “Patient” and She Survives! She’s the “Goat” of New City Hospital,” Cincinnati Post, January 15, 1915. Archives of the Archives of the University of Cincinnati Libraries, Cincinnati, OH. Archives and Rare Books Library, Blegen Library. Holmes scrapbook, 9/22/1914 – 5/17/1917, M10.5.

¹²⁸ Logan, “Nursing in Cincinnati, 1820-1920,” 15.

¹²⁹ The City of Cincinnati, “Announcement of the School of Nursing and Health of the Cincinnati General Hospital 1915-1916,” 13. Personal Copy. The year of 1896 is noted as the year the Training School reorganized as the Cincinnati Hospital Training School for Nurses within this quote/source. Although it differs from the evidence found illustrating the true year of reorganization in 1893, the point within the argument remains.

¹³⁰ Louise M. Powell, (1937) “The History of the Development of Nursing Education at the University of Minnesota,” in *The Alumnae Quarterly University of Minnesota School of Nursing*, Vol. XVIII, No. 1 (1937): 7. Microfiche at the East Carolina University, William E. Laupus Health Sciences Library; University of Minnesota Board of Regents, “University of Minnesota Board of Regents Meeting Minutes,” (Minnesota: University of Minnesota, October 1, 1908), 4, <http://purl.umn.edu/44921>.

¹³¹ University of Cincinnati Board of Trustees Minutes, dated Jun 29, 1916, 385.

¹³² Annual Reports of Officers, Boards and Departments of City of Cincinnati for 1914, 396.

¹³³ National League for Nursing webpage at <http://dev.nln.org/aboutnln/info-history.htm> – American Society of Superintendents of Training Schools for Nurses became the National League for Nursing Education in 1912; Birnbach and Lewenson, Address of Clara D. Noyes, 22nd Annual Convention of the NLNE, 1916, New Orleans, Louisiana, 125.

¹³⁴ Powell, 7.

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- ¹³⁵ Ibid., 9
¹³⁶ As cited in Russell, 21.
¹³⁷ Stewart, 139.
¹³⁸ As cited in Stewart, 139.
¹³⁹ Rosenberg, 229.
¹⁴⁰ Reverby, 143.
¹⁴¹ Ibid., 126.
¹⁴² Stewart, 136.
¹⁴³ Rosenberg, 236.
¹⁴⁴ Ibid., 233.
¹⁴⁵ Ibid., 234.
¹⁴⁶ Reverby, 121.
¹⁴⁷ Ibid., 132.
¹⁴⁸ Ibid., 127; Rosenberg, 234.
¹⁴⁹ Reverby, 127, 131-2.
¹⁵⁰ As cited in Reverby, 135.
¹⁵¹ Rosenberg, 224-5.
¹⁵² Ibid., 225.
¹⁵³ Reverby, 123.
¹⁵⁴ Ibid., 142.
¹⁵⁵ Ibid., 143.
¹⁵⁶ Stewart, 140; Louie Croft Boyd, *State Registration of Nurses* (Philadelphia: W. B. Saunders Company, 1915, 12. Retrieved from Google Books.
¹⁵⁷ Ibid., 182.
¹⁵⁸ Hanson, 82.

CHAPTER 6

ADN Pathway

In 1952, the third educational pathway to entry-level nursing practice, the Associate Degree in Nursing (ADN) program, developed first at the Orange County Community College (OCCC) in New York. The ADN program created a new worker in nursing, the technical nurse. Why a new worker and educational pathway in nursing developed and how socio-cultural-political changes and research created this pathway will be explained in this chapter. The key players in the pathway's development will be highlighted and include Mildred Montag and Louise McManus. The specific development of the Orange County Community College ADN program, the first of seven programs piloted, will be highlighted. The development of the ADN pathway created the largest resurfacing of the historical debate in the profession of nursing; why and how this debate ensued will be examined.

Despite the success of the woman suffrage in 1920, which afforded women an opportunity to collectively gain power, status, and positions in the public sphere, nursing failed to obtain release from the hospitals' paternalistic control and collectively gain recognized professional status. Nursing education leaders' concern for recognized professional status for nurses continued and served as the primary goal of professional organizations between 1893 and 1952 with focused efforts to improve the training of nurses in the hospital schools and, ultimately, to advance the education for nurses to the professional collegiate level.¹ Nurse leaders within education grew restless of the traditional submissive nature of the nurse and recognized the changing needs of the nurse:

Nursing educators were no longer content with developing an attitude of unquestioning obedience in nursing students. Such a characteristic was not compatible with

contemporary standards of behavior for the woman of the 1920s and 1930s. Neither was this a desirable characteristic for women who would be practicing nursing in the increasingly complex world of health care.²

The increased level of education of the general population and the continued changing role of women influenced nursing, yet minimal significant educational changes ensued due to divisions of gender and class fueling opposition from both inside and outside of nursing.³ All opposition stemmed from the roots of hospitals' paternalistic control over nursing education and practice. Paternalistic control remained strong because of nursing's ties to a traditionally dependent woman's role. Yet changes within the social, cultural, and political context—particularly those influencing health care, medicine, and education—created an official division of labor for nursing care and intensified both the desire and need to enhance the quality of education for nurses. Numerous studies on nursing and nursing education supported the nurse leaders' educational vision and the division of labor for nursing; yet, the changes in health care, advances in medicine, and socio-cultural-political forces paradoxically paralyzed and triggered nurse leaders' efforts to advance the quality and level of education for nurses. Montag, supportive of the division of labor concept and of the desire for collegiate education for nurses, developed the ADN educational pathway predominantly within junior and community colleges with an implicit motive to replace the diploma educational pathway to nursing practice that perpetuated paternalistic control, and to replace the role of the practical nurse whose limited vocational training challenged the professionalization of nursing. The development of the ADN program served two major purposes: to ultimately abolish hospitals' paternalistic control of nursing education rooted in division of gender, and to restructure divisions of labor and class with the preparation of a new worker in nursing—the technical nurse—educated within an institution of

higher learning to work with the professional nurse to provide the complex care of the twentieth century patient within the technologically rich hospital.

Historical Context

Changing Role of the Trained Registered Nurse

The role of the trained nurse changed drastically between 1916 and 1952 as her work environment changed. The autonomous role of the public health nurse came to a halt as medicine and the government became involved in the public health movement. Private-duty nurses became a luxury for patients and hospitals as patients now received the majority of nursing care in the hospital. More complex cases and new financial management strategies forced hospitals to hire graduate nurses to staff wards rather than use students to provide the nursing care of the hospital. The changing role of the public health nurse, private-duty nurse, and hospital nurse altered the educational needs of the registered nurse.

It is historically important to clarify the identity of the “registered nurse.” State registration laws began in 1903 as noted in *CHAPTER 5 – BSN Pathway*. By the mid 1920’s, all the states enacted laws acknowledging professional accreditation of nursing schools based on selected criteria, but the states did not enforce the law or require all schools to earn accreditation.⁴ Students who graduated from the accredited schools could submit their diploma to their state board and receive the stamp of approval and thus hold the title registered nurse.⁵ The individual accredited schools or state boards of nursing did not require graduate nurses to register and, more importantly, state registration laws did not legally restrain non-registered nurses from practicing.⁶ The optional, nurse registration state laws based on school accreditation, known as permissive legislation, carried little impact or effect on the education or practice of nurses. In 1938, thirty-five years after the permissive legislation for nurse registration passed in North

Carolina, New York passed the first mandatory registered nurse licensing law.⁷ Most states retained permissive legislation regarding nurse registration until after World War II and standards varied widely from state to state. Today, nurses must hold a registered nurse license to practice as a registered nurse. For clarity within the chapter because of the long time frame and varied existence of permissive legislation for registration, the term “trained nurse” will refer to a nurse who graduated from a diploma hospital school in the 1920’s and 1930’s whereas the term “registered nurse” will refer to a nurse who graduated from a diploma hospital school after 1940 and to a nurse who graduated from a nursing program within a collegiate institution. The term “graduate nurse” will refer to the broad category of any nurse who attended a formal nurse training program.

Barbara Melosh’s narrative in her book, *“The Physician’s Hands:” Work Culture and Conflict in American Nursing*, captures the complex changing social contexts of nursing care from the 1920’s to the 1970’s. Her analysis of the culture and work settings of nurses will be predominantly used to illustrate the roles and respective settings of the trained nurse between 1920 and 1950 to build the historical context of the ADN Pathway case study.

The Demise of the Public Health Nurses’ Autonomous Role

The reorganization of public health with expanded public funding in the 1930’s and 1940’s drastically altered the autonomous role and self-proclaimed, professional identity of the public health nurse. In the first three decades of the twentieth century, the lay organization of public health permitted nurses’ authority “beyond the traditional bounds set by medical prerogatives” and thus facilitated the public health nurses’ autonomy and self-proclaimed elite, professional status.⁸ In the 1920’s, visiting nurse agencies, administered by nurses and lay boards, fostered nursing initiatives and provided the most favorable environment of all the public

health settings.⁹ Physicians opposed public health work to defend the professional prerogatives of medicine; the lay public health movement threatened physicians' claims to the "exclusive right to define the content and organization of medical care, to control related services, and to work without constraints from outsiders."¹⁰ Not surprisingly as a result of the fear of losing control, physicians pushed for involvement, and themes of preventative medicine and tax support for comprehensive public health services surfaced repeatedly in the American Medical Association's majority report of the 1932 national survey.¹¹

Public health grew as a prominent concern considered in national planning during the Depression and World War II and resulted in federal and state funding. Government funding in the 1930's moved public health nursing away from the "nonofficial" visiting nurse agencies to health departments and boards of education.¹² The health departments and boards of education assumed most preventive and educational work and referred bedside nursing to private agencies, nearly replacing every function of the public health nurse role.¹³ By the 1940's, the public health work shifted to the hospitals or "community health centers" where outpatient clinics or social service departments assumed most of the services formerly provided by the official and nonofficial agencies.¹⁴ As public health services reorganized under the control of the hospital and medicine, public health nurses lost autonomy, distinctive identity, and marginal status.¹⁵

Reorganization of public health changed and weakened the unique nurse-patient relationship once characterized by intimacy within the home and an all-inclusiveness of the public health nurses' role in relation to the patients' needs. The public health nurse now functioned as an administrator and "liaison nurse" who delivered outpatient services through the referral of patients to the community social services and thus lost a good portion of direct patient contact.¹⁶ Additionally, nutritionists, physical therapists, and social workers each claimed a

unique role within public health.¹⁷ Division of labor occurred with the intrusion of workers from fields outside of nursing but also from within nursing. Demands of the war, along with the shortage of adequately prepared public health nurses, prompted agencies to increase their use of volunteers, practical nurses, and registered nurses with no experience or training in public health.¹⁸ The public health nurse's loss of independence with the location of the nurse's services moved to the hospital, and the new division of labor for public health services, forced the unique professional and autonomous role of the public health nurse to disintegrate, and the nurses returned to the dependent role under the physician.

The independent initiatives realized by the public health nurses in the early decades of the twentieth century evolved from the social organization of their work separate from mainstream medicine and organized in semiautonomous agencies.¹⁹ The public health nurses' elite position within nursing formed partly because of their educational credentials but all nurses shared the actual nursing knowledge and skills the public health nurse used in her practice.²⁰ This commonality along with the lessened value of education for nurses held by most health care authorities secured the public health nurses' place as outsiders who held little influence on the authorities that controlled medical services.²¹ As the institutions and physicians of mainstream medicine embraced the public health movement and asserted control of public health services, the autonomy of the public health nurse role diminished. With public health gaining recognition and support from the elite center of medicine, the public health nurses—the practical authority of the public health movement—may have initially celebrated their success as the professional elite medical community joined their efforts. Ironically, the public health nurses' success cost them their authority and autonomy. In 1953, the separate identity of public health nursing officially dissolved when the National Organization of Public Health Nursing (NOPHN) disbanded.²² The

argument for professional collegiate education for the public health nurse weakened as paternalistic control caused the loss of the separate and autonomous identity of the public health nurse and created the new division of labor within public health.

Private-Duty Nurses Become a Rare Luxury

The increased use of hospitals by patients changed the work setting and role of the trained nurse in private-duty. The movement of the private-duty nurse to the hospital created a new distinct identity for the trained nurse and a new division of labor between the practical and trained nurse. Coupled with a shift in hospital management strategies, trained nurses hired to work as hospital general staff nurses eventually replaced the private-duty nurses within the hospital by the 1940's.

Hospitals failed to hire trained nurses, resulting in an uncertain freelance market of private-duty nursing as the primary means to work as a trained nurse. Since hospitals staffed the wards with students rather than trained nurses, recruitment of new students served to replenish the hospitals' workforces.²³ The process of recruiting students rather than hiring trained nurse graduates created a "severe employment crisis" by the mid-1920's; "between 1900 and 1920, the number of trained nurses rose from 11,804 to 149,128, while the populations of the United States increased by less than 50%."²⁴ The unbalanced supply and demand of private-duty nursing resulted in many private-duty nurses without work. The majority of private-duty nurses "lived uncomfortably close to the margin of economic insecurity."²⁵ The informal hiring networks, introduced in *CHAPTER 5 – BSN Pathway*, continued to either secure or destroy a private-duty nurse's livelihood depending on her reputation and relationships with physicians and their authority over the care of the patients.

The poor economic arrangements of private-duty nursing forced many trained nurses to accept positions that required more or less than skilled, nursing care, thus undermining the skills and knowledge of their nurse training. Additionally, both the physicians' authority over the patient and the patients' whimsical demands interfered with nurses' need and ability to autonomously define the work of the nurse.²⁶ Private-duty nurses continued to compete, at times, for work with the less expensive, practical nurses. The need to economically survive coupled with physicians' control and practical nurse competition hindered the development of a distinct role with professional range of functions for the trained, private-duty nurse. Again, divisions of gender and class served as a challenge for the resolution of the historical debate, yet nursing gained recognition as skilled work by 1920. The beginning of a suitable division of labor between the trained and practical nurse resulted.

In the early 1920's, trained, private-duty nurses began to care for their patients in the hospital setting due to the available medical resources within the hospital and for the convenience of the physician. By 1930, eighty percent of all private-duty nurses attended cases in the hospital.²⁷ The move into the hospital appeared advantageous for the private-duty nurse. Private-duty care in the hospital remained more limited to skilled nursing care and, therefore, suspended the use of private-duty nurses for domestic services. The clear distinction between the nurse's trained skills and the work done by domestic servants or laywomen in the family allowed the nurse to restrict her duties more closely to bedside nursing care. Furthermore, the technical skills demanded by acute care in the hospital extended beyond the abilities of most laywomen, thus securing identification of the unique skill of the trained nurse. The hospital setting afforded the trained, private-duty nurse recognition of differentiation of skill and training from that of the practical nurse and laywomen. Trained nurses attended private-duty cases involving sicker

patients in the hospital setting while practical nurses attended chronic cases, convalescences, and many obstetrical cases within the home; “a 1943 survey indicated that 90% of the home cases were attended by such workers, known as practical nurses, subsidiaries, auxiliaries, or “short-course” nurses.”²⁸ Despite the success of differentiation of role and functions based on the acuity of the patient, the hospital setting also held some of the same disadvantages of the traditional home setting for the private-duty nurse.

Continued existence within the freelance market and isolation still held true for the private-duty nurse working in the hospital. Despite the change of the work setting from the home to hospital, the private-duty nurse still obtained cases through the same hiring system. This system required the nurse’s connection and reputation with physicians to guarantee her work. Often the private-duty patient and nurse remained isolated within a private room apart from the hospital staff and student nurses. The isolation whether within the home or private hospital room limited nurses’ opportunities to stay abreast with medical and nursing innovations.²⁹ Additionally, the continuance of the unregulated private-duty freelance market offered no incentive for nurses to continue education. Nurses understandably were reluctant to expend time, money, and efforts for further education when no raises or promotions would result.³⁰ Lack of both broadened experiences and further education threatened the nurses’ continued learning within the nursing discipline.

A shift in hospital management also served as a major disadvantage for the livelihood of the private-duty nurse. Hospitals, a “once-charitable institution, . . . modified its philanthropic ethos with a business sensibility.”³¹ Hospitals organized the setting and services for greater economic efficiency of the business as a whole. Hospital administrators created centralized services such as central kitchens and central supply, and organized beds by medical needs rather

than the traditional segregation by gender and class.³² By the 1930's, hospitals recognized the inadequacy of the hospital nursing workforce of freelance private-duty nurses and students to meet the demands of the industry of patient care.³³ The nursing workforce of students and private-duty nurses lacked the flexibility required for personnel management within the new economically savvy and efficient hospital business. Hospitals started to hire trained nurses to supplement student nursing staff. A series of cost studies on the economy of hospital schools was completed; although the studies "found that student nursing services provided a slight economic advantage over graduate staffs, all recommended the transition to graduate nurs[es]" for staffing.³⁴ As the level of general care within the hospital elevated through staffing the hospital with trained nurses, the need for a special or private-duty nurse within the hospital lessened. The hospital private-duty nurse increasingly became "a luxury rather than a necessary adjunct to hospital care."³⁵ Hospital management grew critical of private-duty nurses because the use of one nurse to care for one patient seemed to misuse skilled labor.³⁶ Trained nurses now had a choice —stay within private-duty nursing and hope for work, or work for the hospital as a general staff nurse. Likely surprising to most nurses today, trained nurses reluctantly headed to the hospitals to work as general staff nurses; the nurses resisted the paternalistic control they had once experienced in nursing school.

The shift of private-duty nursing to the hospital allowed the trained nurse to gain a distinction based on training and expert skill from that of the practical nurse. Yet, as the hospital administrators recognized the trained nurses' skill, the private-duty nurse lost her perceived autonomy as the hospitals hired the trained nurses to staff the hospitals. Although hospitals began to hire trained nurses in the 1930's, interestingly, student nurses continued to work in supervisory roles up into the 1950's.³⁷

Graduate Nurses Now Staff the Hospital

The changing role and environment of the trained nurses' work from home and hospital private-duty nurse to hospital staff nurse created both challenges and opportunities for nursing. Challenges involved the return to the center of paternalistic control where the hospital's business goals changed the nature of the trained nurse's work, which "undermined traditional skills and ultimately threatened the very identity of nursing itself."³⁸ Yet, the movement to the hospital provided economic security and expanded experiences for the trained nurse as well as provided nursing an opportunity to gain a distinct professional identity within the hospital based on the nurses' contribution to the care of patients. Division of labor for nursing care served as the major factor for both the challenges and opportunities.

Return to paternalistic control

The paternalistic control of hospital nurses extended from the nurse's expected place of residence to detailed steps of the nurse's care. Most hospitals expected the trained nurses to live in the hospital's nurse residence and the nurses' low wages forced many to abide.³⁹ Not surprisingly, most hospitals did not offer a higher wage for the nurse if she did not use the institutional residence.⁴⁰ Use of the institutional residence denied nurses the privilege of independent living that young women of this time were accustomed to enjoy.⁴¹ Nurses became annoyed and irritated by the restraints and constant supervision.⁴² The expectation of nurses to reside in the hospitals' nurse residences declined through the 1940's; "by the end of 1946, less than ten percent [of hospitals] still required staff nurses to 'live in,' and most had made adjustments in salaries for 'living out.'"⁴³ The graduate nurses resisted hospital policies that regulated their social lives and instituted the same fervor for policies that constrained their work.⁴⁴

In addition to the ever-existing traditional restraints of medical authority, the new business-minded administrators' authority also interfered with the nurses' work. Institutional demands for efficiency changed the content of the nurses' work with a new emphasis on speed of care and division of labor.⁴⁵ The new expected pace of the nurses' work threatened traditional methods of nursing care. Some veterans of private-duty objected to the hospital's methods for efficiency because the methods caused a deterioration in the art of bedside nursing.⁴⁶ Nurses struggled with frustration from the pressure for speed and efficiency. As the trained nurses resisted encroachment, they "sometimes refused to follow revised procedures, defending the venerable traditions they had learned in training school."⁴⁷ A nurse's method and procedure of performing nursing care held deep roots with her training and experiences as a student within a particular training school. The nurse's learned methods supported her identity as a trained nurse; nurses "resisted standardization of education and practice, defending themselves against an upgrading that would devalue their own skills and their hospital school diplomas."⁴⁸ Furthermore, nurses feared that "standardization of procedures might reduce nurses to being mere technicians, mechanical and unthinking."⁴⁹ Nurse leaders of the National League for Nursing Education (NLNE) supported the efficiency efforts of the hospitals, including standardization of procedures and division of labor. The nurse leaders embraced the underlying logic of efficiency and supported the increasing division of labor within the hospital because they recognized the expanding role of hospitals in medical care, and saw hospitals as a strategic practice setting for nurses.⁵⁰

Hospital schools remained at the center of the debate between professional, nurse leaders and working nurses. The superintendents and graduate nurses who opposed the nurse leaders' efforts held a strong interest in the existing system, despite its flaws. Hospital programs provided

a common experience shared by generations of student nurses that supported the nurse's known identity. Influenced by the ideology of division of gender and paternalistic control, superintendents also fought to retain their control; "superintendents exercised a considerable autonomy under the apprenticeship system, running their schools and their wards according to their own notions of proper training and discipline."⁵¹ Superintendents tried to apply the same strict discipline to the newly hired, trained nurses and clearly preferred the student staff because they were "more amenable to correction and discipline."⁵² The hospital schools represented their own unique ideology that offered a prevailing alternative and, at times, direct challenge to the values and principles of professional ideology that the nurse leaders endeavored to carry out for the trained nurse within the hospital.

Division of labor within the hospital

Economic and practical reality supported the use of auxiliary personnel, to include the practical nurse, within public health and private-duty nursing as previously noted. The economically-conscious and efficiency-focused hospital management implemented the same division of labor and turned to lower-paid auxiliary workers to most economically and efficiently solve their staffing problems.⁵³ The hospital's division of labor for nursing care created unrest for nurses and nurse leaders because the continued existence of self-proclaimed nurses who lacked formal hospital training provided an annoying reminder that nursing failed to gain full professionalization.⁵⁴ Nurse leaders switched from unsuccessful attempts to abolish auxiliaries altogether in the 1920's to an agreement in 1932 to develop guidelines to define and control the work of the auxiliaries.⁵⁵ In the 1930's and 1940's, nurse leaders resigned to establish and enforce standards for mandatory licensing of practical nurses in order to defend the trained, registered nurse position within nursing.⁵⁶ The NLNE soon realized the difficulty to differentiate

clearly defined nursing tasks among the workers. In 1936, the NLNE advocated in its *Manual of the Essentials of Good Hospital Nursing* a “flexible division of labor based on skills or ‘functions’ rather than on fixed tasks.”⁵⁷ Practical reality allowed the limitations of auxiliary work to gain fluidity during a busy day within the hospital and thus “further blurred the boundaries of a nurse’s special expertise.”⁵⁸ Such realities drove the NLNE to work to secure the registered nurse’s control over the new division of labor whereas the registered nurse would hold authority to delegate tasks to the auxiliary nurse.⁵⁹ Control assured nursing that the auxiliary nurse would not replace the registered nurse. In January 1941, both the American Nurses’ Association (ANA) and the NLNE recommended that only registered nurses provide the direct patient care of bedside nursing within the hospital.⁶⁰ The outbreak of World War II in December 1941 prompted a shortage of nurses, which compelled the professional associations to resign their positions and accept auxiliaries as an official part of the nursing workforce.⁶¹ Interestingly, nurses reluctantly conceded to the professional associations’ acceptance; a 1944 slogan expressed their reluctance: “A nurse for everything, but every nurse in her place!”⁶²

Active participation of the professional associations in the development of practical nursing in the 1940’s secured practical nursing’s official membership into organized nursing and solidified a position for practical nursing within the division of nursing labor. Hospitals always supported an informal division of labor among non-nurse attendants, student nurses, advanced students, and graduate trained nurses, and trained nurses always competed for work with untrained nurses; but, as the auxiliary personnel secured clearly defined positions within the division of labor, nurses experienced uneasiness. Just as physicians feared the competition of nurses, practical nurses—without clear limits on the scope of the practical nurse’s training and practice—served as competitors for the work and professional identity of the trained nurse. The

new supervisory role of the trained, registered nurse over the auxiliary personnel reinforced the argument that registered nurses need a collegiate education. A definitive difference between the practical nurse's training and the registered nurse's collegiate education would ensure clear differentiation of practice within the division of labor and separation of professional identity.

Professional advantages to the hospital setting

The division of labor within the hospital pushed nurses' professional associations to support and define the role of practical nurses within organized nursing. Although initially opposed, the clear division of labor of the practical nurse provided an opportunity for the registered nurse to clearly define her role. The hospital setting presented nursing with several advantages to clearly define the professional identity, both the role and functions, of the trained, registered nurse. As noted previously, nurses gained economic security within the hospital with consistent work and working conditions that private-duty nursing could not offer all nurses.⁶³ Hospital work offered nurses a stronger position in the labor market. Ward work within the hospital provided consistent exposure to a social support network of nurses compared to the isolation of private-duty nursing.⁶⁴ The support and solidarity of the social network within the workplace fostered an awareness of common interests and grievances.⁶⁵ The expanding responsibilities within the technological environment of the hospital strengthened trained nurses' claims to "special expertise" compared to the lay, self-proclaimed nurses.⁶⁶ The advancing complexity of medicine and hospital care secured an "interdependent" professional relationship between medicine and nursing.⁶⁷ Advances in medical and surgical techniques promoted aggressive medical interventions, thus the observation and intervention of a skilled nurse proved to be more vital in the care of complex patients.⁶⁸ The close collaboration between nurse and physician demanded by the complexity of the patient's medical situations encouraged physicians

to “treat nurses more like medical colleagues.”⁶⁹ The interdependent role and nurses’ increased functions related to advanced medical care heightened patients’ recognition of nurses’ skilled contribution to their care.⁷⁰ The role and functions of the trained, registered nurse softened the division of gender and changed to an interdependent rather than dependent role with medicine as the complexity of patient care increased within the new hospital system; “every new development in medicine create[ed] new responsibilities for nursing.”⁷¹ The new role and functions coupled with the division of labor placing the registered nurse as the team leader of hospital nursing care provided an opportunity for the registered nurse to gain recognized professional status. A collegiate education for the registered nurse distinctly different from that of the practical nurse could secure professional differentiation within the division of nursing labor.

Trained nurses resist new role

A mounting challenge existed in the resistance of the diploma-prepared, trained nurse to accept the new team leader role:

Many nurses were unhappy with the growing division of labor and with their new administrative duties. As administrators increasingly placed registered nurses in supervisory positions in charge of delegating bedside care to [practical nurses] and aides, many nurses regretted the loss of their traditional relationship with the patient.⁷²

Many nurses expressed frustration with the functional division of labor that created a greater distance between the nurse and bedside care of the patient and threatened their known identity.

Rather than embrace the nurse leaders’ view of their new role as an opportunity for recognized professional status, many trained nurses fought the loss of their traditional role and identity:

A sense of threat to [the graduate, registered nurses’] own security as well as the traditional conception of the nurses’ function as all inclusive, and the feeling that any part of the patient would suffer if it were delegated, led registered nurses to view the admission of others to their precincts with suspicion and reluctance.⁷³

Part of the frustration and anger may have stemmed from lack of educational preparation to assume the new role. The education of the trained and registered nurse changed little despite the many changes that occurred in the nurse's practice; "such fears [of the registered nurses] are justified only if one group stands still while another advances."⁷⁴

The division of labor for nursing care created an identity crisis for the diploma-prepared nurse. As the practical nurse secured her bedside position within organized nursing care and nurse leaders pushed for the registered nurse prepared in a professional, collegiate education program to serve in the team leader role, diploma nurses lost the role and functions previously afforded to them and lacked a defined role and identity within the division of labor for nursing care.

Nurse Training and Nursing Education Since 1916

Nursing education made minimal improvements or significant changes despite the numerous changes in health care that directly affected the role and practice of the nurse. Nursing education's stagnation served as a codependent factor for continued paternalistic control and for unprepared registered nurses to assume the new roles created by the socio-cultural-political forces. Furthermore, the state of nursing education and the paternalistic control of nursing practice served as weak competitive forces for potential candidates and forced careful study of nursing education.

Minimal Improvements

Despite the forward vision of nurse educators such as Laura Logan, degree programs to prepare professional, registered nurses did not rapidly develop. In addition, most of the degree programs that developed over the years did not meet professional education criteria. Hospital-

based, three-year, apprenticeship-style diploma programs maintained a strong existence and produced the greater majority of trained and registered nurses.

Many of the collegiate institutions with nursing programs “failed to maintain for students in nursing the same policies and standards as for those in other professional curricula leading to a baccalaureate degree.”⁷⁵ As late as 1951, less than five percent of the 102,509 students enrolled in a nursing program received their entire collegiate nursing education, both general and nursing courses, directly from the collegiate institution in which they were enrolled.⁷⁶ Greater than ninety percent of nursing students received their entire nurse training in diploma hospital schools and the remaining students enrolled in collegiate institutions received the general education courses from the college and the nursing courses “in hospital schools with instruction by hospital school teachers in classes usually shared with diploma students.”⁷⁷ The latter programs, dual BS/diploma programs, proved to be a means of perpetuating the apprenticeship model rather than elevating the education of the nurse to a professional level because the nursing courses still remained within a hospital school.⁷⁸ Additionally, in 1950, approximately 12,000 diploma nurses secured enrollment in a program to earn a baccalaureate degree. The common practice of the collegiate program granting “blanket credit” for the diploma degree without evaluating the students’ knowledge or skills, and the questionable quality of these programs resulted in an “erroneous impression” of professional nursing education.⁷⁹ Essentially, the hospitals still predominantly controlled nursing education; “the extension of collegiate opportunities [was] more apparent than real.”⁸⁰

Despite the low professional quality of many of the collegiate nursing programs, the connection to a collegiate institution provided advantages for the student both personally and professionally. Advantages for the student, not afforded to hospital school students, included

better facilities, a variety of social opportunities, and cultural exposure to students of other fields that broadened the student's social vision.⁸¹ These student advantages also proved valuable for the nursing faculty as well.⁸² Organization advantages for the educational program that directly impacted the student professionally included stricter admission and academic policies and a strengthened theoretical component of the curriculum.⁸³ The mere existence of nursing on the campuses of the collegiate institutions provided an opportunity to interpret nursing to other educators.⁸⁴

Nurse leaders through continued efforts effected small improvements for the educational standards in hospital schools for nurses such as pre-clinical classes, shorter clinical hours per day, and the required three-year length of the program for registration of the graduates. Despite the small improvements toward standardization, the diploma hospital-based program of students' educational experience differed greatly from the professional education of other fields and still harbored deficiencies. Hospital nursing students still endured an average 48-hour week, which included class time but not study time, while the "normal college program [was] based on a 45-hour week, with about one-third devoted to instruction and two-thirds to study."⁸⁵ Diluted science courses resulted because students were too tired and unprepared for class and because of the insufficient time allotted to properly conduct the class.⁸⁶ The number of the pre-clinical hours and clinical hours as well as the diversity of specialty rotations varied among the hospital schools.⁸⁷ The hospital schools did not intentionally coordinate the theory instruction provided to the students with the practice experiences of the student; the hospital school assigned the students to a practice area based on the service needs of the hospital.⁸⁸ The service needs of the hospital gained priority over the educational needs of the student. Often as the student advanced through the program they experienced less teaching and more practice hours.⁸⁹ Often, the

hospital schools held legal designation as a “professional school,” yet “obviously [they did] not fit into that category as it is generally defined in higher education.”⁹⁰ The interchangeable use of the terminology “professional,” “registered,” and “graduate” nurse led to the misunderstanding that hospital schools of nursing were professional schools.⁹¹ Even the best hospital schools, restrained by paternalistic control, held the “traditional attitude of treating students as subordinate workers,” thus “maximum educational results [could] not be achieved.”⁹² Whether the place of the hospital school should provide the education for nurses remained a crucial question.⁹³ Hospitals experienced conflict to balance quality nursing education and training for the student, and economic management of quality and affordable care for the patient. The conflict between responsibility for the student and the patient existed as the “fundamental reason for the persistent opposition to educational improvements within the hospital schools.”⁹⁴ Hospital service needs repeatedly gained priority over the students’ education. Serious deficiencies in the students’ education resulted regardless of the students’ proficiency in technical skills.

The Disconnect Between Education and Practice

Division of labor, as described previously, naturally surfaced as a plausible solution and desperate necessity to ensure supervised nursing care of the patient within the ever-changing medical and health care environment. Inadequacies of number and preparation of the professional, registered nurse challenged effective and safe division of labor within the nursing team.

All health care service agencies hired an extraordinarily large number of non-registered nurse (non-RN) personnel with limited training and expected these workers to “carry only simple nursing functions under supervision.”⁹⁵ The problem arrived in the unbalanced proportion of non-RN personnel to registered nurses (RNs) providing the supervision of the nursing care;

“when the proportion becomes unbalanced, this policy [supervised division of labor] is clearly inoperable.”⁹⁶

Both the collegiate and hospital programs failed to adequately prepare the graduate for the professional leader role and functions of the registered nurse within the new division of labor. The many socio-cultural-political changes affecting nursing practice, specifically health care authorities’ support for the division of labor for nursing care, demanded reorganization of nursing education:

Attention is being concentrated on the question of how nursing service can be made quantitatively and qualitatively adequate to meet ever-increasing demands, and how education can be used more largely and constructively to prepare personnel for such service.⁹⁷

In order to assume the role responsibilities and work and social functions placed upon the nurse both within the hospital and community, the registered nurse required a true professional, collegiate education. Bridgman in her 1953 book, *Collegiate Education for Nursing*, illustrates four main reasons registered nurses required a professional, collegiate education: expanded clinical responsibilities; responsibility for supportive, holistic care of the patient; responsibility in an inclusive health care program to include community and public health, clinics, and outpatient departments; and responsibility for auxiliary personnel.⁹⁸ The many changes in medicine and health care altered the role of the professional, registered nurse to the leader of the nursing team and thus required a professional, collegiate nursing education.

A clearly defined nursing team including the registered nurse, practical nurse, and nurse aide achieved the position as the most promising division of labor strategy to provide adequate supervision of auxiliary personnel and conserve nursing resources, yet the qualifications of the team leader determined the team’s effectiveness.⁹⁹ The concept of this coordinated nursing team

required clear differentiation of nursing functions among the personnel who held varied qualifications.¹⁰⁰

Education of Nurses Gains Attention

As the role and functions of the registered nurse increased in complexity due to evolving social forces and the division of labor, preparation and education of registered nurses also needed to change. Several reports on nursing suggested different levels, or a hierarchy of nurses, to provide a team approach to nursing care of patients, thus supporting the division of labor assumed by most health care agencies. These reports also echoed nurse leaders' desire to advance the education of nurses into the colleges and universities, and away from paternalistic, hospital control. The reports illustrated a recognized need to move nursing education to the higher institutions of learning to match the educational requirements of other professions—not only to maintain status quo with other professions but to ensure registered nurses receive a true and adequate professional education. As the paternalistic control of the hospitals held nursing education hostage to advance and other professional programs developed for other fields of discipline, nursing education gained the attention of several entities. Several studies on nursing education were conducted between 1916 and 1952. Three major hallmark studies include: *Nursing and Nursing Education in the United States*, published in 1923; *Nursing Schools: Today and Tomorrow*, published in 1934; and *Nursing for the Future*, published in 1948.¹⁰¹ Each of the noted hallmark nursing reports suggested differentiation of nursing functions for the division of nursing labor and elevation of the registered nurse and registered nurse education to true professional status.

Goldmark illustrated in the 1923 *Nursing and Nursing Education in the United States* report the inadequacy of the hospital-based diploma schools' capability to produce a professional

nurse. She emphasized the students' need for an organized, coordinated, and sufficient education was often "sacrificed to practical hospital experiences."¹⁰² The hospital training schools proved "inadequate for the preparation of the high grade nurses required for the care of serious illness."¹⁰³ Goldmark continued with the declaration of "importance in the furtherance of nursing education" to develop and strengthen the University Schools of Nursing to be of a "high grade."¹⁰⁴ She outlined the "high grade" university degree program to include two years of liberal studies education or general courses, and two years of an intensive hospital training followed by one year of postgraduate education in public health, institutional supervision, or nursing education.¹⁰⁵ Additionally, Goldmark addressed the auxiliary nursing personnel; "subsidiary service is an existing fact, whether we [nursing] like it or not."¹⁰⁶ She concluded that the subsidiary grade of nursing service should receive licensure after the worker completed an eight- to nine-month training course governed by the same governing body of nursing training schools. Essentially, Goldmark illustrated that nursing should ensure appropriate training and subsequent licensure of the subsidiary grade worker to legally separate the trained subsidiary worker from those not trained. The *Nursing and Nursing Education in the United States* report recommended professional education for the nurse in the university setting, pointed out that the diploma programs did not provide adequate education for professional nurse status, and solicited nursing control of subsidiary workers in nursing.

The 1934 Committee on the Grading of Nursing Schools' final report, *Nursing Schools: Today and Tomorrow*, built on Goldmark's recommendations and began to plainly define the role and functions of the professional nurse. The committee summarized the role and functions into eight conclusions (See APPENDIX B). Qualities of the professional nurse requested by patients, physicians, hospital administrators, community members, and nurses alike included

intelligence, judgment, technical skill, devotion, and willingness.¹⁰⁷ Furthermore, the committee illustrated the deficiencies of the hospital-based diploma programs and the inability of these programs to produce professional nurses. The weak apprenticeship system, lacking true one-on-one student and graduate nurse relationship, served to be the main deficiency; “despite the many advantages it [hospital] offers, working as an apprentice in a hospital is not the same as studying in a school.”¹⁰⁸ The committee emphasized how the hospital-controlled schools focused first on service needs and second, on the education of the students.¹⁰⁹ The report continued to outline the criteria of a professional school for nursing. The Committee on the Grading of Nursing Schools echoed the need to elevate the nurse to the role of professional nurse and to do so through reformation of the nursing education program into the universities and colleges, and away from the hospital-controlled schools.

Brown reemphasized differentiated practice, ideals of professional nursing, and deficiencies of the hospital-based diploma schools in her 1948 study report, *Nursing for the Future*. Brown adamantly supported the practical nurse as one member of the coordinated nursing team and recommended “sound legislation relating to trained practical nurses.”¹¹⁰ She also addressed the controversy over the practical nurse and the fear nursing held in relation to the practical nurse. Brown succinctly wrote:

That there would be any substantial future threat from them [practical nurses], should they become readily available, is still more unlikely *provided graduate nurses [RNs] move in the years ahead to true professional status.*¹¹¹

Brown continued to explain that the professional or registered nurse would be the “responsible leadership” and the practical nurse “with trained skill in uncomplicated general nursing” would be viewed by professional nurses and society as “essential helpers, certainly not as competitors.”¹¹² Brown then outlined the professional education programs found in “universities

or colleges, hospitals affiliated with institutions of higher learning, medical colleges, or independently,” which served as the schools to educate the professional nurse. Questions of whether the diploma programs and its product, the graduate nurse, still held a place within nursing surfaced in the study report. Brown suggested official examination of every school with subsequent closure of the weaker schools and affiliation of the stronger schools with colleges and universities, not to exclude junior and community colleges.¹¹³ She also recommended study and experimentation of the role of the hospital schools.¹¹⁴ The *Nursing for the Future* report detailed how to differentiate nursing practice and delineated the titles and education preparation for each nurse, both the practical and professional, registered nurse.

The reports on nursing clearly demonstrated the need to reform nursing education away from the hospital-based school of nursing and dissolve the division of gender; to elevate the registered nurse to professional status through professional, collegiate education preparation and clearly delineate class division by education; and to differentiate the functions of nursing care among nurse workers who will work as a coordinated team within the division of nursing labor. Despite the repeated pleas within the nursing reports, reform for nursing education moved amazingly slow the first half of the twentieth century due to paternalistic control, the very force from which nursing tried to escape. Lack of reform created a workforce of nurses inadequately prepared for the existing reality of division of labor for nursing care.

Team Leader Lacks Qualifications

Because few degree programs existed, few degree-prepared nurses existed in practice as well. Without a sufficient supply of adequately prepared BSN nurses, the BSN nurses’ professional leader role of the nursing team would remain indeterminate. The diploma-prepared RN often assumed the leader role and functions within the nursing team merely due to the

insufficient supply of BSN nurses with a professional, collegiate education. Fortunately, many nurses “handicapped by inadequacies in their education...had invaluable experience and...by their own efforts kept up amazingly well with the expanding demands.”¹¹⁵ The continued stagnation of nursing education forced nurses to learn to carry out their new role and functions largely from practical experience rather than through the benefit of a thorough scientific and theoretical education. The advancement of nurses into positions for which they received inadequate preparation to assume created a false competence and identity for these nurses and served to pose as the greatest challenge for efforts to require a higher professional level of education for the registered nurse. This challenge still exists today. As noted previously, many hospital nurses, trained and registered, resisted and disliked the leader role of the nursing team as the division of labor entered the hospital. Distance from the patient and loss of a traditional bedside role with related functions served as the core of their frustration. Bridgman suggested that the “conception of nursing as an all-inclusive, indivisible function of doing everything for the welfare of patients stem[med] from the circumstances under which the earliest training programs were established.” Bridgman’s suggestion of the trained nurses throughout the early twentieth century illustrated the stagnation of nurse training and education in America. Bridgman further suggested that the nurses’ resistance to their new role grew from insecurity with their own capabilities for the expanding role and functions:

Everyone wishes to be needed but the importance of the lesser responsibilities is likely to be exaggerated only when larger ones are lacking or cannot be assumed.¹¹⁶

Regardless whether Bridgman’s suggestion of insecurity holds truth, nursing education programs—both hospital schools and collegiate programs—failed to adequately prepare registered nurses for the leader role of the nursing team within the new division of labor.

Nursing Education Competes for Candidates

With only a small number of degree programs for nursing, diploma hospital-based programs served as an almost exclusive means to enter RN practice. The diploma programs' limitations became increasingly apparent in relation to the demand and comparison with the educational programs for other fields, thus a limited supply of nurses resulted.¹¹⁷ The combination of the expanding role for nurses and comparatively decreased enrollment into nursing programs resulted in a looming national shortage of RNs. The critical deficiency in the supply of RNs existed as both a national and individual concern:

It is an intensely personal problem to the patient requiring nursing care, his family, his physician, and the short-handed nursing staff directly responsible for his safety and welfare, but in large it is a national problem of quantitative, qualitative, and distributive supply for an indispensable service to society.¹¹⁸

Essentially, four groups of high school graduates existed from which nursing could recruit candidates. High school graduates who desired: 1) immediate employment, 2) short-term preparation for a vocation, 3) two years of education post high school in a liberal arts college, junior college, technical school, community college, or specific school such as a hospital nursing school to learn an occupation, or 4) four years of education within a college or university to learn a profession.¹¹⁹ Most of the workers within nursing's division of labor grew from the first three groups of high school graduates. The majority of women in college did not consider nursing as a career; "only 1.2% of the 720,906 young women in the colleges and universities in 1950-1951 were enrolled in nursing programs."¹²⁰ The traditional nature of nurse training and nurses' work caused family, teachers, advisers, and friends to discourage able candidates interested in nursing. Considering the four groups of candidates and the majority type of the nursing programs available, it serves as no surprise that the collegiate nursing programs unsuccessfully competed for students aspiring to learn a profession.

The nursing programs did not offer the students the same level of social and recreational opportunities as the women enrolled in colleges for other fields of study experienced. The rigorous schedule and imposed social constraints limited the student's opportunities to fully participate in the college experience. The experiences outside of the classroom gained importance and value for the college youth:

To study, to play, to grow as a person, to meet obligations to society, to have men and women friends, all these motives and desires filled the consciousness of modern females. These college women, like those earlier in the century, received a significant portion of their education outside the classroom.¹²¹

The repetitive nature of the extensive apprenticeship-style programs which primarily focused on service rather than the student's learning served as a major deterrent for potential candidates. Four years of education in the college or university "included a richness and introduced [female students] to a variety of non-academic adventures" that hospital schools for nursing did not offer.¹²² Young ladies could enjoy the recreational and social opportunities of college and learn a marketable occupational or vocational skill in less time especially within the junior and community colleges that rapidly developed in the 1940's.

The junior and community colleges rapidly developed to provide a means for every capable American to obtain education up to fourteen years, or two years beyond high school.¹²³ Providing an affordable and accessible means for individuals to obtain needed work skills or prepare for a four-year degree served as the primary purpose of these two-year colleges and remains such even today. Due to the dynamic nature of the needs of society and its communities, the junior and community colleges embraced flexibility, experimentation, and innovation. These characteristics proved essential for experimentation of the third educational pathway, the ADN program.

Impact of War

The initiation of World War II in December 1941 increased the demand for even more nurses. Nursing care performed by trained nurses proved instrumental in the survival of soldiers as first prominently demonstrated by Florence Nightingale and her nurses during the Crimean War and then demonstrated by American nurses during the Civil War, Spanish American War, and World War I. The experiences of nurses and nurse leaders during the previous wars helped the nation and nurse leaders to recognize the need for an abundant supply of nurses with the threat of World War II. The increased demand for nurses influenced by the war required nurse educators to “re-examine some of their nursing education practices, the length of the basic nursing curriculum, and their attitude toward levels of practice.”¹²⁴ Strategies to increase the supply of nurses began before the war and continued throughout the war. Nursing focused on three main strategies: “1) economic and effective utilization of all professional resources; 2) the use of auxiliary nursing personnel for every function not requiring nursing skill; and 3) the preparation of increasing numbers of student nurses.”¹²⁵

Economic and effective utilization required bringing retired nurses back into practice and determining eligibility of nurses for military service. Nursing used positive patriotic campaigns and offered refresher courses to lure retired nurses back into practice.¹²⁶ The tasks of determining nurses’ eligibility and preparing nurses for military service required a balance with ensuring nurses not eligible for military service moved into essential home positions.

Increased use of auxiliary nursing personnel resurfaced an old concern for the profession of nursing. The category of auxiliary nursing personnel included practical nurses as well as nurse aides. The training, and role and functions of the auxiliary nursing personnel varied greatly. Variation of this magnitude created uncomfortable nurse leaders and threatened unsafe nursing

care of patients. The American Nurses Association (ANA), the National League for Nursing Education (NLNE), and the National Organization of Public Health Nursing (NOPHN) met together in 1941 to outline policies and principles related to subsidiary workers, or auxiliary nursing personnel.¹²⁷ The suggestions of this group included: preparation according to recognized standards, licensure by the state, and supervision of the practice of all auxiliary nursing personnel by a professional nurse.¹²⁸ Despite nursing's concern regarding the use of auxiliary nursing personnel, practical nurses and nurse aides filled the gaps created by the shortage of RNs. The reality of the shortage of RNs to meet the nation's needs demanded the use of auxiliary nursing personnel as a necessary means to provide patient care.

Recruitment to the existing nursing schools required positive advertisements for the profession of nursing in general. Positive proved difficult due to the apprentice-style, repetitive, and lengthy educational programs, and the poor working conditions and low income earned post graduation. Patriotic service equivalent to the men on the frontlines of war, females occupying the top positions within the field, and remarkable preparation for a later career as homemaker served as useful to positively recruit candidates to the profession of nursing. Additionally, a new educational opportunity, the Cadet Nurse Corps, increased enrollment significantly during the war.

In 1942, Representative Frances Payne Bolton (1885-1977), Congresswoman from Ohio and a friend to nursing, fought for federal monies to assist funding to increase the enrollments in the following schools of nursing: basic student training, postgraduate training, public health training, and refresher courses.¹²⁹ In 1943, Bolton proved instrumental in passing the Bolton Act, which formed the Cadet Nurse Corps. The Cadet Nurse Corps, somewhat of an accelerated education program, included 24 months of training in a state accredited school of nursing

followed by one year of work as a senior nursing student in a military or essential civilian position.¹³⁰ The cadets received a free education and, in return, every cadet pledged to stay active in military or essential civilian nursing for the duration of the war.¹³¹ Within one year, the Cadet Nurse Corps enrolled approximately 100,000 students.¹³² The enrollment of students into these Cadet programs dramatically increased the production of nurses during the war but not without some backward steps. Now the enormous amount of students in training and cadets in their final service year of training replaced the hospital RNs. The removal of the RNs renewed “the practice of making the school of nursing synonymous with nursing service.”¹³³ Service rather than learning remained the priority focus.

With the continuance of the war, steps to create a draft for nurses into military service occupied the minds of leaders in nursing and Congress in the early months of 1945. Fortunately, the war ended in September 1945 before the Senate voted on the draft bill, thus a nurse draft never manifested in the United States.

After the war, a total of 125,000 student nurses graduated from the Cadet Nurse Corps programs; yet, many military nurses did not return to bedside nursing or stopped nursing altogether.¹³⁴ The retired nurses enticed back to practice welcomed retirement once more. As the last students graduated from the Cadet Nurse Corps, hospitals began to lose its cadet nursing staff. In addition, the increased presence of auxiliary nursing personnel created a cloudy boundary with the functions of the RN. The loss of cadet nurses at the bedside coupled with the many soldiers returning from war with injuries and the numerous medical advances resulted in a continued demand for nurses. Although the various strategies to increase the quantity of nurses worked during the war, nurse leaders desired to remedy the fundamental reasons that enrollment

into existing nursing programs had decreased. Education reform for nursing and clearly defined role and functions for the professional RN served as priority topics for the profession of nursing.

Development of the ADN Pathway

Culture of Teachers College

Teachers College, Columbia University in New York City, earned recognition as a place of innovation, creativity, and outstanding leadership for nursing education. Well-known nurse leaders such as Isabel Hampton Robb (1860-1910), Mary Adelaide Nutting (1858-1948), Isabel Maitland Stewart (1878-1963), and Lavinia Dock (1858-1956) held positions as nursing faculty or chairman/director of the nursing department/division at Teachers College since its development in 1899. As noted previously in *CHAPTER 2 – Literature Review*, Teachers College offered the first graduate nurse courses to prepare nurses for careers as nurse educators. Courses to prepare the graduate nurse for roles in supervision and administration of training schools as well as roles in public health nursing also developed rapidly at Teachers College.

In 1945, Isabel Maitland Stewart served as the director of the nursing division of Teachers College and obtained a grant from the Kellogg Foundation to conduct five studies within nursing education: investigation of field experiences, student teaching experience, advanced clinical nursing studies, student personnel administration, and practical nurse education.¹³⁵ Two years later, in 1947, Stewart retired and Dr. R. Louise McManus (1896-1993) became the new director. McManus, born in Rhode Island, served as the first non-Canadian director of Teachers College Division of Nursing.¹³⁶ After earning a diploma in Institutional Management from Pratt Institute in Brooklyn, McManus earned her diploma in nursing at the Massachusetts General Hospital School of Nursing. McManus taught nursing at the Waterbury School of Nursing in Connecticut where she later became the director. She completed her PhD in

educational psychology in 1947, the year she became the director of the Division of Nursing at Teachers College.

Opposition to the Practical Nurse

McManus desired to complete all the projects initiated by Stewart, the preceding director. One project, the Kellogg Project on Practical Nurse Education, also referred to as Project V, caused McManus “a fair number of headaches.”¹³⁷ It is historically important to examine this project because of its close relation to the development of the associate degree in nursing program; the development of the associate degree in nursing education programs attempted to abolish the role of the practical nurse.

The aim of Project V concerned the “study and plan for preparation of administrators and teachers in programs of practical nurse education.”¹³⁸ Nurse leaders and nurse faculty including those at Teachers College remained divided on the position of the practical nurse (PN) within organized nursing. One side of the argument rested on the profession of nursing having no part in the preparation of this substandard auxiliary personnel whereas the other side felt the PN would remain in practice and, therefore, it would be best to oversee the education of the PN. A significant division and controversy created by the PN ensued. One nurse, Ms. Shay, resigned from the project for fear that “being identified with the practical nurse movement would jeopardize her opportunities in other fields of nursing.”¹³⁹ In 1948, the Dean of Teachers College denied Virginia Henderson (1897-1996), a nursing faculty member of Teachers College, reappointment of tenure because of her opposition to the practical nurse movement.¹⁴⁰ Despite challenges, the faculty of Teachers College forged ahead with completion of Project V with the understanding that the Division of Nursing Education at Teachers College had “no obligation...to actually implement a program for the preparation of professional nurses for

leadership positions in practical nursing, even perhaps if the study warranted it.”¹⁴¹ The faculty completed Project V in 1948.

Steps Toward Educational Reform

The opposition and controversy surrounding PN education held deeper roots because of the needed education reform for the current RN educational programs. As noted above, Henderson opposed PN education and she felt “that we [nursing] were wishing on the ‘practical nurse’ students all the things that were wrong with the hospital-controlled diploma programs.”¹⁴² The RN educational pathway programs showed deficiencies and needed reform; lack of a defined role with associated functions for the existing RNs challenged the needed reform. McManus recognized this challenge and initiated steps to define the role and functions of nursing.

McManus identified the ambiguity between the Bachelor’s and Master’s programs in nursing at Teachers College. Students in both programs enrolled in the same classes with the exception of the Master’s program students enrolling in graduate courses of other disciplines. Graduate level *nursing* courses did not exist. In order to revise the curriculum of each program, McManus recognized the need to clarify the nurse’s future role and associated functions needed by society. In the fall of 1947, McManus initiated the Committee on the Functions of Nursing and appointed Eli Ginzberg, chairman of the School of Business at Columbia University, as chairman of the committee.

Adopting a Division of Labor Assumption

The Committee on the Functions of Nursing discussed the shortage of nursing personnel and the role and functions of nurses in all work settings. With regard to the shortage, the committee encouraged recruitment of nontraditional students to include males, blacks, and

married students to alleviate, but not resolve, the shortage. The committee also recommended two tiers of nurses, separating the functions of nursing between these tiers. One tier included the professional nurse, who would be a degree-prepared nurse educated in a college or university for four years. The other tier included the practical nurse or nursing technician, educated in the adult and high school vocational system for nine to twelve months. The committee recommended two tiers of nurses, both the professional and technical or practical nurse, to provide care for patients using a “team approach.”

The recommended two-tier structure failed to include the diploma-prepared nurse who received her education within the hospital-based programs and who, interestingly, held the greater majority of RN licensure. The committee recommended diploma programs and diploma-prepared nurses “be phased out since she [diploma-prepared nurse] possessed only a few more skills than the projected practical nurse and has an insufficient academic background to function as a professional nurse.”¹⁴³ The committee also recommended decreasing the length of diploma programs to “two years or perhaps eighteen months without any sacrifice in quality by deleting repetition in clinical practice.”¹⁴⁴ The recommendation to decrease the length of the diploma programs produced confusion as such a program or the nurse it would produce failed to exist on the two-tier structure the committee created. The committee discussed inclusion of a third tier but decided against it: “Narrow differences in training and competence and unclear areas of responsibility would only contribute to confusion, jealousy, insecurity, and recrimination.”¹⁴⁵ Lack of a more definitive transition for the diploma programs troubled the recommended two-tier structure.

Despite the unsoundness of the two-tier structure, the idea of nursing with differentiated levels of education and practice roles and functions remained “one key idea in McManus’

mind.”¹⁴⁶ The nursing faculty at Teachers College adopted the assumptions of differentiation of nursing functions by education level for the division of nursing labor and worked to change their baccalaureate curriculum to include “‘professional undergraduate’ content focused on the nurse as the ‘team leader’ of the nursing team.”¹⁴⁷

The hallmark reports on nursing and nursing education previously noted supported McManus’s idea of differentiated nursing functions with specific educational programs to prepare each role. McManus and her committee did not originate the concept of differentiated practice, but McManus led Teachers College to begin experimentation.

New York State’s Push for Experimentation

In June 1951, the University of the State of New York, Department of Education (USNY-DOE) initiated an Advisory Committee on Experimental Programs with the following purpose:

The Board of Regents approves the creation of a representative committee of educators, hospital representatives, and nurses to analyze existing courses of study for the training of nurses, especially to the end that essential requirements of a basic program of study may be determined. Recommendations of the committee may well lead to the creation of Department-sponsored experimental programs for the training of nurses; such experimental programs should be in both hospital schools of nursing and in college-affiliated schools.¹⁴⁸

In the letter requesting McManus join the advisory committee, the underlying purpose of the committee was described as such: “That we may produce better nurses in the same, or perhaps shorter, time.”¹⁴⁹ New York demonstrated a forward step to alleviate the nursing shortage by determining the “essential requirements of a basic program of study” and developing the shortest program allowable to meet the minimum requirements.

The meeting of the advisory committee on experimental programs, held on July 11, 1951, served as the first of many as the committee continued to meet every two to four weeks for the remainder of the year. During the first meeting the advisory committee members decided to

focus experimentation on "programs in preparation for submission to registered nurse licensing examination" with the exception of "the one leading to a baccalaureate degree."¹⁵⁰ The guidelines or foci of the advisory committee continued to take form and one decided main goal included that the amounts of practice, or clinical time, in the experimental program would serve "sufficient to assure competence in nursing service."¹⁵¹

Although not explicitly discussed at the first advisory committee meeting, the original projected aim of the USNY-DOE centered on "a new design of education for the professional nurse in a program leading to a Bachelor of Science degree."¹⁵² Yet, urged by the "New York State Interdepartmental Health Council and others," the USNY-DOE redirected the aim to include "experimentation in education for professional nursing but also for nursing of a more technical type involving a more limited scope of responsibility."¹⁵³ The report of the USNY-DOE, dated more than one year prior to the first advisory meeting, described the recommendation for "experimental programs preparing for the more technical function nursing be established in some of the institute of applied arts and sciences or technical institutes under the auspices of the New York State University," and reviewed the support for this recommendation found in studies on nursing education.¹⁵⁴ With the knowledge of the "others," who happened to also serve as advisory committee members, and their urging that directly influenced the USNY-DOE's aim, the proceedings of the advisory committee seem predetermined.

As the advisory committee members began to suggest ideas for experimentation, they realized without preparation of a master list of RN duties, it proved difficult to decide on the elements of the RN curriculum.¹⁵⁵ The committee members analyzed the list of nursing duties and discussion of whether certain tasks fell under the realm of the RN rather than the PN

resulted. At the August 15, 1951 meeting, the discussion of differentiation of nursing tasks concluded and the committee decided "that the degree of illness and needs of the individual patient must determine who should provide the necessary services."¹⁵⁶ The committee recognized certain "pressures" that fell upon the committee in regard to the experimental program; the program needed to turn out more nurses faster, use the public education system of the state, and prepare nurses better in the most socially-economical manner.¹⁵⁷ The pressures leaned the committee toward the two-year technical program. The committee also decided that the faculty of the experimental program, rather than the committee, should determine the curriculum; the committee merely needed to develop criteria for evaluation of a curriculum plan. First the committee needed to determine the required knowledge and skills of the RN.

By the fifth meeting on November 2, 1951, the advisory committee "shifted the emphasis of committee activity from the time-consuming projects of spelling out course content and functional analysis to the development and refinement of criteria for experimental programs."¹⁵⁸ Members asked additional clarifying questions before working on the criteria. Questions regarded the "degree of expertness" of the graduate of the experimental program, whether the aim was to create "new programs on various levels," and if the need to improve nursing education included "gearing it into the system of general education."¹⁵⁹ On December 14, 1951, the committee met for the sixth time and managed to create suggested criteria for an experimental program in nursing to submit to the State Department of Education for approval.

Although the committee switched gears from functional analysis to selection of criteria for the experimental program, documents found with the Advisory Committee on Experimental Programs minutes included a preliminary plan for differentiation based on the functional analysis. Beginning documents demonstrate differentiation of functions by professional nurse,

practical nurse, and hospital nursing aide.¹⁶⁰ Yet, as the committee considered the new experimental program, differentiation of functions changed to include three categories: professional nurse, technical or semi-professional nurse, and assisting nurse.¹⁶¹ The technical nurse functions referenced both the practical nurse and technical nurse.¹⁶²

The atmosphere in New York related to nursing, encouraged by the hallmark nursing reports, embraced reform through experimentation with nursing education. The desire proved present but the procedure left unknown. Mildred Montag provided the much-desired framework for experimentation.

Montag's Research

Mildred Montag, a faculty member and doctoral student at Teachers College, held a research interest on the use of auxiliary nursing personnel in hospitals; more specifically, how vocational education may prepare auxiliary personnel. Her dissertation research provided the framework for the experimental program.

Montag earned a Bachelor of Art degree in history from Hamline University in St. Paul, Minnesota and her Bachelor of Science degree in nursing from the University of Minnesota in 1933.¹⁶³ She taught at St. Luke's Hospital School of Nursing and earned her Master's degree in nursing education from Teachers College in 1938, the same year she began teaching at Teachers College. She began working on her doctoral studies in the fall of 1938. She left Teachers College to establish a generic baccalaureate program in nursing at Adelphi College. Montag returned to Teachers College as a full-time doctoral student and part-time nursing faculty member in 1948.

Due to her research interest, Montag enrolled in courses regarding vocational education, and these courses introduced Montag to community colleges and technical education. As Montag's studies continued, her view of the practical nurse differed from the supporters of the

PN role: “The more that Montag researched, the more it became apparent to her that practical nurses were not the answer to any of nursing’s problems.” In an interview, Montag explained:

I concluded from my reading and from my own knowledge of practical nurses which was in fact quite limited, that the contribution of practical nurses was indeed too small to warrant their use...It is my firm conviction that the direct care of patients is too important to be turned over to a variety of partly trained or completely untrained persons.¹⁶⁴

Although Montag did not believe that the practical nurse served as the solution, she did believe that nursing functions could be differentiated enough to specify an educational program to prepare each role. Montag began to contemplate a new worker for nursing, the technical nurse.

Montag completed her dissertation, *Education for Nursing Technicians*, at Columbia University in 1951. Montag’s dissertation research proposed a two-year program within the junior and community colleges that would result in graduates with associate degrees in nursing who would qualify to test for RN licensure and enter practice as technical nurses.

Montag’s doctoral research was based on the assumption that nursing functions could be viewed on a “continuum” differentiating the practice of nursing into three distinct roles with specified functions: the nurse aide, the technical nurse, and the professional nurse.¹⁶⁵ According to Montag, the nurse aide could be trained “on-the-job” without completing a training course distinct from the employing agency.¹⁶⁶ Montag defined the BSN-prepared nurse as the “professional” nurse and the ADN-prepared nurse as the “technical” nurse.¹⁶⁷ The technical nurse performed within the role that fell in the center of Montag’s model. Within the role in the center, were the technical, also called semi-professional or intermediate functions. The technical functions were more limited in scope and restricted to largely repetitive and routine situations that required skilled techniques and exercise of judgment. The technical nurse carried out these functions under the supervision of a physician or a professional, BSN-prepared nurse. Montag based her research on the assumption that different educational programs could prepare

individuals to perform a specific range of functions along her model from the nurse aide to the professional nurse.¹⁶⁸ The research proposed a new worker in nursing, the technical nurse.

Montag altered the nursing functions continuum from that proposed by the nursing education reports and that preliminarily developed by the Advisory Committee for Experimental Programs. As noted previously, Goldmark and Brown suggested two tiers of nurses, the subsidiary worker or practical nurse, accordingly and the professional nurse. Advisory Committee for Experimental Programs supported a three-tier structure to include the nurse aide (assistant), diploma and practical nurse (technical), and the BSN nurse (professional). In the Advisory Committee for Experimental Programs model, the two nurses within the technical role floated; the practical nurse, at times, fell under the assistant role and the diploma nurse, at times, fell under the professional role largely due to lack of quantity of the practical and BSN nurses. In Montag's model, the technical role holds a clearly defined educational program. Although not explicitly stated in Montag's research study, the clearly defined educational program of the technical nurse abolished the diploma and practical nurses and their corresponding educational programs. The hospital-based, diploma programs prepared technical level nurses despite the three-year length because they focused on service needs of the hospital rather than education needs of the student.¹⁶⁹ The two-year program in the community college would prepare the technical nurse focusing on education rather than service in a more effective and economical way. Due to the vast majority of diploma-prepared RNs and hospital-based diploma programs, exclusion of the diploma programs and RNs from the nursing functions continuum and absence of explanation within the research study report presented a challenge and served as the foundation for controversy and debate. Major reorganization and restructuring of nursing practice and education resulted from Montag's modifications to the nursing functions continuum.

Interestingly, McManus, Montag's dissertation advisor, believed the range of nursing functions could still include the practical nurse but the technical role could be the priority experimental focus "at the expense of the practical nurse for a while." No evidence exists demonstrating her committee's concern for the diploma programs or diploma-prepared nurses.

Proposed Technical Nurse [Associate Degree] Preparation

The technical nurse preparation designed by Montag allowed students to gain a "combination of social understanding and technical competence," thus preparing graduates "to carry [out intermediate nursing functions] in the hospital and in the home and to live effectively as persons and citizens of the community."¹⁷⁰ The curriculum was an integrated program with general and technical courses combined. Montag's research proposed the community or junior colleges and technical institutes as the locations for the technical nursing education programs because technical or semi-professional preparation already existed within these institutions.¹⁷¹ The graduate would earn an associate degree in nursing and be eligible for RN licensure as a technical nurse; that is, the ADN graduate would be tested for the minimum RN competence required for the "safety of the public."¹⁷²

The associate degree in nursing earned at the junior or community college would be a terminal degree. The graduate would not need further education to enter the workforce as a technical nurse.¹⁷³ Yet, the fact that the program existed as terminal would not prevent the individual from advancing to a higher level of educational preparation if desired.¹⁷⁴

Montag provided the framework for an experimental program within the community and junior colleges. The specifics of the framework provided to the community and junior colleges for the associate degree in nursing program will be illustrated in the description of the first program at Orange County Community College.

Orange County Community College Desires to Experiment

Community and junior colleges grew rapidly in the 1940's. As these colleges searched for semi-professional and technical programs to offer, nursing presented as a viable option. Conversely, as nursing searched for avenues to reform nursing education, the junior and community colleges presented as viable options. Formal discussions began in 1949, with the initiation of a joint committee including the National League for Nursing Education (NLNE) and the American Association of Junior Colleges (AAJC) with Ralph Fields of Teachers College elected chairman.¹⁷⁵ The joint committee proposed to the NLNE board two program ideas: 1) a two-year program in nursing with transfer to a senior university; and 2) a three-year program that would culminate in an associate of arts or science degree and that would qualify the graduate for RN licensure.¹⁷⁶ During this time, many junior and community colleges held affiliation arrangements with hospital schools of nursing, providing students instruction in social and biological sciences, and some humanities courses; yet, no junior or community college freestanding nursing program existed.¹⁷⁷ Orange County Community College served as one of the colleges that held affiliation agreements.

Orange County Community College (OCCC) was founded in 1950, located in the southeastern section of New York and comprising mostly rural areas. Newburgh, New York, served as the largest city in the county, with a population of 32,000.¹⁷⁸ Correspondence dated as early as April 20, 1951 between President Edwin Miner of OCCC; McManus, the director of the Division of Nursing Education at Teachers College; and the director of the New York State Board of Examiners indicated advanced involvement and coordination for an experimental nursing program at Orange County Community College. While waiting for approved criteria of the experimental program from the Advisory Committee for Experimental Programs, OCCC

joined in affiliation agreements with two hospital schools of nursing: Middletown State Hospital School of Nursing and St. Luke's Hospital School of Nursing. In 1950, OCCC provided microbiology courses to first-year students at Middletown and in 1951, Middletown's first-year nursing students enrolled full time at OCCC for their general courses.¹⁷⁹ OCCC faculty provided psychology and sociology courses to the first-year nursing students of St. Luke at the hospital in 1951 and in 1952, St. Luke's first-year nursing students enrolled at OCCC full time for all of their general courses.¹⁸⁰ OCCC demonstrated confidence and desire to host the experimental nursing program because of the "growing need for nurses in the local area and the decrease in student enrollment in the two nursing schools in Orange County."¹⁸¹

President Miner initiated informal contacts with "medical, health, nursing and hospital groups in the area" before the approved criteria of the experimental program from the Advisory Committee for Experimental Programs became available.¹⁸² His forward initiative prepared the community and fostered interest, willingness, agreement, and a spirit of cooperation for the experimental program when it came to fruition.¹⁸³

In February 1952, the Advisory Committee for Experimental Programs released the criteria for the experimental nursing programs (See APPENDIX C).¹⁸⁴ Following release of the criteria, OCCC immediately began to organize a research plan and create the proposal for hosting the experimental program. President Miner submitted the proposed plan on April 2, 1952 at a conference in Albany, New York.

As previously noted, Montag's research concluded in 1951. Teachers College Division of Nursing Education proposed in November 1951 to serve as the host institution for the research pilot project, later to be known as the Cooperative Research Project in Junior and Community College Education for Nursing (CRP).¹⁸⁵ In 1952, after securing an anonymous grant in the

amount of \$110,000 and receiving final approval, Montag was named director, and a national advisory committee formed.¹⁸⁶ The advisory committee first met on March 12-13, 1952.¹⁸⁷ At this meeting, McManus and Montag informed the advisory committee of the background and interest in the project and summarized the proposed experimental program to include:

1. The development of a new type of nursing education program in a new educational setting, which would be a junior or community college;
2. Development of new types of educational programs within hospital schools of nursing;
3. An experimental project that will be accomplished through actual research;
4. An advisory service available to other selected schools; and
5. Establishment of a council of colleges and hospitals.¹⁸⁸

McManus and Montag also reviewed the characteristics of the new type of educational program, the criteria for selecting the pilot schools, and expected criteria for the graduates of the new educational programs.

Orange County Community College quickly developed the nursing curriculum through consultation with the advisory committee, secured approval from the New York State Education Department, and secured acceptance from the New York State Board of Nurse Examiners permitting the graduates of the experimental program eligibility to take the RN licensure exam. In August 1952, OCCC received final approval of the nursing curriculum plan (See APPENDIX D) and obtained authorization to begin experimentation.¹⁸⁹ OCCC scrambled to hire qualified faculty and successfully began the first associate degree in nursing program in September 1952 with thirteen students enrolled.¹⁹⁰

Preliminary Results of the Pilot Study

Orange County Community College was only one of seven schools ultimately selected to participate in the Cooperative Research Project in Junior and Community College Education for Nursing (CRP) despite numerous requests (See *CHAPTER 2 – Literature Review* for a full list of the seven schools). In addition, many other schools initiated associate degree in nursing programs outside of the CRP. The Advisory Committee provided consultative services to the schools outside of the CRP.

Over the next five years, between 1951 and 1956, the Advisory Committee met annually to discuss the progress of the project. Discussion included a wide range of topics and illustrated the debate that would ensue following the rapid growth of the ADN programs; the number of ADN programs grew rapidly and doubled every four years between 1952 and 1974.¹⁹¹ Minor items regarding the operation of the educational program such as admission criteria, student evaluation, qualifications and preparation of faculty, and retention and attrition of students surfaced through the years at the annual meetings.¹⁹² More significantly, discussion regarding the practical implementation of Montag’s differentiated practice model also surfaced.

In 1954, OCCC reported difficulty with curriculum design due to the lack of a “clear definition of nursing and the differentiation of functions.”¹⁹³ The difficulties with curriculum design foreshadowed the complexity that followed in practice to differentiate the role and functions of the ADN-prepared, technical registered nurse (RN) from that of the diploma and BSN-prepared RN. The graduate surveys of the OCCC in 1956 provided further support for the emerging complication for differentiated practice of the RN; “[ADN] graduates assum[ed] more responsibility than the college anticipated, but [the ADN graduates] were able to fulfill this responsibility well.”¹⁹⁴ The lack of a sufficient number of professional, BSN-prepared RNs also

created a problem for true implementation of Montag's differentiated practice model. At the 1956 annual meeting, the committee concluded that the diploma and ADN-prepared RNs would need to "fill the gap" until a sufficient number of professional, BSN-prepared RNs entered practice.¹⁹⁵ The negligence of attention for sufficient preparation, both in quantity and quality, of the professional BSN-prepared RN continued for nursing education and thus clear differentiation of a division of nursing labor using Montag's model failed. Furthermore, laxity on a defined and communicated plan for the diploma hospital schools and diploma nurses in practice created confusion and resistance; the NLNE consultant to the junior colleges reported "skepticism" of nurse leaders and "lack of understanding by nurses and hospital administrators" regarding the two-year, ADN program and its approach in nursing education.¹⁹⁶ The forward innovative movement by a minority group without support from the greater majority served as a common occurrence throughout the history of nursing education. It is historically important to note that the leadership of the professional organizations throughout nursing history differed by education from the majority of nurses. In the 1940's, the leadership of the professional organization, NLNE, primarily held nurse educator positions within colleges and universities whereas the nurses holding membership came primarily from hospital schools of nursing.¹⁹⁷ The professional aspirations of the nurse leaders in the late nineteenth and early twentieth century demonstrate this trend; leaders sought to secure the privileges of a few at the expense of many" and this behavior "proved both unproductive and divisive."¹⁹⁸ Despite the forward innovation, efforts often proved damaging. Melosh succinctly explained the reason:

They [nurse leaders] believed in women's education and tried passionately to make nurses' training equal to the best of it. But as they looked to the future of nursing and strived to make their vision real, they seldom gave more than a backward glance to those who would be left behind.¹⁹⁹

In the earlier years of the twentieth century when young women rarely worked after marriage, the duration of over half of all graduate nurses' career lasted no more than 10 years.²⁰⁰ Nursing existed as a temporary occupation for many of the nurses; therefore, the number left behind seemed minimal. Yet, in the 1950's, more women, comparatively, continued to work even after marriage and children thus, the number left behind grew substantially.²⁰¹ The largest resurfacing of the historical debate ensued following the addition of the ADN-prepared RN in practice; the enormous pool of diploma RNs ignored by Montag's model created the debate of such magnitude.

When the committee compared the two-year, ADN graduate to the diploma graduate, they concluded that both programs produced the same level worker but the programs differed in "control, philosophy and purpose, organization of clinical experiences, and teaching methods."²⁰² Additionally, the ADN programs within the junior and community colleges opened the profession of nursing to candidates who otherwise may never enroll in a hospital school of nursing. The firm social restrictions for the students enrolled in the diploma hospital programs proved difficult and impossible to endure for candidates who were other than single, white, young, and female. The ADN students of the CRP programs compared to the traditional students of nursing programs included older women, men, single mothers, and married women.²⁰³ The inclusion of the nontraditional persons into nursing created an anomaly for the traditional nurse within the hospital family. The ADN program within the junior and community colleges offered a viable solution to release nursing education and practice from the traditional paternalistic control of the hospital. The ADN programs led to the demise of the hospital-based diploma programs over the next several decades as implicitly planned within Montag's research study; however, the dissolve of the diploma programs did not occur without a fight.

Debate and Division Within Nursing

As introduced at the Annual Meetings of the CRP Advisory Committee, lack of a clearly defined role with differentiated functions in nursing not only challenged curriculum development but blurred the practice boundaries for the diploma-, ADN-, and BSN-prepared nurses working side-by-side in practice. ADN graduates were not used in practice as intended by Montag's research and practice model. Service agencies, the employers of the ADN graduates, hired the graduates into positions with the same nursing role and functions as the diploma- and BSN-prepared graduates, some of which were considered beyond the intended scope of practice for ADN nurses.²⁰⁴ The RN licensure rather than the educational preparation determined the role of the ADN graduate in the service agencies. Service agencies improved their orientation programs and ADN programs added content and courses that facilitated the ADN graduates' success in practice.²⁰⁵ Blurring of the technical nurse's role and functions in practice resulted in Montag's concept of the ADN nurse becoming "almost unrecognizable."²⁰⁶

The Plea for Differentiated Practice

Articles concerning the role of the ADN-prepared nurse in practice flooded the nursing literature in the 1960's and 1970's. The literature demonstrated various responses ranging from enthusiastic support to firm opposition regarding the inclusion of the new ADN-prepared nurse in nursing practice. A central theme within the literature emerged—a plea for differentiation of nursing roles and associated functions for the differently prepared RNs. Martha Rogers, a nurse leader and known nurse theorist, dedicated an entire book to plead for differentiated practice of RNs by educational preparation.

Rogers acknowledged that the initiation of the associate degree in nursing education programs "represented the first real break with the apprentice system" of the diploma hospital

schools.²⁰⁷ Yet, she also recognized that the future development of professional education demanded differentiation of nursing roles and functions:

The implications of these criteria [vocational, technical and professional] for differentiating levels of nursing care are unequivocal. The outcomes of society and to nurses as a result of such differentiation can be measured in safer and more adequate health services to people and in a renewed confidence and security among nurses who know who they are and who can seek excellence of performance within the framework of their preparation.²⁰⁸

Rogers believed that differentiated practice by educational preparation would not only augment nursing as a profession but also improve the welfare of society. Without differentiation, the public would have “little cognizance of the services it seeks or receives.”²⁰⁹ Rogers defined lack of differentiated nursing practice by educational preparation as “monuments of conflict and confusion.”²¹⁰ In 1961, 50 years ago, Rogers labeled the refusal to differentiate nursing practice as “one of the most significant problems facing nurses.”²¹¹

Rogers fully appreciated the value of education for the practice of nursing; “experience cannot be equated with knowledge, nor can one’s practice reflect more than the knowledge one brings to a situation.”²¹² To distinctly differentiate nursing, educational preparation rather than mere practical experience needed to separate the roles. Rogers explains:

Work experience will not transform a practical nurse into a technical nurse nor a technical nurse into a professional practitioner, any more than it will transform a dental hygienist into a dentist or an engineering technician into an engineer.²¹³

Reliance on experience pushed nursing back to the apprenticeship model and away from acquisition of recognized professional status. The long-held existence of diploma hospital schools resulted in the majority of nurses in 1961 prepared for technical rather than professional nursing practice and “the critical group—beginning professional practitioners [BSN-prepared nurses]...dangerously low.”²¹⁴ Rogers undoubtedly identified the challenge before nursing;

differentiation of nursing practice remained difficult, if not impossible, without a sufficient number of nurses from each level of educational preparation.

Position Statements of Professional Organizations

Attempts to categorize and title the existing nurses and nursing programs by the national organizations resulted in the 1965 NLN and ANA position papers, introduced in *CHAPTER 1 – Introduction* and summarized in *CHAPTER 2 – Literature Review*. Neither organization maintained its position due to extensive opposition received against the “technical” nurse title. The diploma-prepared nurses wanted to maintain the “professional,” registered nurse status they held by default for the past several decades and ADN-prepared nurses also wanted “professional” nurse status because they performed the same role and functions as the diploma- and BSN-prepared nurses in many practice settings and, after all, held RN licensure. By 1982, both the ANA and NLN shared official agreement that the baccalaureate degree should be minimal preparation for “professional” nursing practice and the NLN “supported all education programs in nursing, in response,...to the social reality.”²¹⁵ The professional organizations deleted the designated title of “technical” for any nurse. Both organizations still support all education programs in nursing today. Professional organizations hold the power to suggest but lack the ultimate power to implement; licensure and scope of practice ultimately determines the practice limitations of the nurse.

Summary

Several reports on nursing throughout the beginning of the twentieth century and select nurse leaders supported the need to differentiate nursing functions to properly and legally implement division of labor for nursing by educational preparation. Montag’s research attempted to differentiate nursing functions into three distinct roles—the aide, technical nurse, and professional nurse—and designated an educational program to prepare each role. Montag

expected the ADN RN, as a technical or semi-professional nurse, to perform the repetitive and routine functions of bedside nurses. The ADN programs proved successful in preparing an adequate bedside nurse; yet, the quantitative and qualitative inadequacy of the professional, BSN-prepared nurses coupled with the existence and resistance of the diploma programs and diploma nurses sabotaged realization of Montag's practice model. The fact that the diploma-, BSN-, and ADN-prepared nurses all hold RN licensure created an additional problem. The employing agencies merely recognized the RN licensure rather than the educational preparation when staffing nurses. In 1954, when the first ADN graduates entered practice, and even now, no legal differentiation of practice by educational preparation exists within RN licensure.

As noted by Rogers, the ADN educational program offered a comparable alternative to the apprenticeship system and successfully moved nursing education away from the division of gender and paternalistic control of the hospital schools for nursing. Between 1963 and 1970, ADN programs produced an increase from four percent to twenty-six percent of all new graduates.²¹⁶ Unfortunately, the BSN programs did not experience the same increase; BSN programs produced a minor increase from fourteen percent to twenty percent of all new graduates between 1962 and 1970.²¹⁷ Montag's implicit motive to dissolve the role of the practical nurse failed as PN programs continued to produce practical nurses. Despite Montag's success to replace the diploma programs with the ADN programs, her differentiated practice model with inclusion of the BSN-prepared, professional RN and exclusion of the practical nurse was never fully implemented. The insufficient supply of BSN RNs, the continued unidentified role of diploma RNs, and the continued existence of PNs in practice created the greatest barriers to its realization and sustained disorder in the division of nursing labor.

The thriving development of the ADN programs formed from the foundation of Montag's differentiated practice model did not resolve the historical debate regarding the identity of the professional nurse, the role and associated functions of the professional nurse, and educational preparation designated to prepare the professional nurse. The professional identity of the registered nurse remained disordered through divisions of class and the historical debate continued.

The "BSN in 10" serves as the most recent resurfacing of this historical debate. Whether Montag's practice model can be reframed for the division of labor in the nursing profession today or whether this historical study can contribute to the decision regarding the "BSN and 10" will be discussed in *CHAPTER 7 – Conclusion*.

Notes

¹ Kathleen Shirley Hanson, *A Historical Analysis of the Liberal Education Theme in Nursing Education: 1893-1952* (Ann Arbor, MI: University Microfilms International, 1989), 196. East Carolina University, William E. Laupus Health Sciences Library.

² *Ibid.*, 123.

³ *Ibid.*, 99.

⁴ Barbara Melosh, *The Physician's Hand: Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982), 40. East Carolina University, William E. Laupus Health Sciences Library.

⁵ *Ibid.*

⁶ *Ibid.*

⁷ *Ibid.*

⁸ *Ibid.*, 126.

⁹ *Ibid.*, 146.

¹⁰ *Ibid.*, 129.

¹¹ *Ibid.*, 143.

¹² *Ibid.*, 145.

¹³ *Ibid.*, 146.

¹⁴ *Ibid.*, 147.

¹⁵ *Ibid.*, 144.

¹⁶ *Ibid.*, 147.

¹⁷ *Ibid.*, 149.

¹⁸ *Ibid.*, 148.

¹⁹ *Ibid.*, 157.

²⁰ *Ibid.*, 156.

²¹ *Ibid.*, 157.

²² *Ibid.*, 155.

²³ *Ibid.*

²⁴ *Ibid.*

²⁵ *Ibid.*, 89.

²⁶ *Ibid.*

²⁷ *Ibid.*, 92.

²⁸ *Ibid.*, 92.

²⁹ *Ibid.*, 93.

³⁰ *Ibid.*

³¹ *Ibid.*, 161.

³² *Ibid.*, 162.

³³ *Ibid.*, 166.

³⁴ *Ibid.*, 165.

³⁵ *Ibid.*, 94.

³⁶ *Ibid.*

³⁷ *Ibid.*, 37.

³⁸ *Ibid.*, 159.

³⁹ *Ibid.*, 172.

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- ⁴⁰ Ibid.
- ⁴¹ As cited in Melosh, 173.
- ⁴² Ibid.
- ⁴³ Melosh, 196.
- ⁴⁴ Ibid., 173.
- ⁴⁵ Ibid., 169.
- ⁴⁶ Ibid., 177.
- ⁴⁷ Ibid., 176.
- ⁴⁸ Ibid., 39.
- ⁴⁹ Ibid., 177.
- ⁵⁰ Ibid., 173-4, 168.
- ⁵¹ Ibid., 38-9.
- ⁵² Ibid., 170.
- ⁵³ Ibid., 178.
- ⁵⁴ Ibid.
- ⁵⁵ Ibid., 177-9.
- ⁵⁶ Ibid., 179.
- ⁵⁷ Ibid.
- ⁵⁸ Ibid., 180.
- ⁵⁹ Ibid., 179.
- ⁶⁰ Ibid., 180.
- ⁶¹ Ibid.
- ⁶² As cited in Melosh, 181.
- ⁶³ Melosh, 160.
- ⁶⁴ Ibid.
- ⁶⁵ Ibid., 184.
- ⁶⁶ Ibid., 160.
- ⁶⁷ Ibid., 189.
- ⁶⁸ Ibid.
- ⁶⁹ Ibid., 190.
- ⁷⁰ Ibid., 184.
- ⁷¹ Margaret Bridgman, *Collegiate Education for Nurses* New York: Russell Sage Foundation, 1953), 27. University of North Carolina University Wilmington, William Madison Randall Library.
- ⁷² Melosh, 196.
- ⁷³ Bridgman, 34.
- ⁷⁴ Ibid., 34-5.
- ⁷⁵ Ibid., 96.
- ⁷⁶ As cited in Bridgman, 16.
- ⁷⁷ Ibid.
- ⁷⁸ Bridgman, 113, 118-20 - provided a list of reasons underlying the adoption and continuance of the dual BS/diploma programs.
- ⁷⁹ Ibid., 16.
- ⁸⁰ Ibid.
- ⁸¹ Hanson, 129.

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- 82 Ibid.
- 83 Ibid.
- 84 Ibid.
- 85 Bridgman, 51-2.
- 86 Ibid., 56.
- 87 Ibid., 56-9.
- 88 Ibid., 61-2.
- 89 Ibid., 52.
- 90 Ibid., 69.
- 91 Ibid., 118.
- 92 Ibid., 62.
- 93 Ibid., 14, 39.
- 94 Ibid., 43.
- 95 Ibid., 22
- 96 Ibid.
- 97 Ibid., 7.
- 98 Ibid., 27-38.
- 99 Ibid., 37.
- 100 Ibid., 75.
- 101 J. Goldmark, *Nursing and Nursing Education in the United States* (New York: MacMillan Company, 1923). Microfiche, East Carolina University, William E. Laupus Health Sciences Library; Committee on the Grading of Nursing Schools, *Nursing Schools Today and Tomorrow: Final Report of the Committee on the Grading of Nursing Schools*. (New York: National League for Nursing Education, 1934), 119-149, 215. East Carolina University, William E. Laupus Health Sciences Library; Esther Lucille Brown, *Nursing for the Future: A Report Prepared for the National Nursing Council* (New York: Russell Sage Foundation, 1948). East Carolina University, William E. Laupus Health Sciences Library.
- 102 Goldmark, 21.
- 103 Ibid.
- 104 Ibid., 26.
- 105 Ibid., 25.
- 106 Ibid., 26.
- 107 Committee on the Grading of Nursing Schools, 62-6.
- 108 Ibid., 84, 92 - speaks to lack of one-on-one apprentice relationship.
- 109 Ibid., 94
- 110 Brown, 70.
- 111 Ibid., 63.
- 112 Ibid.
- 113 Ibid., 116.
- 114 Ibid., 127.
- 115 Bridgman, 35.
- 116 Ibid., 79.
- 117 Ibid., 69.
- 118 Ibid., 11.
- 119 Ibid., 71-2.

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- ¹²⁰ Ibid., 74.
- ¹²¹ Barbara Miller Solomon, *In the Company of Educated Women* (New Haven: Yale University Press, 1985), 164. East Carolina University. J. Y. Joyner Library.
- ¹²² Ibid., 170.
- ¹²³ Walter Eugene Sindlinger, *Experimentation in Education for Nursing at Orange County Community College, A Report for a Type A Project* (New York: Teachers College, Columbia University, 1956), 65. Copy of Dissertation for Degree of Doctor of Education. Archives of Columbia University, Teachers College, Gottesman Libraries, PDF b11642002 accessible through <http://pocketknowledge.tc.columbia.edu>; Patricia T. Haase, *The Origins and Rise of Associate Degree Nursing Education* (Durham, NC: Duke University Press, 1990), 29. Personal Copy.
- ¹²⁴ Hanson, 180.
- ¹²⁵ As cited in Mary Thomson Champagne, *Innovation in Nursing Education: A History of the Associate Degree Nursing Program, 1940-1964* (Ann Arbor, MI: University Microfilms International, 1981), 14. Retrieved from ProQuest Dissertations through East Carolina University, J. Y. Joyner Library.
- ¹²⁶ Ibid., 15.
- ¹²⁷ Ibid., 20.
- ¹²⁸ Ibid.
- ¹²⁹ Ibid., 10.; Haase, 69.
- ¹³⁰ As cited in Champagne, 23.
- ¹³¹ Ibid., 25.
- ¹³² Ibid.
- ¹³³ Champagne, 27.
- ¹³⁴ As cited in Hanson, 129 - total of cadet graduates.
- ¹³⁵ Champagne, 115.
- ¹³⁶ Ibid., 115-66. All personal information on McManus retrieved from Champagne's dissertation
- ¹³⁷ Ibid., 118.
- ¹³⁸ As cited in Champagne, 118.
- ¹³⁹ Ibid., 120.
- ¹⁴⁰ Ibid., 121-2.
- ¹⁴¹ Champagne, 121.
- ¹⁴² As cited in Champagne, 121.
- ¹⁴³ Champagne, 128.
- ¹⁴⁴ As cited in Champagne, 129.
- ¹⁴⁵ Ibid., 128.
- ¹⁴⁶ Champagne, 132.
- ¹⁴⁷ As cited in Champagne, 135.
- ¹⁴⁸ Minutes of 1st meeting of the Advisory Committee on Experimental Programs dated July 11, 1951. Archives of Columbia University, Teachers College, Gottesman Libraries, PDF 87 accessible through <http://pocketknowledge.tc.columbia.edu>.
- ¹⁴⁹ Louise McManus Letter from the New York State Department of Education dated June 28, 1951. Archives of Columbia University, Teachers College, Gottesman Libraries, PDF 87 accessible through <http://pocketknowledge.tc.columbia.edu>.

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- ¹⁵⁰ Minutes of 1st meeting of the Advisory Committee on Experimental Programs dated July 11, 1951.
- ¹⁵¹ Ibid.
- ¹⁵² Document of Unknown Publishing. "Experimentation in Nursing Education Under the State University" dated March 23, 1950. Archives of Columbia University, Teachers College, Gottesman Libraries, PDF 87 accessible through <http://pocketknowledge.tc.columbia.edu>.
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- ¹⁵⁶ Minutes of 3rd Meeting of the Advisory Committee on Experimental Programs dated August 15, 1951. Archives of Columbia University, Teachers College, Gottesman Libraries, PDF 87 accessible through <http://pocketknowledge.tc.columbia.edu>.
- ¹⁵⁷ Ibid.
- ¹⁵⁸ Minutes of 5th meeting of the Advisory Committee on Experimental Programs dated November 2, 1951. Archives of Columbia University, Teachers College, Gottesman Libraries, PDF 87 accessible through <http://pocketknowledge.tc.columbia.edu>.
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- ¹⁶² Ibid.
- ¹⁶³ Champagne, 135-9. All personal information on Montag retrieved from Champagne's dissertation.
- ¹⁶⁴ As cited in Champagne, 139.
- ¹⁶⁵ Mildred L. Montag, *The Education of Nursing Technicians* (New York: G. P. Putnam's Sons, 1951), 3-8. East Carolina University, William E. Laupus Health Sciences Library.
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- ¹⁶⁷ Ibid., 4-8.
- ¹⁶⁸ Ibid., 8.
- ¹⁶⁹ Champagne, 144.
- ¹⁷⁰ As cited in Montag, 76.
- ¹⁷¹ Montag, 79.; Mildred L. Montag, T. Tilton, and C. L. Hartley, *The Associate Degree Nurse: Technical or Professional?* (New York: National League for Nursing, 1983). East Carolina University, William E. Laupus Health Sciences Library.
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- ¹⁷³ R. S. Swenson, "Associate Degree Nursing: The Gift of Thirty Years," in *Associate Degree Nursing Education at Thirty Years* (New York: National League for Nursing, 1983), 1-9. East Carolina University, William E. Laupus Health Sciences Library.
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- ¹⁷⁵ Sindlinger, 49.
- ¹⁷⁶ As cited in Haase, 23.

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- ¹⁷⁷ Ibid.
- ¹⁷⁸ Sindlinger, 66.
- ¹⁷⁹ Ibid., 83-4.
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- ¹⁸² Orange County Community College Program for Nursing, Progress report dated March 1953, 4. Archives of Columbia University, Teachers College, Gottesman Libraries, PDF 88 accessible through <http://pocketknowledge.tc.columbia.edu>.
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- ¹⁹³ Report of the Third Meeting of the Advisory Committee on the Cooperative Research Project in Junior and Community College Education for Nursing.

¹⁹⁴ Report of the Fifth Meeting of the Advisory Committee on the Cooperative Research Project in Junior and Community College Education for Nursing.

¹⁹⁵ Ibid.

¹⁹⁶ Ibid.

¹⁹⁷ Hanson, 176.

¹⁹⁸ Melosh, 28.

¹⁹⁹ Ibid., 42.

²⁰⁰ Ibid., 70

²⁰¹ Solomon 184-5. A dual marriage and career life for women initiated after WWI. WWII encouraged many women to enter the workforce and at the end of WWII many women welcomed the return back to domestic duties within the home. Return of the men after war flooded the colleges and universities often taking seats previously awarded to women. Women thus flocked to the community and junior colleges (an excellent perk for the ADN programs). Despite the increase movement of women back to domesticity, the “pattern of college women working before and after marriage” was already well established.

²⁰² Report of the Fifth Meeting of the Advisory Committee on the Cooperative Research Project in Junior and Community College Education for Nursing.

²⁰³ Haase, 38.

²⁰⁴ Ann Benedict Moore, “Utilization of Graduates of ADN Programs,” in *Nursing Outlook*, 15, no. 12 (December 1967), 50-2. Microfilm at East Carolina University, William E. Laupus Health Sciences Library; Michael H. Miller, “Work Roles for the Associate Degree graduate,” in *American Journal of Nursing*, 74, no. 3 (1974), 468-70. Microfilm at East Carolina University, William E. Laupus Health Sciences Library; Mildred O. Hogstel, “Associate Degree and Baccalaureate Graduates: Do They Function Differently?” in *American Journal of Nursing*, 77, no. 10 (1977), 1598-1600. Microfilm at East Carolina University, William E. Laupus Health Sciences Library; Haase, 104-106.

²⁰⁵ A. B. Martin, “Associate Degree Nursing...Are Changes Needed in Practice Field for New Graduates?” in *The Journal of Nursing Education*, 8, no. 3 (1969), 7-12. Microfilm at East Carolina University, William E. Laupus Health Sciences Library; B. J. Macy, “Identification of Major Curriculum Threads Based on the Philosophy and Objectives of the Program,” in *Preparing the Associate Degree Graduate* (New York: National League for Nursing, 1977), 42-46. East Carolina University, William E. Laupus Health Sciences Library; R. M. Channing, *Associate Degree Nursing—Problem or Solution?* (New York: National League for Nursing, 1979). East Carolina University, William E. Laupus Health Sciences Library.

²⁰⁶ Channing, 5.

²⁰⁷ Martha E. Rogers, *Educational Revolution in Nursing* (New York: The MacMillan Company, 1961), 3.

²⁰⁸ Ibid., 5.

²⁰⁹ Ibid., 4.

²¹⁰ Ibid.

²¹¹ Ibid.

²¹² Ibid., 5.

²¹³ Ibid., 6.

²¹⁴ Ibid., 11, 14.

²¹⁵ As cited in Haase, 92-6.

²¹⁶ Melosh, 207-8.

²¹⁷ Ibid.

CHAPTER 7

Conclusion

The historical debate continues as a distinct professional identity and role fails to exist for the entry-level registered nurse (RN). The presence of entry-level educational pathways lacking the criteria of a professional, collegiate education serves as the major reason entry-level RNs fail to achieve a collective and distinct professional identity. Prolonged paternalistic control, coupled with divisions of class and gender, prevented the full realization of a professional, collegiate education for entry into RN practice and thus challenged the professionalization of the entry-level nurse's role and disordered the division of labor within nursing. Nursing failed to achieve professional, collegiate education for every entry-level RN because of the strong and sustained roots of nurse training within the apprenticeship system. Multiple educational pathways ranging from vocational, technical, and professional programs prepare individuals for the traditional nurse role. Lack of clear differentiation of role and functions within nursing practice for each pathway nurse creates an education-practice division of labor disorder, sustains class division within the profession of nursing, and permits continued division of gender and paternalistic control over nursing.

A consistent theme of attempts to define the professional identity and role of the nurse within the public sphere emerged throughout the three case studies. The Diploma pathway development initiated efforts to identify a professional nurse role for middle-class women within the public sphere; the BSN pathway offered an entry-level collegiate education for the professional autonomous role of the public health nurse; and the ADN pathway attempted to differentiate a technical and professional entry-level RN role to eliminate paternalistic-controlled

and non-collegiate nurse training. As illustrated in the case study chapters, related themes of class and gender division, and paternalistic control surfaced as challenges for each educational pathway development and, ultimately, served to prevent a distinct professional identity and role for the entry-level RN.

Review of Themes

1873 – Diploma Pathway Development

Florence Nightingale utilized division of gender and combined the calling to serve, womanly attributes, and theoretically-based rationale of nursing techniques to introduce a new trained nurse public role for middle-class women. As illustrated by Reverby, Nightingale emphasized the characteristics of a good woman within the role of the trained nurse to establish an accepted public role for the nurse:

The domestic order created by a good wife, the altruistic caring expressed by a good mother, and the self-discipline of a good soldier were to be combined in the training of a good nurse.¹

America adopted the Nightingale model for training nurses as illustrated with the development of the Bellevue Training School for Nurses. Eventually America succeeded in the development of an accepted role for women within the public sphere as a trained nurse and American nurse leaders initiated standardization efforts to professionalize the role of the trained nurse.

Differentiation occurred between nurses and training schools based on the standards of Nightingale's model for training nurses and thus created a division of class within nursing. The establishment of the American Society of Superintendents of Training Schools for Nurses solidified the division of class within nursing; as the elite group of superintendents worked to establish strict educational standards, they segregated themselves from the majority of nursing schools and nurses. The professional aspirations of this group proved to be divisive; "adopting

the exclusionary tactics of professionalization, leaders sought to secure the privileges of a few at the expense of many.”² The continued utilization and production of untrained nurses challenged the professionalization efforts to implement strict educational standards. Initially resistant to training schools for nurses because of fear of competition, the hospital administrators and physicians quickly recognized selfish advantages of the trained nurse within the hospital. The hospitals swiftly sought oppressive control over the training schools and thus the education and practice of the trained nurse. The hospitals’ exploitation and paternalistic control of the training schools, student nurses, and trained nurses rooted in divisions of gender further challenged the standardization and professionalization efforts of the Superintendents’ Society leaders. The Superintendents’ Society leaders failed to establish a distinct professional role for the trained nurse through the establishment of educational standards for all training schools and, unfortunately, succeeded in the creation of a division within nursing between education and practice.

1916 – BSN Pathway Development

By 1916, permissive licensure in most states afforded trained nurses from schools meeting educational standard criteria the title of registered nurse (RN). Although the RN title displayed the quality of the nurse’s educational training received, the title did not differentiate a distinct professional role for the RN. RNs assumed the same role as the untrained and non-registered, trained nurses in private-duty and hospital practice and thus further confused the possibility of differentiation and professionalization. Additionally, the registration efforts divided nurses in practice from the leaders who adamantly pushed for registration. The nurse leaders sought registration to legally professionalize trained nurses through the regulation of educational standards of the training schools; yet, the nurses resisted the differentiation by title because of

projected and perceived challenges for those trained in the schools that failed to meet the educational standards for registration. Nurses feared the possibility of losing work and their identity as a nurse. Fear fueled the division in nursing as nurses opposed registration efforts; yet, in actuality, registration would not legally identify the nurse and lack of registration would not restrict the practice of nurses for many years.

The role of the nurse predominantly existed in the community as private-duty nurses because the hospitals utilized the student nurses to staff the hospital wards. Paternalistic control remained rooted in the division of gender and continued to control the nurses in practice outside the hospital. Paternalistic control continued because nurses cared for the physicians' patients and the physicians determined the role and duties of the nurse for each private-duty case. Physicians also continued to use untrained nurses for the care of their patients in private-duty. The sustained paternalistic control and continued use of untrained and non-registered, trained nurses challenged professionalization of the private-duty nurse role. A strong disconnection between training and practice existed. Training did not differentiate a professional role for the nurse in practice; continued use of untrained nurses demonstrated this truth.

An opportunity to differentiate and professionalize a distinct autonomous role for the trained nurse presented with the public health movement; yet, this missed opportunity also further divided nursing by class. The assumed role of the public health nurse supported the need for a higher-level education beyond the training received in the hospital training schools. The University of Cincinnati School for Nursing and Health developed as a means to offer a collegiate education along with hospital school training to prepare graduates to assume the role of the public health nurse. The practicing public health nurses demonstrated a self-proclaimed elitism founded on the postgraduate educational preparation of the nurse. The education of many

public health nurses exceeded the education or training of the majority of practicing nurses; many of the public health nurse leaders received postgraduate education in public health nursing. The National Organization of Public Health Nursing's (NOPHN) consistent rejections of attempts to include public health training in the hospital training schools' curriculum demonstrated the intentional exclusion and elite separation of the public health nurse role based on educational preparation—a separation not based in reality. A gap remained between the desired educational preparation of the public health nurse and the actual qualifications of most practicing public health nurses. Unfortunately, rapid development of quality collegiate education programs for undergraduate nursing students failed to occur; therefore, the nurses' experience rather than educational preparation permitted the nurse to assume the public health role in most instances. Professional identity of the public health nurse based on a collegiate educational preparation failed to occur. Additionally, the establishment of the NOPHN with the organizational aim to form a cooperative effort committed to the public health movement rather than with the aim to professionalize nurses demonstrated the public health nurses' segregation from the nurse leaders.³

1952 – ADN Pathway Development

Movement of the trained nurse's role to the hospital first within private-duty cases and then as hired staff nurses of the hospital presented yet another opportunity to create a distinct and differentiated professional role for the trained nurse. Nurse leaders recognized the opportunity but the practicing nurses and superintendents of many training schools resisted the movement of the trained nurse to the hospital. Paternalistic control rooted in division of gender and continued division of class within nursing challenged the achievement of a distinct professional identity for the trained nurse role within the hospital. Nurses resisted movement back to the hospital because

of their memories of the paternalistic control over the nurse training yet, ironically, also clung to the ideology of hospital training for nurses. The apprenticeship culture of nurse training substituted the professional ideology for nurses because the apprenticeship style training permitted the nurses to “affirm their skills and define their work” within a structure different from other professions.⁴ Nurses “valu[ed] their work for what it was instead of yearning for what it might become.”⁵ Several superintendents resisted the movement of trained nurses to the hospital because of the loss of control and power that they held over students; “student staff [was] more amenable to correction and discipline.”⁶ Traditional philosophies and beliefs of the nurses and superintendents clouded the professionalization opportunity before them. Many superintendents of training schools opposed the nurse leaders’ efforts to advance the education of nurses because movement of nursing education to the collegiate level threatened the system in which they held perceived control when, in actuality, they held minimal power to improve the education of nurses within the hospital training schools.

The increased complexity and technology of medicine and the health care system along with the demand of nurses with the initiation of World War II demanded official division of labor for nursing. The untrained, practical nurses (PN) gained official position within organized nursing as hospitals utilized their services to resolve staffing problems and nurse leaders began efforts to develop and regulate PN education and practice. Inclusion of the PN into organized nursing under the supervision of the registered nurse (RN) offered RNs a new professional, leadership role. Continued division of class within nursing challenged a defined development of the leadership role for the RN.

Since 1923, reports on nursing recommended division of labor for nursing and a professional, collegiate education for the RN. Prolonged paternalistic control based on division

of gender and the division of class within nursing prevented the realization of a clear and defined differentiation of nursing practice and an exclusive elevation of RN education to the professional, collegiate level. The development of the associate degree in nursing (ADN) programs based on Montag's differentiated nursing practice model attempted to meet the requests of the reports on nursing and more rapidly produce a greater number of nurses to meet the heightened demand. Montag's model differentiated nursing practice into assistant, technical, and professional roles, and delineated an educational program away from paternalistic control to prepare the technical and professional RN roles. Montag excluded the many practicing practical and diploma-prepared nurses within her model and failed to provide a transitional educational plan for these nurses. Coupled with the insufficient supply of BSN-prepared nurses to assume the professional role and the shared RN title of the technical and professional nurse, implementation of Montag's model failed; "what was envisioned to be an orderly transition to an educational system of two levels and subsequent differentiated practice never occurred."⁷ Diploma, ADN, and BSN RNs assumed the same nursing role and functions within the paternalistic controlled hospitals, thus a distinct professional identity and role for the entry-level nurse based on educational preparation remained undefined.

State of Nursing in 2011

Disordered differentiation of practice exists in nursing today. The licensed practical nurse (LPN) holds a clear differentiated identity from that of the registered nurse (RN). The differentiated role and functions of the LPN are maintained through a distinct educational preparation at the vocational level, different licensure designating the LPN title, and a separate scope of practice for the LPN. The diploma, ADN, and BSN nurses share the same licensure designating the RN title and practice under the same RN scope of practice, which determines the

role and functions of the RN. RN licensure and practice, therefore, includes both technical and professional prepared nurses. Although only a few diploma programs remain, diploma-prepared nurses continue in practice and the diploma preparation compares to the ADN technical preparation. Different competencies exist for the ADN and BSN nurse to facilitate the curriculum design for the ADN and BSN programs; yet, the competencies do not translate into differentiated practice. The continued existence of multiple entry-level educational pathways to RN practice challenges the professional identity of the registered nurse. The practice of the nurse must represent the education the nurse receives; “the level and scope of nursing practice will not exceed the kind and amount of education that precede it.”⁸ The nurse should not be expected to practice beyond the education received nor should a nurse be expected to practice below educational capabilities. The continued acceptance of experience in lieu of education demotes nursing back to the apprenticeship culture rather than elevating nursing to professional recognition. Montag’s model provides a framework for which nursing could use to build a defined division of labor for nursing practice today and thus specify the professional identity, role and functions, and educational preparation for each nurse role.

Recent studies and reports on nursing suggest the RN receive a professional, collegiate education, or the BSN to enhance the quality of nursing care. The hallmark research study article by Linda Aiken and colleagues in 2003, “Educational Levels of Hospital Nurses and Surgical Patient Mortality,” stimulated the most recent resurfacing of the historical debate.⁹ The conclusion of Aiken’s research illustrated in the article reads: “In hospitals with higher proportions of nurses educated at the baccalaureate level or higher, surgical patients experienced lower mortality and failure-to-rescue rates.”¹⁰ Additional reasons to advance the education of RNs include but are not limited to higher job satisfaction scores among BSN-prepared nurses;

increasingly more complex health care needs of a multicultural and aging population; needed leadership skills essential for case management and supervision of assistive personnel; and expectation for nurses to participate as full partners on the health care multidisciplinary team whose members hold higher professional education requirements.¹¹ The most recent hallmark study on nursing, the Institute of Medicine's (IOM) *Nursing for the Future: Leading Change, Advancing Health* report, echoes the recommendation for professional, collegiate education for the professional RN in light of the current complexity of the health care system.¹² As nursing considers the recent studies, nursing must reach a decision regarding the needed division of labor within nursing for the health care system of today and tomorrow, and prepare a defined plan to match an educational preparation to each role needed in order to resolve the historical debate. A major step within the division of labor decision lies in determining the role and functions of the professional BSN RN. The BSN RN lacked a distinct professional role in practice throughout the history presented in this research; lack of a distinct role for the BSN RN from that of the diploma and ADN RNs continues today.

A new reorganization opportunity presents for the profession of nursing to reach consensus and, ultimately, resolve the historical debate within the current "BSN in 10" legislative proposals. Reframing Montag's model may facilitate appropriate and distinct differentiation of nursing practice to support nursing's necessary division of labor and clearly identify the professional nurse role within today's complex health care system.

Reframing Montag and the "BSN in 10"

The nursing history presented in this study demonstrated a transition from informal to formal division of labor for nursing practice. From the existence of the trained and untrained nurse in practice to the establishment of the legal identities of the licensed practical nurse (LPN)

and registered nurse (RN) through licensure, division of labor for nursing practice served necessary and practical for organized nursing in America. As the complexity of medicine and the health care system increased, the nurse assumed additional roles expanding the continuum of nursing care to a “wide range and variety of essential functions” thus “requiring large numbers of different types of personnel with varying kinds and amounts of preparation.”¹³ Clearly defined division of labor or differentiation of nursing practice requires nursing and society to change from the “traditional...outworn conception...that the group [all nurses] is a homogeneous one with approximately the same preparation, the same skills, and the same functions for all members.”¹⁴ Currently, diploma, ADN, and BSN programs primarily prepare graduates for the same role. Nursing and society must gain a collective understanding that “out of [the] current indiscriminate lumping of nurses must arise a coherent conception of levels of nursing, consistent with the needs of society.”¹⁵ In 1961, Rogers believed that the “vocational, technical, and professional members of the nursing profession [were] significant contributors to the health and welfare of mankind.”¹⁶ Nursing must decide if all three educationally prepared nurses need to remain in nursing practice today and then determine a legally differentiated role for each nurse from the different educational program types. As noted previously, the major step to defining the division of labor lies in determining the role of the professional BSN RN within nursing practice and then decide on the role of non-professional nursing personnel.

Montag attempted differentiation of nursing practice and designated an education program to prepare each role. The concept of her model supported the reality of division of labor for nursing care; yet fundamental flaws—insufficient professional, BSN-prepared nurses; exclusion of the diploma and practical nurses that prominently existed in practice; and shared RN licensure with nurses of varying preparations—defeated the implementation of Montag’s model

in practice. Reframing Montag's model will serve to differentiate nursing practice for today's and tomorrow's health care system. How to reframe Montag's model rests on the decision of whether nursing practice can support inclusion of nurses from vocational, technical, and professional educational programs. Essentially, three options exist: adopt a sole educational program to prepare the nurse for practice; or adopt a two- or three-tier educational hierarchy to prepare nurses to practice within nursing's division of labor. Change to any of the three options requires reorganization of nursing education and practice.

Adoption of a sole educational program to prepare all nurses for practice appears unrealistic in light of the complex health care system, the wide range of nursing functions within nursing practice, and the nursing shortage. Division of labor has existed throughout the history of organized nursing in America. The feasibility of expecting nurses from only one educational preparation to perform all the nursing functions appears outrageous; "the multiplicity of services needed to promote the health of mankind demands prompt and aggressive action toward definitive preparation of a variety of workers in nursing."¹⁷ Additionally, development of a suitable curriculum plan for preparation of the nurse for such a diversified role proves impractical and may deter or exclude potential candidates. Consideration of advancing the education of all nurses to the BSN level ignores the well-established concept and practice of division of labor in nursing.

A two-tier educational hierarchy could present in different ways. Nursing could maintain the current legal differentiation between the LPN and RN and choose one educational program to prepare nurses for each role. The current "BSN in 10" legislative proposals introduced in *CHAPTER 1 – Introduction* support this option and essentially mark the BSN preparation as the desired educational pathway for RN practice. Although the "BSN in 10" proposals support

continuance of ADN and diploma programs for entry into practice, the proposals dissolve the terminal nature of the diploma and ADN education for practice as an RN. The diploma and ADN programs serve as a 10-year stepping stone to transition into professional, RN practice. The “BSN in 10” proposals do not differentiate the practice of the diploma, ADN and BSN nurse. Another possible two-tier structure could include the BSN RN and replacement of the LPN role with an ADN nurse role. Such a change requires legal differentiation of the ADN and the BSN nurse’s role, thus the ADN nurse would need to lose the title and identity of RN or the BSN nurse would need to gain a new identity and title.

The third option, adoption of a three-tier educational hierarchy, includes the currently available vocational, technical, and professional educational program types. To realize true differentiation of practice between the vocational, technical, and professional nurse, legal differentiation between the technical and professional nurse must occur. Again, the ADN nurse would need to lose the title and identity of RN or the BSN nurse would need to gain a new identity and title. As previously noted, the “BSN in 10” legislative proposals do not address or support differentiation of nursing practice between the diploma, ADN, and BSN nurses; therefore, the proposals prove useless if nursing chooses the three-tier educational hierarchy structure for the practice of nursing.

Option one appears unrealistic and options two and three, reframing Montag’s model, require legal reorganization of nursing education and practice for successful differentiation. Without legal differentiation through licensure, paternalistic control over nursing practice will continue as learned from the failed implementation of Montag’s model. Historically, employing agencies, predominantly hospitals, disregarded the differing educational preparations and differentiated competencies of the ADN and BSN graduates and allowed the differently prepared

nurses to share a practice role because of the shared RN licensure and title.¹⁸ The desire to hire BSN RNs has increased for many hospitals due to external sources either requiring or encouraging a sufficient staff ratio of BSN-prepared RNs; yet an increase in BSN-prepared RNs does not resolve the lack of practice differentiation between differently prepared RNs.¹⁹

Summary

Review of nursing's history illustrates the necessity of division of labor for nursing practice and the push for a professional, collegiate education for the RN. The decision nursing needs to make today in order to resolve the historical debate focuses on determining the practice role and associated functions of the professional, BSN-prepared nurse. Once nursing delineates the role of the BSN-prepared nurse, nursing can determine whether a role remains for nurses at the vocational and technical preparation level. Legal reorganization of nursing education and practice must then follow.

Until nursing decides on the division of labor for nursing practice, the "BSN in 10" legislative proposals serve only to complicate the fundamental disorder between nursing education and practice. From the transition of informal to formal division of labor, organized nursing failed to clearly define the practice role with associated functions for each educational preparation level. Prolonged apprenticeship style training under paternalistic control coupled with the lack of rapid development of quality professional, collegiate education nursing programs served as the major challenges and resulted in the education-practice disorder within nursing today. The recent "BSN in 10" legislative proposals and the IOM study report demonstrate resurfacing of the historical debate and provide an opportune time to reach resolution through collective decision and consensus on reorganization of nursing education and practice. Careful study of the past and true projections of the future will guide dialogue and

decisions for today; repeating the words of Rogers in 1961: “Nursing is faced with evaluating its past and designing a new pattern compatible with future needs.”²⁰ This study identified successful and failed patterns within nursing education and practice through historical analysis of the developments and debates surrounding the three educational pathways to entry-level RN practice. Nursing must consider the history of the developments and debate to make sound decisions today. As nursing moves forward to implement reorganization, preparation for opposition must arise: “Reorganization is more difficult than initial planning. Resistance to change is inevitable.”²¹ Additional studies of nursing practice related to patient outcomes and worker satisfaction may assist nursing to prepare the most sound reorganization plan. Inclusion of employers’ role expectation of nurses proves essential for preparation of reorganization; “every plan to revise nursing practice must ultimately confront the structural constraints imposed by hospital administration.”²²

Since the late nineteenth century the education and practice of nursing has been challenged by divisions of class and gender, and paternalistic control. The educational pathway development case studies within this research demonstrate the persistence of these challenges and provide a new lens in which to guide the reframing of Montag’s model and thus decide on the “BSN in 10” legislative proposals. It is now the twenty-first century and nursing must once and for all overcome these persistent obstacles to establish a clearly defined division of labor for nursing and thus professional identity for the entry-level nurse. For success, nurses from every level of differentiation must be respected and recognized for their contribution to the populations’ health.²³ Differentiation can be accomplished only if all nurses maintain a “feeling of high self-worth.”²⁴ Defensive division of class must end and nurses must come together collectively to determine the division of labor for nursing practice that is needed for today’s and

tomorrow's health care system. It is time to become equal partners with the professionals of the health care team. Nursing must stop moving forward without studying its past and must stop developing new educational programs before resolving the historical debate and the nursing education and practice disorder.

Notes

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- ¹ Susan M Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (New York: Cambridge University Press, 1987), 41.
- ² Barbara Melosh, *The Physician's Hands: Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982), 29.
- ³ *Ibid.*, 122.
- ⁴ *Ibid.*, 209.
- ⁵ *Ibid.*, 69.
- ⁶ *Ibid.*, 170.
- ⁷ American Nurses Association (ANA), "Nursing Education" retrieved from http://www.nursingworld.org/MainMenuCategories/ANAPoliticalPower/State/StateLegislativeAgenda/NursingEducation_1.aspx.
- ⁸ Martha Rogers, *Educational Revolution in Nursing* (New York: The MacMillan Company, 1961), 8.
- ⁹ Linda H. Aiken, Sean P. Clarke, Robyn B. Cheung, Douglas M. Sloane, and Jeffrey H. Silber, "Educational Levels of Hospital Nurses and Surgical Patient Mortality," in *The Journal of the American Medical Association (JAMA)*, 290, no. 12 (September 2003), 1617-23. Ovid Medline Database through East Carolina University, William E. Laupus Health Sciences Library.
- ¹⁰ *Ibid.*, 1617.
- ¹¹ ANA.
- ¹² Institute of Medicine (IOM), *Nursing for the Future: Leading Change, Advancing Health* (Washington, D.C.: The National Academies Press, 2011).
- ¹³ Margaret Bridgman, *Collegiate Education for Nurses* (New York: Russell Sage Foundation, 1953), 18.
- ¹⁴ *Ibid.*, 17-18.
- ¹⁵ Rogers, vii.
- ¹⁶ *Ibid.*
- ¹⁷ *Ibid.*, 8.
- ¹⁸ National League for Nursing (NLN) Division of Associate Degree Programs, *Competencies of the Associate Degree Nurse on Entry into Practice* (New York: National League for Nursing, 1978). Personal Copy.
- ¹⁹ IOM, 281; American Nurses Credentialing Center (ANCC), "Magnet Recognition Program Overview." Retrieved from <http://www.nursecredentialing.org/Magnet/ProgramOverview.aspx>. Magnet Recognition by the ANCC requires a greater percentage of BSN-prepared nurses providing direct care and at least a Master's degree for 100% of all nurse decision makers within the system or facility.
- ²⁰ Rogers, 2.
- ²¹ Bridgman, 13.
- ²² Melosh, 212.
- ²³ Rogers, 5.
- ²⁴ *Ibid.*

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APPENDIX A



EAST CAROLINA UNIVERSITY

University & Medical Center Institutional Review Board Office
1L-09 Brody Medical Sciences Building • 600 Moyer Boulevard • Greenville, NC 27834
Office 252-744-2914 • Fax 252-744-2284 • www.ecu.edu/irb

TO: April Matthias, PhD Candidate, 491 Riggs Road, Hubert, NC 28539

FROM: UMCIRB *WZ*

DATE: May 18, 2010

RE: Expedited Category Research Study

TITLE: "Reframing disorders: A History of the Decisions and Resurfacing Debate Surrounding the Development of Three Entry-level Registered Nurse Educational Pathways (1873, 1916, & 1952) and a Revisiting of Mildred Montag's Nursing Functions continuum Practice Model in Light of the Current "BSN in 10" Legislation"

UMCIRB #10-0268

This research study has undergone review and approval using expedited review on 5.14.10. This research study is eligible for review under an expedited category number 6 & 7. The Chairperson (or designee) deemed this **unfunded** study **no more than minimal risk** requiring a continuing review in **12 months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of 5.14.10 to 5.13.11. The approval includes the following items:

- Internal Processing Form (dated 4.27.10)
- Informed Consent (dated 5.14.10)

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.



East Carolina University



Informed Consent to Participate in Research

Information to consider before taking part in research that has no more than minimal risk.

Title of Research Study:

Reframing Disorder: A History of the Decisions and Resurfacing Debate Surrounding the Development of Three Entry-Level Registered Nurse Educational Pathways (1873, 1916, & 1952) and a Revisiting of Mildred Montag's Nursing Functions Continuum Practice Model in Light of the Current "BSN in 10" Legislation

Principal Investigator: April D. Matthias MSN, RN, CNE, PhDc

Institution/Department or Division: East Carolina University College of Nursing

Address: 491 Riggs Road Hubert, North Carolina 28539

Telephone #: 910.330.1746

Researchers at East Carolina University (ECU) study problems in society, health problems, environmental problems behavior problems and the human condition. Our goal is to try to find ways to improve the lives of you and others. To do this, we need the help of volunteers who are willing to take part in research.

Why is this research being done?

By doing this research, I hope to learn the history of the decisions to develop the diploma, Baccalaureate Degree in Nursing (BSN), and Associate Degree in Nursing (ADN) educational pathways and the history of the resurfacing debate regarding role and functions, the educational pathway, and the professional identity of the entry-level RN in 1873, 1916, and 1952. The decision to take part in this research is yours to make.

Why am I being invited to take part in this research?

You are being invited to take part in this research because you have been identified as a significant individual who may contribute to the historical understanding of the decisions to develop the diploma, BSN, or ADN educational pathway. If you volunteer to take part in this research, you will be one of about four people to do so.

Are there reasons I should not take part in this research?

Personal preference not to participate.

What other choices do I have if I do not take part in this research?

You can choose not to participate.

Where is the research going to take place and how long will it last?

The research procedures will be conducted at a location agreed upon by you and me. You will need to participate in dialogue with me at least one time during the study. The total amount of time you will be asked to volunteer for this study is approximately one to six hours from May 2010 to January 2011.

UMCIRB Number: 10-0268

Consent Version # or Date: 5-14-10
UMCIRB Version 2010.05.01

UMCIRB
APPROVED
FROM 5-14-10
TO 5-13-11

Participant's Initials

Title of Study: Reframing Disorder: A History of the Decisions and Resurfacing Debate Surrounding the Development of Three Entry-Level Registered Nurse Educational Pathways (1873, 1916, & 1952) and a Revisiting of Mildred Montag's Nursing Functions Continuum Practice Model in Light of the Current "BSN in 10" Legislation

What will I be asked to do?

You are being asked to do the following: Provide an accurate description from your personal perception of the past events and interactions that pertain to the decision to develop the entry-level RN educational pathway (diploma, BSN, or ADN). Notify me if you recall further information or choose to clarify information after the interview has been completed. Share any historical data that you may possess that will support your description or involvement in the decision to develop the entry-level RN educational pathway. The interviews will be audio-recorded and stored as an electronic file that will be protected in perpetuity. You may request that audio-recording not take place; if this is requested, note-taking during the interview will take place.

What possible harms or discomforts might I experience if I take part in the research?

It has been determined that the risks associated with this research are no more than what you would experience in everyday life.

What are the possible benefits I may experience from taking part in this research?

Other people who have participated in this type of research have experienced satisfaction when contributing to the collective professional history of nursing. By participating in this research study, you may also experience this benefit.

Will I be paid for taking part in this research?

You will not be paid for the time you volunteer while being in this study.

What will it cost me to take part in this research?

It will not cost you any money to be part of the research.

Who will know that I took part in this research and learn personal information about me?

To do this research, ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

- Any agency of the federal, state, or local government that regulates human research. This includes the Department of Health and Human Services (DHHS), the North Carolina Department of Health, and the Office for Human Research Protections.
- The University & Medical Center Institutional Review Board (UMCIRB) and its staff, who have responsibility for overseeing your welfare during this research, and other ECU staff who oversee this research.
- The interview will be recorded and the data potentially used in journal and book publications.

How will you keep the information you collect about me secure? How long will you keep it?

The interview will be stored electronically on a flash drive and will be secured in a private, locked file cabinet. Any historical documents shared by you will be secured in the same private, locked file cabinet. All data will be protected in perpetuity.

What if I decide I do not want to continue in this research?

If you decide you no longer want to be in this research after it has already started, you may stop at any time. You will not be penalized or criticized for stopping. You will not lose any benefits that you should normally receive.

UMCIRB Number: 10-0268

Page 2 of 3

Consent Version # or Date: 5-14-10
UMCIRB Version 2010.05.01

UMCIRB
APPROVED
FROM 5-14-10
TO 5-13-11

Participant's Initials

Title of Study: Reframing Disorder: A History of the Decisions and Resurfacing Debate Surrounding the Development of Three Entry-Level Registered Nurse Educational Pathways (1873, 1916, & 1952) and a Revisiting of Mild Montag's Nursing Functions Continuum Practice Model in Light of the Current "BSN in 10" Legislation

Who should I contact if I have questions?

The person conducting this study will be available to answer any questions concerning this research, now or in the future. You may contact the Principal Investigator at 910.330.1746 (days, between 8:00 am and 6:00 pm).

If you have questions about your rights as someone taking part in research, you may call the UMCIRB Office at phone number 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about the research study, you may call the Director of UMCIRB Office, at 252-744-1971.

Is there anything else I should know?

By participating in this study, your name and oral history may be used in journal and book publications.

I have decided I want to take part in this research. What should I do now?

The person obtaining informed consent will ask you to read the following and if you agree, you should sign this for

- I have read (or had read to me) all of the above information.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I know that I can stop taking part in this study at any time.
- By signing this informed consent form, I am not giving up any of my rights.
- I have been given a copy of this consent document, and it is mine to keep.

Participant's Name (PRINT)	Signature	Date
----------------------------	-----------	------

Person Obtaining Informed Consent: I have conducted the initial informed consent process. I have orally reviewed the contents of the consent document with the person who has signed above, and answered all of the person's questions about the research.

Person Obtaining Consent (PRINT)	Signature	Date
----------------------------------	-----------	------

UMCIRB Number: 10-0268

Consent Version # or Date: 5.14.10
UMCIRB Version 2010.05.01

UMCIRB
APPROVED
FROM 5.14.10
TO 5.13.11

Participant's Initials

APPENDIX B

Committee on the Grading of Nursing Schools:

Conclusions on the Functions of Professional Nurses

1. All professional nurses, irrespective of the special field in which they have elected to practice, should be able to give expert bedside care. They should also have such knowledge of the household arts as will enable them to deal effectively with the domestic emergencies arising out of illness.
2. All professional nurses, irrespective of the special field in which they have chosen to practice, should be able to observe and to interpret the physical manifestations of the patient's condition and also the social and environmental factors which may hasten or delay his recovery.
3. All professional nurses should possess the special knowledge and skill which are required in dealing effectively with situation peculiar to certain common types of illness.
4. All professional nurses should be able to apply, in nursing situation, those principles of mental hygiene which make for a better understanding of psychological factor in illness.
5. All professional nurses should be capable of taking part in the promotion of health and the prevention of disease.
6. All professional nurses should possess the essential knowledge and the ability to teach measures to conserve health and to restore health.
7. All professional nurses should be able to cooperate effectively with family, hospital personnel, and health and social agencies in the interest of the patient and community.
8. Every nurse should be able, by means of the practice of her profession, to attain a measure of economic security and to provide for sickness and old age. It should be possible for her to conserve her physical resources to seek mental stimulus by further study and experience, and to follow that way of life which she finds those spiritual and cultural values which enrich and liberate human personality.

Source: Committee on the Grading of Nursing Schools, *Nursing Schools Today and Tomorrow: Final Report of the Committee on the Grading of Nursing Schools*. (New York: National League for Nursing Education, 1934), 66-79. East Carolina University, William E. Laupus Health Sciences Library.

APPENDIX C

Advisory Committee on Experimental Programs in Nursing

Suggested Criteria

1. Willingness and ability of the educational institution to accept full control and responsibility for the total program in education for nursing.
2. A definition of the philosophy of the institution and an indication that a spirit of experimentation would prevail.
3. A statement of the aims toward which the nursing program would be aimed together with anticipated results.
4. A plan of experimentation which would indicate the scope of research, the various phases of experimentation, and the points of deviation from the prescribed nursing curriculum.
5. Evidence that an adequate budget would be provided for experimentation.
6. A local advisory committee to share in planning and to provide consultant service during the period of experimentation.
7. A qualified faculty adequate in number and committed to a research point of view.
8. A curriculum plan which would be developed by the school faculty with the assistance of consultants and which would extend over a minimum of two years but no longer than necessary to provide the basis for developing competencies expected of the registered nurses in general nursing practice.
9. Adequate clinical facilities, libraries, and classrooms to provide opportunities for both study and practice in the major clinical areas.
10. Careful admission of students who would understand the nature of the experimental program and tier registration status, especially in other states, after graduation.

Source: Cited in Walter Eugene Sindlinger, *Experimentation in Education for Nursing at Orange County Community College, A Report for a Type A Project* (New York: Teachers College, Columbia University, 1956), 65. Copy of Dissertation for Degree of Doctor of Education. Archives of Columbia University, Teachers College, Gottesman Libraries, PDF b11642002 accessible through <http://pocketknowledge.tc.columbia.edu>.

APPENDIX D

Orange County Community College

Approved Associate Degree Nursing Curriculum

1. Six courses in general education: Communication Skills (two 3-credit courses); Community Problems (two 3-credit courses); and Human Relations (two 3-credit courses).
2. Three laboratory courses in the natural and physical sciences: Survey of Science (two 3-credit courses) and Science of the Human Body (one 3-credit course).
3. Four comprehensive nursing courses: Fundamentals of Nursing (one 6-credit course); Health Problems—Mothers, Infants, and Children (one 6-credit course); Clinical Nursing Science I (one 12-credit course); and Clinical Nursing Science II (one 12-credit course).
4. Three elective courses (2- or 3-credits)

Courses		Credits	
First Year		First Semester	Second Semester
Engl 101-102	Communication Skills	3	3
Sci 101-102	Survey of Science	3	3
Sci106	Science of Human Body	-	3
Soc Sci 221-222	Human Relations	3	3
Nursing 101	Fundamentals of Nursing	6	-
Nursing 102	Health Problems – Mothers, Infants and Children	-	6
	Electives	2-3	-
TOTAL CREDITS		17-18	18

Courses		Credits	
Second Year		First Semester	Second Semester
Soc Sci 101-102	Community Problems	3	3
Nursing 201	Clinical Nursing Science I	12	-
Nursing 202	Clinical Nursing Science II	-	12
	Electives	2-3	2-3
TOTAL CREDITS		17-18	17-18

Source: Walter Eugene Sindlinger, *Experimentation in Education for Nursing at Orange County Community College, A Report for a Type A Project* (New York: Teachers College, Columbia University, 1956), 65. Copy of Dissertation for Degree of Doctor of Education. Archives of Columbia University, Teachers College, Gottesman Libraries, PDF b11642002 accessible through <http://pocketknowledge.tc.columbia.edu>.

