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**Nursing Education in the United States and England
Between 1850-1920: A Critical Analysis of the
Influence of Florence Nightingale**

by

Barbara Anne Svitlik

**A dissertation submitted to the Graduate Faculty in
Sociology in partial fulfillment of the requirements
for the degree of Doctor of Philosophy, The City
University of New York**

1998

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This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

March 20, 1998
Date

3/20/98
Date

Samuel W. Bloom
Chair of Examining Committee
Professor Samuel Bloom

Robert Alford
Executive Officer
Professor Robert Alford

Lindsey Churchill
Professor Lindsey Churchill

Charles Winick
Professor Charles Winick

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

Nursing Education in the United States and England
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by

Barbara Anne Svitlik

Adviser: Professor Samuel Bloom

The work of nurses in all of human society is vitally linked to the value it places on life. As such, the collective activity of nurses—albeit intellectual, social, political, or occupational—can serve as an important indicator for judging the direction of a society's movement in expanding the opportunities for the health and well-being of its citizens.

Today American nurses are demonstrating their enlarging capacity and resolve to shape the direction of health care in this country—motivated in large measure by the ideals and philosophy they inherited from the founder of modern nursing, Florence

Nightingale. But the ability of nurses to gain the leverage they need in achieving their goals depends on the extent to which they can convince influential members of society of their worthiness to control the domain of nursing practice in all its dimensions. According to theorist Eliot Freidson, the attainment of autonomy is an essential step for an occupation wishing to achieve full professional status.

Historically, the preserve for major decisions about health care became exclusively vested in the medical community commencing with the advent of scientific medicine. Physicians alone were granted unprecedented public confidence to control the medical workplace in the belief that they would be able to solve all the health needs of the future. Nurses, in turn, were viewed as subservient partners, incapable of originating the knowledge essential to fuel medical progress. Correlatively, lacking any autonomy approaching that of physicians, they were prevented from fully governing their professionalizing strategies. Hence, their power to influence the public discourse about matters that were important to them as a profession was vastly limited.

This study intends to investigate the genesis of these views about nursing, drawing heavily on discerning Florence Nightingale's motives and decisions in structuring modern nursing through the educational system she propagated. The major question is to what extent did she enhance or constrain the professional ambitions of nursing and, to what extent were her intentions influenced and altered by the larger social system. The answers to these questions may prove enlightening to scholars engaged in the sociology of professions and women's studies.

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I am deeply grateful for having the opportunity to complete my studies in the Doctoral Program in Sociology. My exposure to the outstanding faculty has made me an infinitely better nurse, a better teacher, and more importantly, a better human being.

Professor Patricia Kendall graciously gave me special encouragement when I was a relative neophyte in the program. After reading a paper on Florence Nightingale, Professor Sidney Aronson told me I had the nucleus of a dissertation. Although both of these beloved faculty members are no longer with us, they will always remain in my heart.

Professor Aronson pointed to Professor Samuel Bloom as the best person to direct my research in this area. Professor Bloom could not have been a better mentor. He inspired me with his gentle guidance, his keen intellect and his absolute dedication to scholarly work in medical sociology.

I am indebted to Professor Lindsey Churchill for his ongoing support and for not letting me quit when the circumstances of my life became very challenging. Professor Charles Winick's exquisite kindness and counsel assured that I was equipped to complete the details of my requirements.

Indeed, I am able to experience the joy of this happy occasion because of the good people God has placed in my life. My brother George, at personal sacrifice, expedited tasks for me at the end of the process. I could not have finished on schedule without him.

My acknowledgments would not be complete without remembering those special colleagues and students of nursing who strive every day to live and practice the ideals set by our foundress: Florence Nightingale.

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CHAPTER I

The Problem

Anchored in an analysis of nursing as a profession, the proposed theme of this study is: "Nursing Education in the United States and England between 1850-1920: A Critical Analysis of the Influence of Florence Nightingale."

The purpose of this study is to define the special relationship between nursing and medicine from the perspective of Nightingale's influence on the continuing internal pressure within nursing for the achievement of full professional identity. The focus will be on autonomy which has persisted within the nursing community as the most elusive privilege granted a profession.

For sociologists, this study has import in adding knowledge to our understanding of notions of professions and the professionalization process. In earlier sociological works, professionalization was seen as a natural progression of occupations which include a service defined as vital to society (e.g., theology, law and medicine, in that order, are the classic historical examples). Accepting this premise, it would follow that the ultimate success of any occupational group of this

type lies in its ability to achieve the status of profession. However, if a profession is distinguished from nonprofessional occupations by the fact that it contains an abstract theoretical knowledge base from which applied service for the welfare of the community is derived (see Bloom, 1971, p. 444), medicine is an archetypal case. This definition is compounded by the current trend that views professionalism as a form of control over work. Thus, the study of occupational communities includes an analysis of their on-going struggle for power (Davies, 1982, p. 122; see also Goode, 1957, p. 192).

Modern nursing, as we understand it today, has been identified with the reforms propagated by Nightingale in the last half of the nineteenth century. Writers of nursing history either extol or depreciate her influence on the contemporary status of nursing: an occupation that calls itself a profession yet often seems to lack some of the necessary requisites, especially autonomy (Woods, 1987, pp. 153-154).

Because of her pioneering influence, it is important to investigate the exact nature of Nightingale's ideas about nursing education, and their impact, especially on nursing autonomy during those

crucial early years of modern nursing's development. Nightingale appeared to foster professionalism for nursing when she sought to create schools of education that were free of hospital control and economical exploitation. Thus, she stirred an academic base controlled by its own separate authority. In her approach to the professional role, however, she deferred in large part to medicine, thereby possibly undermining the very purpose of her reforms.

There are sociologists who argue that through deliberate planning or by default, Nightingale provided the means by which nursing has been placed in a position of subordination to medicine and within the hierarchical arrangements of the health care system in general.

My preliminary research has led me to take a different approach. I will argue my points from two basic propositions outlined below.

1. Florence Nightingale provided an intellectual basis for a growing autonomous function for modern nursing. This can be demonstrated by her belief that:
(a) educational programs could be designed to foster autonomy in matters related to the structure of nursing care systems; (b) the proposed system of education for nurses promoted a tradition for creating, objectifying

and passing on specialized knowledge peculiar to the discipline of nursing; this knowledge encompassed Nightingale's definition of what constituted nursing; and that (c) the development of nursing knowledge was crucial to the survival of the new profession.

2. The questionable status of nursing as a profession as it currently exists resulted from the sociocultural accommodations of Nightingale's ideas:

- (a) Florence Nightingale was a pragmatist who realized that, in order to institutionalize her proposed reforms, she would have to tailor them to the customs and traditions of Victorian England which placed constraints on nurses as women and members of a social class;
- (b) from its inception societal forces promoted cross cultural adaptation to the Nightingale plan of reform in both England and the United States; (c) many of these adaptations served to thwart Nightingale's vision for an independent role for nursing within the health care system; and (d) modern nursing's quest for professional autonomy has been hampered to a larger extent by the adaptation to Nightingale's plan rather than by the original philosophical underpinnings proposed by Nightingale.

We begin therefore with the hypotheses that

Nightingale did indeed introduce an approach to education that would qualify nursing as a full-fledged profession, but, adaptation to the hierarchical roles of the modern hospital resulted in the achievement of only a subordinate level of authority which prevented nursing from the control over its own social position that is a hallmark of professional identity. Inquiry concerning the propositions above will be introduced as a test of the hypothesis.

Significance of the Problem

In 1965, after participation in an extensive study of nursing, sociologist, Fred Davies wrote: "It is paradox that despite the considerable responsibility assumed by professional nurses for the treatment and care of patients, their organizational role is so lacking in the autonomy and authority characteristically associated with professional status" (p. VII).

Eleven years later Joanne Ashley acerbically commented on contemporary sociological findings which rarely fail to conclude that nurses "lack autonomy and work in an atmosphere of subordination to physicians," a view, she adds, that is "hardly surprising to any nurse" (1976, p. 73). Few would disagree that there are still comparable descriptions of nurses today. At this moment,

nursing is engaged in a struggle to legitimize itself as a profession believing, once granted the privileges that full professional status guarantees, its members could provide the public with expanded and improved health services at considerably less cost (Aiken, 1983; Fagin, 1982; Hagermann, 1987; Orr, 1987).

The question, then, becomes focused on the major factors in the history of modern nursing that militated against nurses' professional ambitions. Two such forces are: (1) the biases associated with an all-female occupational group, and (2) the notion that physicians have historically acted to prevent nursing from becoming an independent profession. Although Nightingale has been charged with the problem, it is important to weigh the importance of Nightingale's influence in the context of societal attitudes towards nurses as women and the fact that physicians, as men, became their leading and governing partners in health care.

Traditionally professions have been viewed as "occupations with special power and prestige." These rewards are granted by society in the belief that professions possess "special competence in esoteric bodies of knowledge" of high value to the social system

and that its members "are devoted above and beyond material incentives" (Larson, 1977, p. X).

The two core characteristics essential to any true profession are "a prolonged specialized training in a body of abstract knowledge" and a "service orientation" (Goode, 1960, p. 903). These characteristics are drawn from the traditional professions of doctors, lawyers and priests who were singular in medieval times in the extended formal training they received in preparation for a life dedicated to service of others (Bloom, 1963, p. 88). To achieve its status a profession requires mechanisms to ensure its members meet preordained qualifications and to uphold the purpose of the profession. Training schools usually associated with universities are established to develop and transmit its knowledge and to socialize its students with appropriate attitudes. Similarly, professional organizations, codes of ethics, and licensing requirements are created in support of the collective aims of the profession.

Goode (1960) lists ten traits derived from the core characteristics described above:

1. The profession determines its own standards of education and training.
2. The student professional goes through a more far-reaching adult socialization experience than the learner in other occupations.

3. Professional practice is often legally recognized by some form of licensure.
4. Licensing and admission boards are manned by members of the profession.
5. Most legislation concerned with the profession is shaped by that profession.
6. The occupation gains in income, power, prestige and ranking, and can demand higher caliber students.
7. The practitioner is relatively free of lay evaluation and control.
8. The norms of practice enforce by the profession are more stringent than legal controls.
9. Members are more strongly identified and affiliated with the profession than are members of other occupations with theirs.
10. The profession is more likely to be a terminal occupation. Members do not care to leave it, and a higher proportion assert that if they had it to do over again, they would again choose that type of work. (p. 903)

Elliot Freidson (1970) challenges Goode's definitions. He noted that five of the ten derived traits refer to the profession's control of its own work, standards, and membership. He recognizes the core characteristics insofar as they produce professional autonomy, but argues that an occupation becomes a profession only when it assumes "a dominant position in a division of labor so this it gains control over the determination and substance of its own work" (p. XVII). This includes the legitimate right of the profession to determine who can do its work and how the work should be done. Because this privilege is granted by society, it requires the "protection and patronage of some elite

segment of society which has been persuaded that there is some special value in this work" (p. 72). Such patronage discourages competition by occupations closest to it and requires others to occupy statuses of subordination.

Of the three traditional professions: medicine, law and the clergy, medicine is recognized as the archetype because it possesses all of the qualifications in depth. The notion that medicine has successfully achieved the prerogatives of a true profession (as defined by Freidson) can be attested to by the growing number of paraprofessional groups arising in the health care system under the sponsorship or control of medicine. Meanwhile, nurses, who are closest to medicine on the hierarchy, are engaged in an uphill battle to secure functional autonomy and prestige on par with physicians (Twaddle & Hessler, 1977, p. 188). As long as society's image of the physician "ranks him at the very top of the scale on all the basic and secondary criteria of professions" (Wolinsky, 1980, p. 312) occupations being evaluated on their ability to fulfill the mandates associated with professional power and prestige are likely to be compared with medicine.

American nurses assumed a "self-conscious claimant to professional title" around the 1880s (Strauss, 1966, p. 64). Moreover, they are widely accepted as such by lay persons. But, because they lack some critical characteristics, it may be more accurate to portray American nursing as an emerging profession (Kelly, 1987, p. 139).

On the other hand, history credits nursing for being in the forefront in establishing the first respectable occupation for women that allowed them unprecedented independence in controlling their lives. Significantly, in the last century, "Many women physicians . . . turned to nursing because of the barriers put in their way by the male medical establishment. . . ." (Bullough & Bullough, 1984, p. 23) Nurses organized the first major professional association and edited the first professional journal by women (p. 41). Yet, today nursing is still struggling for recognition as a profession.

Questions are continually raised as to whether nursing can be a true profession or whether it is a derivative of medicine. Some maintain that nursing will always be secondary to medicine, its history inextricably bound to its ties to medicine as a source

of its basic knowledge and authority (Strauss, 1966, p. 72).

According to Bloom (1963), nursing "qualifies more than other profession in its orientation toward service"; however it is less qualified in terms of requirements for a "prolonged specialized training in a body of abstract knowledge" (p. 91). Goode (1960) views the matrix of nursing knowledge as simply "lower-level medical education" (p. 903). Paul Montayna (1977) categorizes nurses as semiprofessional, citing their dependence on medicine for the knowledge they use (p. 281).

In 1969, Katz described nurses as functioning in a caste-like status within the division of labor in hospitals. Treated by physicians as non-persons, they are rigidly separated and "disenfranchised from equal participation in . . . the scientific fraternity that exists in hospitals" (p. 70). Consequently nurses have been prevented from "developing their own body of sophisticated knowledge" (p. 75).

While it is justifiable to analyze nursing according to the variables used to describe traditional professions, "one variable—sex . . . has been noted but muted in earlier analysis of nursing. . . ." (Foster & Anderson, (1978, p. 197). Since the era of Nightingale

nursing has remained a sex-segregated occupation. Sex role stereotyping assures that nurses would be subordinate within a health care system while male professionals—physicians and later hospital administrators—dominate. Melosh (1982) asserts that the unique working relationship between nurses and physicians "poses an intractable obstacle to nursing's professionalization." As long as physicians maintain their authority by controlling the division of labor in health care, nurses will remain subordinate and their desire for autonomy constrained (p. 19).

Today nursing is making changes in achieving recognition and status beyond its traditional role, so that earlier sociological studies may not reflect its expanding directions. Nonetheless, nursing has and continues to have a position that is ambiguous with respect to its qualifications as a profession (Hughes, 1980, p. 55). The work of nurses in achieving professional identity will be discussed in my thesis. The study will focus on Nightingale's influence. By a study of nursing, its origins, historical and developing status, a contribution of value can be made to the sociology of the professions, as well as to the field of women's studies.

Literature Review

Medical Practice and Nursing Autonomy

Although Florence Nightingale is honored as nursing's greatest leader, she is also castigated as a source of some of its most troublesome problems (Bullough & Bullough, 1978, p. 100). Among the latter, the most crucial is Nightingale's part in shaping the social construction of modern nursing work specifically as it relates to medical practice and nursing autonomy. The overriding focus of scholars in this area is the concept of "obedience to the physician" that has long been identified as a Nightingale dogma. The events in the Crimea are seen heralding the earliest sign that Nightingale would subsume nursing practice under medicine (Bullough & Bullough, 1978, p. 100; Freidson, 1970, p. 61; Woods, 1987, p. 168).

In October 1854, Nightingale was requested by the British Minister of War, Sir Sidney Herbert, to offer her services in the Crimean War. This appeal arose from distressing reports of high death rates and inhumane conditions among the sick and wounded soldiers (Stewart & Austin, 1962, p. 102). Rather than welcoming Nightingale, military physicians deliberately attempted to thwart her intentions by refusing both the services

of the nurses and the money raised from public subscription that she brought with her. In turn, Nightingale refused to allow any nursing service to be administered, including bathing and feeding patients, unless specifically requested by physicians under the aegis of a "doctor's order" (Freidson, 1970, p. 61).

As the famous story is retold, conditions among the numerous patients in the military hospitals at Scutari became so intolerable that physicians were forced to request Nightingale's assistance. Consequently, mortality statistics in the military hospitals declined dramatically and Nightingale went on to become a national heroine. Capitalizing on these successes and her enormous popularity, Nightingale was later able to reform, among many things, the care of patients in civilian hospitals and in communities through the education of nurses according to her methods (Palmer, 1977, pp. 86-87; Stewart & Austin, 1962, pp. 104-108; 110-130). But, such victories were mixed with precedents that continue to plague modern-day reforms in nursing.

Nightingale's success notwithstanding, Freidson posits that her episode in the Crimea was pivotal in diminishing any potential nursing may have had in

establishing complete control over its practice. We can see strong evidence of this dogma: obedience to the physician that was acted out in the structure and ideology of nursing education in Britain and America from early educational programs, and was continually reinforced in text books, graduation speeches, and in the new ethos which shaped the behavior of nursing students and trained nurses alike (Keys, 1885; Robb, 1912; Spalding, 1920; Weeks, 1891).

Irene Sabelberg Palmer suggests that Nightingale actively negotiated a relationship in which medical men established "absolute medical authority" over nurses (1983b, pp. 229-230). However, other Nightingale documents could be interpreted differently. Arguments exists that Nightingale never envisioned nursing as an occupation completely dependent on physicians for development and direction, but rather, being both practical and wise, she took meticulous care not to arouse undue opposition as she went about creating revolutionary changes within an overpowering social and political system in which women occupied roles of subservience (see Bullough & Bullough, 1984, p. 21). Moreover, nursing historian M. Louise Fitzpatrick contends Nightingale viewed the nurse "as a colleague of

the doctor—working with him, but having a distinct sphere of responsibility" (1983, p. 64).

Nursing Education

On July 6, 1860, the first Nightingale school was inaugurated at St. Thomas's Hospital in London. In 1873, three educational programs patterned after the Nightingale principles were established in America: Bellevue Hospital School in New York, the Connecticut Training School in New Haven and the Boston Training School in Boston, Massachusetts.

Before the reforms of Nightingale, British and American nurses in secular hospitals were drawn largely from the illiterate classes of women who were often perceived to be immoral and unreliable (Schyler, 1975, p. 164). In order to eradicate this perception of nurses, Nightingale instituted a system of nursing education that began with careful recruitment of students who were held to prerequisites of a minimum of educational attainment and impeccable character (Bullough & Bullough, 1978, p. 95; Fitzpatrick, M. L., 1983, p. 64; Schyler, 1975, p. 164). She planned a curriculum consisting of closely supervised hospital experiences, lectures, written assignments, and examinations. Viewing "the student as a learner, not a

worker" she vigorously eschewed using students for hospital service at the expense of their education (Fitzpatrick, M. L., 1983, p. 64). Rather, Nightingale made provisions for nurses to be educated as leaders to spread her reforms (Giarelli, 1990, p. 210).

An important distinction in the Nightingale plan, indeed and unorthodox one considering the mores about women in Victorian England, was to insist that the control of nursing work be taken out of the hands of men—physicians, administrators, and hospital chaplains—and placed solely under the direction of a female head (hospital matron). Nurses were subject to medical authority in carrying out physicians' orders for patient care, but even here, when disciplinary action was necessary, it had to be directed through the hierarchy of female authority within nursing (Abel-Smith, 1960, p. 25; Baly, 1986, p. 187; Bullough & Bullough, 1978, p. 95; Fitzpatrick, M. L., 1983, p. 64; Nutting & Dock, Vol. II, 1907 & 1935, p. 178; Seymer, 1932, pp. 31-37; Schryock, 1959, p. 279). Equally noteworthy Nightingale espoused "complete autonomy" of her school from St. Thomas' Hospital by making it financially, organizationally, and physically independent (Fitzpatrick, M. L., 1983, p. 64).

In America, administrators were readily cognizant that lowered morbidity and mortality rates made hospitals more attractive to heretofore reluctant inpatients, while students provided a cheap source of labor (Bullough & Bullough, 1969, p. 130; Dolan, Fitzpatrick, & Hermann, 1983, p. 206). By 1900, most schools for nursing were assimilated into the hospital system; consequently, nursing lost control of its educational system and practice to the hospital administration and medical staff (Bullough & Bullough, 1969, pp. 148 & 152; Reverby, 1979, p. 210; Dolan, Fitzpatrick, & Hermann, 1983, pp. 202-207; Fitzpatrick, M. L., 1983, p. 69; Wheeler, 1985, p. 31; Kelly, 1987, p. 31).

In the United States philanthropic women rather than nurses founded the first Nightingale schools. Lacking "Nightingale's understanding of what nursing required [as well as] her ambitions for nursing as an occupation for women" (Baer, 1985, p. 35) the emphasis on nursing education centered on preparing nurses to function as workers rather than as teachers or leaders (Dolan, 1975, pp. 989-990).

Until around 1920, many nurses were as well educated as physicians. At the time of the Flexner

study in 1910, most medical schools had no university or college connections (Bullough & Bullough, 1978, pp. 156-159). But while medicine forged ahead to achieve its professionalizing ambitions largely through reforms in its educational system, nurses faced discrimination in attempting the same goals. The major form of discrimination faced by women in the nineteenth century was denial of access to higher education.

At the turn of the century most of the newly founded women's colleges "would have little to do with nursing." Because they were "seeking to establish their own reputations as academic centers" they rejected nursing as "too new to be academically respectable" and "not quite lady like" (p. 158). Coupled with the fact that Nightingale structured her educational system around an apprentice type training in hospitals, the castigation of nursing by academic institutions gave rein to administrators and physicians in confining and subordinating nursing education to hospitals. It is within this milieu that "loyalty and deference to the physician, rather than independence were stressed" (Reverby, 1987, p. 51). Cast more in the role of laborer than learner, the students in many hospital schools were subjected to an inferior education

(Bullough & Bullough, 1978, p. 154).

Leaders rose to rally for a standardized nursing curriculum and registration laws believing that eventually "the professional status of the trained nurse will be defined no less sharply than that of the physician or the lawyer" (Robb, 1900, p. 103). However the work of Tomes (1983) demonstrates that they were continually sabotaged by physicians, hospital administrators, and rank and file nurses who feared displacement in their efforts to control the direction their professionalizing strategies took (p. 108).

In the fall of 1899, the Society of Superintendents of Training Schools (founded in 1894) negotiated a course in hospital economics at Teachers College of Columbia University (Bullough & Bullough, 1984, p. 30). The course was designed to provide advanced training for nurse educators and administrators (Glaser, 1966, p. 12). Eventually it evolved into a permanent, prestigious post-basic education program. Nurses who aspired to higher education were more likely to select Teachers College over other colleges that were beginning to open to them. Consequently Teachers College had a major influence on the views of the early American leaders who shaped the direction of nursing (Bullough &

Bullough, 1984, pp. 45-46; Glaser, 1966, pp. 12-13). It has been suggested that although the movement of nursing into the university was an important step in the professionalizing process, the program at Teachers College inadvertently helped to reinforce divisions between nurses based on differences in education and authority; professionalism became vested in those who could achieve the higher status associated with teaching and administration (Strauss, 1966, p. 97).

Nightingale and Nursing Autonomy

A synopsis of Nightingale's writings and works suggests she had envisioned an autonomous role for nursing within the division of labor devoted to health care (Rogers, 1992, p. 59). Under the rubric of "obedience to the physician, nurses working under Nightingale's reforms demonstrated areas of nursing practice independent of medicine (Ashley, 1976, pp. 128-129). In her earlier work Notes on Nursing (1859/1992) Nightingale prescribed "revolutionary" laws of health that shaped the content of nursing education and practice (Reed & Zurakowsky, 1983, p. 19). These laws required neither the direction of, nor the orders of the physician to execute (Nightingale, 1859/1992, p. 6).

Strikingly, Nightingale had the audacity to claim

that nursing interventions are probably the most important factor in determining favorable outcomes for sick individuals (Nightingale, 1882/1954d, p. 335). Furthermore she is forthright in stating that nurses follow the physicians' orders conditionally (p. 347) since nurses must often make clinical decisions about a patient's life in the absence of medical supervision.

In making a distinction between nursing and medicine Nightingale warned of the inherent risks to the patient if nurses were not careful in understanding their distinctive role as she defined it. Nightingale inferred that there might be

a real danger of being satisfied with [medical diagnosis], or with looking too much at the pathology of the case, without cultivating the resource or intelligence for the thousand and one means of mitigation even where there is no cure. (1893/1949, p. 34)

This admonition spoke to the necessity of avoiding role confusion which could happen if nurses identify the sphere of their activities as originating solely from the physicians' domain. Clearly, Nightingale saw medicine and nursing as different disciplines developing out of common health sciences, yet because the focus of nursing in its construction embraced wider parameters of concern than did medicine, new knowledge had to be

discovered, developed and explored. Illustrating this point, Nightingale rejected Dr. Elizabeth Blackwell's proposal to establish a joint nursing and medical training "in part because perceived medicine as too narrow a realm for women's skills" (Reverby, 1987, p. 42).

Methodology

To study Nightingale's influence on the professionalizing process within nursing in England and the United States through the education she propagated, the methodology of historical sociology will be used.

According to Aronson, historical sociology is the "application of the sociological perspective to documents and other artifacts once living members of society leave behind" (1983, p. 5). This method offers the advantage of investigating sociological problems that cannot be reached by conventional methods.

Kai Erikson, in his study entitled Wayward Puritans, notes that distinctions between the interests of sociologists and historians frequently "lose their crispness" when they are used to characterize a given piece of research (1966, p. VII). However, in explaining why a study is basically sociological rather than purely historical, Erikson points out that his data

were not gathered to "shed new light on the Puritan community in New England" but rather to "add something of our understanding of deviant behavior in general and Puritan life in America has been treated as an example of human life everywhere" (p. VIII).

In like fashion, this study is not undertaken to discover any new particular facts about Nightingale and the institutionalization of modern nursing in England and the United States, but rather to use historical documents already in place as well as reliable secondary sources to obtain a better understanding of how nursing has evolved in its quest for full professional status. Since the roots of this problem lie in the relationship of Nightingale's ideas and the institutionalization of her ideas within the social structure of nursing education, a critical analysis of Nightingale's influence is paramount.

In achieving this goal, the research will rely heavily on the method of immersion in documentary materials of the period under the study so that, following Max Weber (1947, p. 87), this investigator can put herself in other person's shoes and try to arrive at suggestions as to motives and meaning. In addition, case studies will be employed to look at particular

historical situations for patterns of action that shed light on Nightingale's beliefs and their effect on the structure of nursing education and practice in the last century and early 1900s.

The thrust of this reexamination of historical material is to determine that perhaps it was not Nightingale's contribution as an intellectual source that has had a deleterious effect on inhibiting nursing's ability to achieve full professional autonomy, but rather that it was other factors that had relative importance in the development of nursing as a profession. Keeping this position in mind, the research will target primary and valid secondary sources referring directly to Nightingale and significant personalities and circumstances in which modern nursing existed in the time frame of the study: 1850-1920.

Fortunately, Nightingale was a very prodigious writer, having published 147 books and pamphlets in her lifetime. She also left a legacy of thousands of letters, many yet to be fully explored by historians (Vinicus & Nergaard, 1990, p. 1). Moreover, this search will include autobiographical accounts of people who worked alongside Nightingale in the Crimean War, Nightingale biographies, newspaper articles, speeches

delivered at graduation ceremonies and before professional societies. In addition, I will examine letters and other artifacts such as official reports, institutional records of hospitals, schools of nursing and professional organizations, as well as early journal articles and textbooks.

In order to infer a clear understanding of Nightingale's ideas, significant historical documents will be used to discern her beliefs about the nature and organization of nursing work, the purpose, content and methods of nursing, education, and the relationship of the new order of nursing to established systems of authority in health care. Since Nightingale's decisions are sometimes referred to as enigmatic (Seymer, 1954, p. VIII), it is essential to show not only the patterns of consistency in her philosophy but areas where it appears she deviates from or contradicts her stated positions either in writing or through her actions and decisions.

Following the construction of a framework depicting Nightingale's intellectual contributions, the study will highlight the manner in which her beliefs were institutionalized in the nursing reforms that ensued. The development of nursing will be scrutinized from the perspective of its ability to move toward its acceptance

as a profession with autonomy in defining the parameters of its discipline. Accordingly, the following will be studied: (1) the organization of selected early schools of nursing patterned on Nightingale's principles; (2) the development and dissemination of nursing knowledge and ethics that were generated around her reforms; (3) the manner in which nursing work was defined and operationalized; (4) the professionalizing strategies and conflicts within the occupational group; and (5) the evolving system of nursing education up to 1920. In these areas the emphasis will be on American nursing, while the complementary English systems will be juxtaposed for purposes of clarification and understanding Nightingale's contribution. Because of its large influence on the early leaders and educators in American nursing, a case study will be developed using the nursing program at Teachers College, which was founded in 1899.

The data yield derived from this systemic examination can only be interpreted within the social context of the time. Therefore, Nightingale's ideas and their propagation must be viewed within the social framework of: (1) the role of women and the force of strong class distinctions that existed in Victorian

England; (2) the rise of industrialism and the corresponding Progressive Movement that prompted public support for reforms in health care delivery; (3) the move toward universal education and women's rights in England and the United States; (4) the separate experience of democracy and a spirit of egalitarianism in America that forged an ideology of the professional that somehow differed in England; and (5) not the least, the tremendous impact of the strides made in medical education and practice, culminating in the expansion of the modern hospital and the aggressive professionalizing strategies of medicine. Each of these factors helped form, interacted with, gave direction to, or impeded the movement of education and nursing practice.

Since this study is exploratory in nature, it is not inconceivable that new questions and problems may arise in conjunction with the stated propositions. Therefore, an attitude of openness to other areas that suggest the need for exploration will be maintained.

Time Frame

The time frame selected for this study: nursing education in the United States and England between 1850-1920 has special relevance to the task of demonstrating Florence Nightingale's influence.

The use of education to reform the care of the sick in hospitals and homes was already taking place on both the European and American continents before Nightingale's experience at St. Thomas hospital began in 1860 (Nutting & Dock, 1907 & 1935); Shryock, 1959; Abel-Smith, 1960; Kalisch & Kalisch, 1986). Data derived from the earlier period are essential in determining why Nightingale's proposed methods were given prominence. While Nightingale made her staunchest impact in the latter nineteenth century, her ideas pervaded the trajectory that professional nursing followed through the early 1900s. At the turn of the century, the leaders in nursing found themselves either calling upon Nightingale's words and examples to meet their aspirations (Robb, 1900) or, as in the case of the English nurses movement for national registration, doing battle with Nightingale and her ideas (Abel-Smith, 1960, Chapter V).

In summary, by starting with the year 1850, this study can compare and contrast the reforms attributed to Nightingale with the earlier situation in nursing education and practice in England and the United States. Thus, a more cogent examination can be forthcoming. Furthermore, by delimiting the study at the year 1920,

it would be possible to scrutinize Nightingale's impact at a time when crucial decisions were being made by leaders coping with the dilemmas that arose around the earlier "Nightingale" reforms.

Summary

A study of this nature, using the methods of historical sociology, has salience from the perspective that the perceptions of the past are frequently used to explain social phenomena of the present or to predict or plan for the future. As documented in the section on literature search, there can be a wide divergence of opinion regarding Nightingale's influence and motives in the structuring of modern nursing education and practice. Questions continue to abound regarding her ideas about autonomy in nursing, a crucial element in the construction of a practicing profession (Freidson, 1970).

It is my belief that an historical study centered on this issue may be able to challenge some of the emphatic and dogmatic conclusions of many scholars who have written on the topic or, at the very least, it can open the issue to a wider discussion.

CHAPTER II

Significant Historical Antecedents to Nightingale's System in England

At the time Nightingale began what she referred to as an experiment at St. Thomas Hospital in 1860, reforms in nursing education and practice had already been recognized in discrete projects as well as in the organization of nursing on the wards of hospitals, especially in those institutions engaged in medical teaching. Several factors expedited these changes; most notably were (1) the gradual adoption of scientific medicine which placed new demands on physicians who, in turn, aspired to have better qualified nurses; (2) the humanitarian efforts of those who sought to rectify the growing injustices that existed in the care of the sick and infirm members of society which became immeasurably worse with industrialization; and (3) the recognition that although hospital care was becoming essential for an increasing array of health problems, hospitals themselves were perpetuating their own pattern of iatrogenic diseases and infection.

Earlier glorified depictions of Nightingale's nursing reforms tended to characterize them as an event that brought about a sudden, keenly discernible change

in the way nursing conducted its business. But, as Baley illuminates us, "reform came slowly and painfully and what became known as the Nightingale system was not an ideal scheme of Miss Nightingale's but pragmatic experiment and the result of enforced compromise" (1986, p. 4). Suggestions abound that Nightingale plagiarized much of what she propagated from particular experts and systems already in place (Smith, F. B., 1982, p. 155; Goldie, 1987, pp. 9-10). This position is tenuous since Nightingale never intimated that all her ideas were original: rather, she viewed her greatest challenge as the need to work within institutionalized arrangements that were firmly rooted in the British culture. Unquestionably, Nightingale was adept at "adapting the ideas and systems of others" and it is likely she would have considered her actions "entirely justified" (Goldie, 1987, p. 10).

Although many aspects of Nightingale's designs were indistinguishable from the cultural norms of the time, she imputed salient enduring features that veer in the direction of autonomy for the organization of nursing services in institutions. Some core elements of Nightingale's system that are crucial to the imputation of professional status on an occupation may be traced to

earlier attempted reforms by religious leaders and movements, while concomitantly, the obstacles to nursing's full participation as a profession are deeply embedded in the older traditions surrounding British nursing. These vital factors are best illustrated by examining significant historical antecedents that preceded Nightingale.

The events of the past reveal that English nursing suffered a cataclysmic setback following the religious upheaval of the sixteenth century. The unity of the Christian faith in Western Europe was effectively broken by the Reformation propelled by an Augustinian monk, Martin Luther, from Germany in 1517. Along with the destruction of the ubiquitous power of the Roman Catholic Church came the collapse of many of its institutions; Protestant fury attempted to annihilate anything connected with Roman Catholicism leading to the prompt termination of schools, orphanages and hospitals.

In many cases religious nursing Sisters had to flee for their lives as their monasteries were dissolved. England was particularly devastated when King Henry VIII closed more than a hundred of its hospitals (Dietz & Lehozky, 1967, pp. 47-48). Hospitals maintained by monasteries or private patrons were permanently

eliminated while those supported by towns or cathedrals had a chance for survival. For instance, three London Hospitals were closed around 1538: St. Bartholemew's, St. Thomas' and St. Mary's; the latter was never reopened. In the case of St. Bartholemew's, its reopening in 1544 was due to a huge public outcry over the public health problems created by an outpouring of sick and putridly dirty homeless persons lining the streets. When St. Bartholomew's officially reinaugurated its services it was governed by a mayor and its own "self-perpetuating board" rather than falling under the jurisdiction of the city of London (Shryock, 1959, pp. 156-157).

The following description of "St. Bart's" is significant in terms of understanding the old tradition of British nursing with its hierarchical arrangements upon which Nightingale grafted her system; many facets will be recognized, perhaps less directly, in the American system as well.

Curiously enough, all through the period when St. Bartholomew's was officially closed, patients stayed in the buildings. Some attendants must have remained to look after them. After the reorganization, five "sisters" were appointed to tend the sick and one of these was to serve as supervisor or "matron." Obviously, much of the nursing tradition carried on. Not only were the attendants called "sisters," though they were lay people, but it was provided that they should

continue to wear a special habit. To this day most English nurses use the same title. The matron was supposed to take the place of a prioress or superior, the other "sisters" that of nuns. (Shryock, 1959, p. 157)

However, the disappearance of Roman Catholic Sisters in Protestant countries eventually lead to what is commonly known as the Dark Period of Nursing in that, when it was "Stripped of its religious elements of loving care and self sacrificing duty, nursing was revealed as little more than domestic work" (Bingham, 1979, p. 11). In England hospitals would gradually lose the religious atmosphere that dominated them for, even though some towns owned their own hospitals, religious communities were used to administer them. Consonantly, once the orders were disbanded, lay trustees or governors took over the administration of existing institutions (Shryock, 1959, p. 159).

There were never enough Sisters to meet the needs of the numerous patients occupying hospitals, therefore some type of "servant attendant" existed in addition to the sisters.

By the 1600s a class of "women helpers" was clearly defined, some of whom eventually became "sisters." . . . Eventually the "helpers" became known as nurses.

Sisters, and to a lesser degree the helpers or nurses, were expected to observe a rather rigid discipline. This may be traced in part to the

vows taken by nursing groups before the Reformation. . . . It has also been suggested that the discipline followed in military nursing orders had influenced general hospital procedures . . . this example encouraged distinctions in rank among hospital personnel which have survived in a lessened degree to our own time. The sisters . . . were directed to be obedient to the matron who was their "chief governess and ruler." (Shryock, 1959, p. 158)

Insofar as ideas prevailed that respectable women were to live out their lives within the confines of the family or, if called to the religious life, within the convent, in England after the Reformation they were deprived of the means of providing community service that the monastic arrangement provided. Moreover, given Luther's injunction that salvation is based on faith rather than good works, any religious motivation for working with the underclass including the sick poor severely waned. As a result no lay organization came forth to take the place of the Sisters who fled, nor was there any organized system "to develop or teach others to carry on" (Dietz & Lehozky, 1967, p. 48). When nursing was separated from its religious roots, devoid of the Christian mandate to serve the sick and infirm out of a sense of love and self sacrifice, its social value declined; the lay nurses who replaced the Sisters in the hospitals were seen primarily as domestic workers, while the sick poor who inhabited the wards

were no longer considered "worthy objects of Christian charity" by the upper classes (Bringham, 1979, pp. 10 and 14). In as much as "the better types of women tended to abandon it," nursing fell into the hands of "those who because of age, poverty, or ignorance could get nothing better" (Shryock, 1959, p. 160). Wealthy women, however, continued to practice nursing (and a little surgery) as a domestic art, accepting responsibility for the health of the members of their household and their poorer neighbors (Bringham, 1979, p. 14).

We should notice that the discussion of hospital care at this time makes no mention of a dominant physicians' group. Regardless of the quality of its work, until scientific medicine came to the fore, the nursing staff was the mainstay of inpatient services. In 1820 the physicians at St. Bartholomew's Hospital had to complete rounds on patients only once a week; a second day was reserved for seeing outpatients during which time only could new patients be admitted. In between visits they left their junior assistants to carry on particular functions (Abel-Smith, 1964, pp. 6-7).

By the first half of the nineteenth century four

categories of persons were involved in providing nursing care to some degree. The largest group was the sickpersons' household which cared for them at home. Their "informal work" might be assisted by one of two types of paid helpers: the handywoman or the private nurse. Both of these groups were comprised primarily of women who were independent and self employed; they are differentiated on the basis of whether they rendered "cheap service" for poor families or "premium service" for the better off. It was common for these workers to alternate between domestic and hospital employment in staffing patterns that reproduced "similar social divisions" in their functions. Therefore it is important to consider impressions of the hospital nurse at this time as they correspond to the counterpart role of the nurse in the home.

For instance, in contrast to the handywoman who worked, for the most part, with clients of her own class, "the private duty nurse was a servant of her social superiors." She was considered to have offered more specialized care than the handywoman by virtue of the fact that her clients could afford to pay for medical services, thus she was exposed to "whatever passes as orthodox medicine" (Dingwall, Rafferty, &

Webster, 1988, pp. 14-15). In the hospital the ward sister most approximates the domestic private nurse.

Within the "broad description of nursing care" before 1850, the division of labor in hospitals provided for a fourth category of workers comprised exclusively of men. They filled gender specific roles under the titles of apothecary, dresser, resident or clinical clerk. The genesis of their activities within hospitals originated from a time when prestigious physicians delegated responsibility to their subordinates or apprentices (p. 7). However, by the turn of the century, many of their technical functions would be subsumed under nursing (p. 17).

Teaching hospitals in particular made arrangements for medical students or "residents" to supply many of the bedside treatments. Those who filled these "junior medical posts" were frequently referred to under the older titles as dressers (because they had the responsibility for surgical dressings) and clinical clerks (Abel-Smith, 1960, p. 60). In other voluntary hospitals apothecaries might be the only salaried medical attendants. During the 1600s they began to extend their services from one of compounding and supplying medicines to include other normal functions of

medical men. While they were considered socially inferior to physicians, they were legally united with physicians and surgeons under the Medical Act of 1858 (Dingwall, Rafferty, & Webster, 1988, p. 17).

The lay hospital nurses of the prereform era who, more often than not, were widowed women, although some were married or deserted wives, tended to be depicted in unflattering terms. Their descriptions range from their "being little more than domestic servants of a rather coarse and rough type" (Maggs, 1983, p. 6) to the hyperbole of Nightingale who characterized them as "generally . . . too old, too weak, too drunken, too dirty, too stolid or too bad to do anything else," (1867/1954b, p. 274).

Author Charles Dickens used his novel Martin Chuzzlewit (1871) to make a social commentary on the state of domestic nursing and health care for the poor in mid-century London. Two of the fictional characters portray his conviction: Sarah Gamp, an alcoholic who hires herself out as a handywoman of sorts, and her associate, Betsy Prig, a nurse with experience at St. Bartholemew's Hospital who relieves her when her shift is over. Both are employed around the clock since they move from one case and back to another every twelve

hours. In one situation Mrs. Gamp cares for an alternately confused and unconscious patient, boasting all along that she received her instructions from the learned Mrs. Prig.

"Why, highty tighty, Sir!" cried Mrs. Gamp, "is these your manners? You want a pitcher of cold water to throw'd over you to bring you round; . . . and if you were under Betsy Prig you'd have it too, I assure Mr. Chuffy. . ." (Vol. IV, pp. 136-137).

It is arguable whether Dickens used some satire and exaggeration to get his point across, nevertheless no one challenged his notion that if nursing care was to be upgraded, it was essential that the character of its practitioners be remedied. He argued vehemently that "Sarah Gamp is a representation of the hired attendant on the poor in sickness" (Preface, p. 9). Actually Gamp was modeled on a person hired by a friend of Dickens to care for an invalid (Dietz & Lehozky, 1967, p. 49). In respect to the nurses employed by hospitals, Dickens was equally vociferous.

The hospitals of London are, in many respects, noble institutions; in others, very defective. I think it not the least among the instances of their mismanagement, that Mrs. Prig is a fair specimen of a Hospital Nurse; and that the Hospitals, with their means and funds, should have left it to private humanity and enterprise, in the year Eighteen Hundered and Forty-nine, to enter

into an attempt to improve that class of persons.
(Dickens, 1871, Preface, pp. 9-10).

There are, however, inconsistencies in the accounts of hospital nurses before the imposition of reforms (sometimes referred to as the old system). Rosenberg notes that "their authors were well aware that some mid-nineteenth century nurses had been responsible, stable, and dedicated, even if others had been casual, filthy, and unreliable" (1987, p. 214). This is exemplified by Miss Pringle, a graduate of Nightingale's school, who wrote after twelve years of hospital nursing that "Some of the nurses were the best type of woman—clever, dutiful, cheerful, and kind; endowed above all with that motherliness of nature which is the most precious attribute of a nurse" (quoted in Abel-Smith, 1960, p. 5).

While it has been acknowledged that the old system produced some outstanding nurses and many who undoubtedly functioned with a fair degree of skill, still, the overwhelming opinion seems to support notions that as an occupational group their reputation was inglorious. For, although this was "an era of drinking among all classes," nurses in particular were recruited from among women who were intemperate. Nurses were equivocally condemned and encouraged in their drinking

patterns by hospital authorities who offered alcohol to nurses as a type of payment for their services (p. 9). For instance, it was standard practice for a physician to order a glass of wine at the request of a sister "before she had to do an exceptionally unpleasant dressing," and night nurses believed that taking some beer before going on duty would help them to cope with their assignments (Helmstadter, 1993, p. 48).

Hospital authorities had to contend with nurses who were "uncouth and sometime unlawful," and it was not uncommon for them to steal and sell hospital property. Nurses frequently exceeded their leaves of absence and were typified as being "truculent and disrespectful." Correlatively, "there were constant complaints from the doctors of not only poor discipline in the wards but of nursing incompetence" (pp. 46-49). But patently, it was the abuse of alcohol that particularly marred the reputation of old nurses. In fairness, their plight should be judged on the basis of contradictory societal attitudes toward alcohol consumption. In the hospital the staff and patients were encouraged to drink alcoholic beverages rather than the city water which was polluted. Moreover, alcohol was commonly prescribed as part of the therapeutic regimen for patients in the

conviction that it was "strengthening" and would "provide physical stamina." These beliefs would not be effectively challenged by the medical profession until the 1870s (p. 51).

Unquestionably, the most exploitive and dismal working conditions belonged to nurses who labored well into the nineteenth century under the voluntary hospital system that changed little in the years following the Reformation. Typically, in the London Hospital nurses began their work at 6 a.m. in summer and 7a.m. in winter and remained on duty until supper at 10 p.m. They were not granted days off nor did they receive any pension. Living conditions for the nurses were notoriously filthy and inadequate, forcing them to do their own cooking in the ward kitchens and to sleep next to the wards or in the basement and attic. It was not unusual for nurses to be illiterate which was in keeping with their class origins—although some hospitals attempted to enforce rules that would require literacy for medication administration (Bringham, 1979, pp. 14-15). The sleeping arrangements offered to nurses by other hospitals contributed to their appellation as "women of low character." Female nurses were often assigned to work alone in the male wards and were known to bed there

at night among the patients (Abel-Smith, 1960, p. 10).

Through most of the nineteenth century until nursing reform took root on a large scale, the role of the nurse in hospitals hardly distinguishable from that of the "charwoman." During this time domestic service was the largest field for working women, and it was from this class that literally all paid nurses in existence were drawn. Since most of them were or had been married, the experience they acquired in caring for family members could be transferred to the hospital setting. Moreover nurses could always count on female convalescent patients to assist them with their chores (p. 4). The subsistence pay they received and their abominable working conditions formed a barrier against attracting women from the educated classes into their ranks (pp. 6-7).

Hierarchical Distinctions Among Nurses

Significantly, the organization of the staff of larger eighteenth and early nineteenth century hospitals resembled those of larger landed estates. The system of authority was paternalistic in nature, in keeping with the master-servant relationship that characterized the association between employer and workers in the last century.

Because of the stark distinctions in their functions and, in some cases, their social origins, the matron, sisters and nurses were usually recruited separately. Traditionally the matron functioned exclusively as an administrator whose tasks were many and varied in carrying out the domestic functions of the hospital. She was not required to have any nursing experience in as much as her duties directed her to overseeing the housekeeping (Bringham, 1979, p. 11). Since these tasks were so overwhelming the matron usually had to forego any direct involvement in the supervision of patient care; more likely, she was scarcely involved, if at all, in the daily operation of the wards (Abel-Smith, 1960, p. 8). The matron was answerable to the Board of Governors; the governors in kind related to the staff and patients as a parent to minors (Helmstadter, 1993, p. 45). Women attracted to the position of matron tended to be the widows of "marginal" members of the middle class such as clergymen or army officers, with experience in managing a large Victorian household (Dingwall, Rafferty & Webster, 1988, p. 16).

As indicated above, the title of sister was derived from the monastic term and is used to denote the nurse

in charge of a ward. In earlier times it was not unusual for the sisters to be appointed from among the nurses or attendants; but in a more progressive institution, she was hired directly into the position from the upper domestic classes or, like the matron, she may have been a widow from the respectable ranks of society who fell on reduced circumstances. St. Thomas' Hospital is an example of the latter: it hired those who had experience as "head servants in gentlemen's families," which served them well in their primary role as domestic supervisors (Bringham, 1979, p. 12; Abel-Smith, 1960, p. 7-8). At Guy's, another leading London hospital, it was a frequent practice to make the selection for the post of ward sister from "one of the ordinary [nurses] whose promotion was merited from length of service and presumed stability" (Williams, 1980, p. 60).

Customarily, a sister would be assigned to one ward for years, working under the supervision of the same physician. This system contributed to her being able to acquire a semblance of practical skills, even though no formal system of education existed (Bingham, 1979, p. 16). Although the training lacked a systematic method, it did produce some capable nurses. Most notably, Mrs.

Roberts, "the best nurse" to accompany Nightingale to the Crimea, "had been brought up under the old regime" at St. Thomas Hospital (South, 1857, p. 14).

The ward sister was considered to be on duty for twenty-four hours a day; for instance, if there were acutely ill patients such as those with serious accidents or surgery, she was expected, in addition to her normal day schedule, to be on the ward through the night. Usually, as was the case at St. Thomas, modest living quarters were provided adjoining the ward and opening into it (p. 10).

Since the day nurses were equated with ward maid or handywoman (charwoman) status they required little teaching beyond that of poultice-making and the enforcement of cleanliness and attention to patients' basic needs. According to an account of Guy's Hospital in 1874, because the nurse would be responsible for cleaning and scrubbing the wards and staircases, "it was necessary to select from a class of inferior grade to others . . ." (Dingwall, Rafferty, & Webster, 1988, pp. 10-11). Usually a night nurse worked alone until 6 a.m., remaining on her "watch" until the day staff arrived. During this time she would give medicines and alert the sister of any changes in a patient's condition

that might require her attention. Between 6 a.m. she remained on the ward to assist with domestic chores (South, 1857, p. 11).

Clearly the plight of the hospital nurse was not an enviable one as chronicled by a sympathetic reporter for The Times on April 15, 1857.

Hospital nurses have been much abused;—they have their faults, but most of them are due to want of proper treatment. Lectured to by committees, preached at by chaplains, scowled on by treasurers and stewards, scolded by matrons, sworn at by surgeons, bullied by dressers, grumbled at and abused by patients, insulted if old and ill favored, talked flippantly to if middle aged and good humoured, tempted and seduced if young and well-looking—they are what any woman might be under the same circumstances. (quoted in Bringham, 1979, p. 16)

It wasn't until the 1830s that anyone signaled a serious need to remedy the manner in which nursing care was delivered to the sick, especially in hospitals. Not surprisingly, however, the nurses and patients who were closest to the problem were not among those who used the public arena to enter the debate. Indeed, their common class origins constrained even the literate among them from leaving extensive written documents.

According to the evidence two groups of people were noticeable in the early movement for change: (1) the physicians and surgeons who needed a competent nursing

staff that could keep pace with the radical transformation affecting simultaneously the practice of medicine and the nature of hospital care, and (2) the distinguished philanthropists who applied their own pressure from a different set of motives derived from their "reforming spirit of Evangelical Christianity" and their concerns about the disintegrating effects of industrialization and urbanization on the social order (Dingwall, Rafferty, & Webster, 1988, p. 19). The blending of goals for these groups would eventually culminate in elevating the standards of care delivered by nurses in the home and hospital.

In the case of physicians, the constant process of refining diagnostic accuracy and the attendant treatment for new diseases required they have a skilled partner who could, while remaining subservient, function in their absence as their eyes, ears, nose and hands; someone who would follow their directions unquestionably and alert them when they were needed. Originally it was thought that medical students could function in this role, but circumstances would alter this direction.

Physician Control of Nurses Through the Ward System

Eventually many diseases and health problems became predictable in terms of their signs and symptoms and clinical course. Once a diagnosis was made, physicians began to find it was "uneconomic and uninteresting" to use their time in observing the patient's progress. At first they found it convenient to use their assistants or apprentices (the dressers, clinical clerks, or apothecaries). Later it seemed natural to turn to medical students who were spending more time in the hospital in conjunction with the new emphasis on clinical medicine. But the transient presence of these students provided a major flaw in the arrangement. Increasingly physicians saw nurses as the ideal health care workers to fill this niche, if only they could be trained to execute the more complex medical treatments that were being developed (Dingwall, Rafferty, & Webster, 1988, p. 23).

In teaching hospitals:

It was the medical students and junior house staff who were responsible for the acutely ill, although the more able sisters helped. . . . [In caring for a patient] in 1855 with an acute case of erysipelas, complicated by edema of the glottis, which required a tracheotomy Relays of medical students sat at his bedside, two at a time, monitoring his status twenty-four hours

a day, and administering medicine and food at regular hourly intervals by mouth and enemas, which nineteenth-century doctors used in the absence of intravenous lines. . . . His care demonstrates how what by the end of the century would have been strictly the work of nurses was done entirely by the medical students. (Helmstadter, 1997, p. 164)

As the nineteenth century advanced hospital nurses were, to some degree, able to become distinguished as an occupational group possessing various degrees of specialized knowledge and skill, largely through the initiative of ambitious physicians.

There was one group of people in the hospital to whom the work of nurses mattered a great deal—the doctors. The . . . doctor wanted to have an assistant continuously with his patients who could be relied on to carry out his orders and report the patients' progress. Consciously or unconsciously the doctors taught the nurses. Sisters and nurses tended to stay on one ward and thus to learn what was required of them. It was the doctors who gave the nurses their orders and were consulted about [the appointment of] new [nursing staff]. (Abel-Smith, 1960, p. 9)

The tension to find a way to insure that their instructions would be carried out to specification prompt various efforts on the part of physicians to restructure nursing commensurate with the goals of medical practice. And while this had the effect of distinguishing of a group of nurses according to acquired competence in administering delegated medical functions, it resulted in placing nursing substantially

under medical domination. Early movements in this direction are discerned by some apparently loose and unconnected events that merge to form a pattern.

At the Royal Cornwall Infirmary in Truro . . . the house surgeon rather than the matron was appointing nurses by the 1830s and was responsible for granting leave of absence or permission to stay out late. . . . In 1835, the Royal Devon and Exeter Hospital had appointed its first "operation nurse" specifically to care for surgical patients. . . . Ward nurses were gradually distinguished from servants. . . . Sisters began to be recruited on a supernumerary basis so that they could learn the role before taking over a ward of their own. Their accommodation was upgraded, meals were provided and rates of pay rose Similar developments [were taking place] in the United States from about 1840. (Dingwall, Rafferty, & Webster, 1988, pp. 23-24; see also Rosenberg, 1987, pp. 213-214)

An Historical Account of St. Thomas' Hospital

published in 1819 describes duties for ward sisters which are more in line with contemporary nursing. Here we have evidence that they were held personally accountable for insuring that the physicians' orders were carried out—especially those pertaining to prescribed medicines. Undoubtedly St. Thomas was well ahead of its time in respect to the standards it set for its sisters who were thus instructed: ". . . when called upon, you shall be ready to acquaint the physicians, surgeons or apothecary, with the effects of such medicine during their absence, so far as falls

within your observation" (quoted in Abel-Smith, 1960, p. 8, footnotes). Eventually the role of the ward sister in leading hospitals evolved to center responsibility on one person for ensuring that nurses carried out the wishes of the doctors. In addition, she was needed to maintain the ward's supplies and for helping to facilitate communication between the patients and the medical staff (Williams, 1980, pp. 59-60).

In 1857 a St. Thomas' surgeon, John Flint South, who had been attached to the hospital for forty-four years, wrote Facts Related to Hospital Nurses in which he vehemently reacted against the letter in The Times which portrayed the situation of nurses working in London hospitals as pitiful; he debated each accusation point by point.

What South left was a fairly accurate description of the hierarchical structure and function of nursing at St. Thomas, albeit a firmly biased one. In one sense St. Thomas differed little from the other voluntary hospitals in the way it used its nurses; but there is evidence that it was attempting to rationalize and stabilize its patient care through a selective recruitment of the ward sisters and to offer them a semblance of training. It is significant to note here,

however, that South was very cognizant that the political climate in London, under the sway of Nightingale and other philanthropists, was bent on more radical reform (Bullough & Bullough, 1978, p. 94; Howlett, 1993, p. 1). Nonetheless he was adamantly opposed to any changes that would alter the existing system, particularly as it related to the authority of the physicians and surgeons (South, 1857).

When nineteenth century physicians referred to their desire for improvement in nursing it was in terms of the character of nurses. There is no evidence that they intended to support a change in the status or work of the nurses that "did not stem from a medical definition of nursing—as a set of practices, deriving mainly from medical knowledge . . ." (Williams, 1980, pp. 52-53). Meanwhile philanthropists, who repeatedly used the inflammatory image of Sarah Gamp to get their views across, regularly agitated for amelioration in articles written for popular magazines. They demanded change on a grand scale involving an upgrading of the quality of all nurses and specialized training. However leading physicians were not interested in sweeping reforms of hospital nursing; instead they envisioned relatively smaller improvements that would leave the

established system intact (pp. 55-56).

By the mid-nineteenth century some London hospitals had begun to improve the working and living conditions of the ward nurses with the perspective of attracting women with a higher level of character and some type of probation was initiated. Congruent with this aim, attempts were made to some degree to separate the domestic from the nursing work, but as the Guy's Hospital report indicated, nurses were still required to do the scrubbing (pp. 56-57). The function of the nurses at Guy's in 1859 entailed learning "nursing tasks that were easily taught" and which were "not clearly demarcated from the domestic service of the hospital." However, even though the ward nurse was beginning to elevate herself in terms of skills and character, she would still be "subject to the immediate supervision and control of the ward sister" (pp. 56-57). This was the case at St. Thomas Hospital.

As South intimated in 1857, the sisters at St. Thomas' were "selected from among intelligent and active persons in the prime of life—usually about thirty years of age—who are ascertained to be . . . capable of understanding and attaining the knowledge required of them." At first they were taken in as "supernumeraries"

which enabled them to undergo a probationary period that could last a year or two. The turnover rate of the sisters was low (pp. 12-13). This poses a sharp contrast to the subordinate ward nurses . . . who were, in most cases throughout London, paid on a weekly basis and "were sacked without notice" (Abel-Smith, 1960, p. 6).

After completing the probationary period South (1857) makes it clear that the sister has still much to learn, which can only be

attained in the ward by the kind and patient guidance of the physician and surgeon to whom she is attached. What sort of attendant she shall be depends . . . mainly on him [emphasis added]. If he directs, assists, and encourages her, and she be moderately intelligent and attentive, she will soon become efficient, and repay his trouble by her trustfulness. If he be careless and indifferent to her, she will probably take no pains to learn, take little interest in her case, and ultimately become more trouble than profit. I have examples of both classes. . . . (p. 15)

Clearly, the advancement of nursing under this system hinged on a set of variable that lacked any uniformity of standards in terms of what nurses learned, since that depended on the particular specialty and practice of the physician teacher, nor was there any guarantee, according to South's observations, that even a minimal quality of nursing practice would be maintained. In terms of future goals related to nursing autonomy, this

arrangement firmly established the physician as the architect and arbiter of nursing practice. Moreover, there is no evidence that the ward sisters ever received any formal theoretical classes for their work, so that their preparation was essentially a matter of practical experience. Patently, the "pupillage" of hospital nurses was controlled by means of a direct, long standing relationship with the ward physician. More often the sister, like the matron, enjoyed permanent tenure in her position so that over time nursing would be shaped by "a set of practical duties to be defined by him [emphasis added]" (Williams, 1980, p. 63).

Early Philanthropic Efforts in Nursing Reform

Although efforts to improve the performance of the nurses were beginning to materialize through changes initiated by the hospital under the management of the ward sister who acted in direct accordance with the wishes of the ward physician or surgeon, the status of "the nurse only as performer of ward duties and thereby servant of the hospital" did not change significantly until philanthropists outside the hospital intervened with their own plans to establish a system of selective recruitment and training. The earliest case has its

roots in a reform movement which started in 1825 when an attempt was made to establish a nursing order similar to the Sisters of Charity in France. This venture did not last. In 1840, under the patronage of royal and distinguished persons, the work was taken over by Quaker philanthropist Elizabeth Fry, whom many refer to as the real pioneer of modern nursing in England. Her organization was originally referred to as the Protestant Sisters of Charity, although no vows were taken. Shortly thereafter it was known as the Institution of Nursing Sisters (Widerquist, 1993, p. 27; Williams, 1980, p. 43).

More, however, was involved in Fry's decision: originally her philanthropic activities were centered on prison reform. A Protestant Pastor, Theodor Fliedner, of Kaiserwerth in Germany galvanized by Fry's work in prison reform, went on to form a small institution to care for women who were discharged from prison. At the same time he established a modest hospital and began a program for training nursing deaconesses. The candidates were chosen based on strict character requirements and were "submitted to rigid discipline and a life of Spartan simplicity while they cared for the sick." Two months following her visit to Kaiserwerth,

Fry initiated her own training scheme (Cope, 1955, p. 10). Many consider the work begun by Pastor Fliedner as the real forerunner of nursing reforms in England since it served to inspire Nightingale, as well.

The object of Fry's Institute was

to supply "a deficiency long felt and complained of by the public, that of experienced, conscientious and Christian nurses of the sick; and also to raise the standard of this useful and important occupation; so as to engage the attention and enlist the services of many who were desirous of devoting their time to the Glory of God, and for the mitigation of human suffering." (Tooley, 1906, p. 34)

The Sisters were not permitted to receive any private remuneration; all fees and gifts were forwarded to the Institute which, in turn, granted them an annual stipend. Since no probationer could be admitted without being able to read or write, it meant that she had access to better education than most women in England had at the time. The nurses were drawn primarily from "the higher domestic or small farming and trading classes" (Tooley, 1906, pp. 34-35; see also Cope, 1955, p. 10).

At first the training was for two hours a day for three months and then it extended to six months and finally to one year. The training consisted primarily of practical experience in hospital wards and was

dependent upon the "good will of the head ward nurses [ward sisters]" some of whom "were not well disposed towards the new invasion and promptly hurried the probationers away when the doctors came round, and there was anything likely to be learned." If the probationer was judged to have successfully completed the hospital training she was awarded a certificate from the matron of the hospital in which she was assigned. The Institute, in turn, was obliged to pay a weekly fee to the hospital for each probationer (Tooley, 1906, pp. 35-39; see also Williams, 1980, p. 49). Thus, the hospital standards of nursing work became the basis for practice by these Protestant Sisters in caring for the sick in private homes (Williams, 1980, p. 49).

For their training Mrs. Fry's Institute of Nursing Sisters were assigned to Guy's Hospital beginning in 1840 and St. Thomas in 1851. The reports of the hospital surgeons from these two institutions are remarkably similar in alluding to the fact that it was their hospitals and not the Institute that defined what the nurses learned and ultimately practiced. From this account it is hard to make a case that Fry, aside from her innovations for selective recruitment, made any serious inroads in changing the established system of

nursing. Nevertheless, "Fry's nurses were called nursing sisters and therefore were compared with their counterparts in the hospitals at the time" (p. 65).

Around this time a revival in the Church of England, often referred to as the Oxford Movement, resulted in the establishment of English Sisterhoods along the line of the older Catholic orders still prevalent on the continent of Europe. These new Sisterhoods were able to rekindle the impression that nursing could be a desirable vocation for proper English women, providing they engaged in it from a religious and philanthropic motive (p. 45). We should bear in mind that, in general, people of all classes tended to distrust the notion that secular hospital nursing could be practiced in an honorable manner. This is perhaps best exemplified by the fact that the English citizens would periodically clamor to the government about the dismal conditions in their hospitals relative to those staffed by Catholic Sisters in neighboring countries (Shryock, 1959, p. 270). As such, in the early stages of nursing reform in England there was a pervasive perception that unless a movement was founded according to a strong religious motive it would not succeed. This underlying theme, markedly evident in Fry's institution,

dominated the new Sisterhood at St. John's House which would follow (Tooley, 1906, p. 57).

Between 1845 and 1855 several Anglican groups were started primarily to do "general welfare work among the poor" including volunteer nursing during epidemics. In 1848, twelve years before Nightingale opened her school at St. Thomas, the English established St. John's House: the first Protestant religious order fully devoted to nursing. It would become prominent for its education of nursing students (Shryock, 1959, p. 270).

But, as we shall soon see, the plan to initiate an Anglican nursing order was supported by more than religiously motivated philanthropy. Actually Kings College Hospital in London first launched the plan in order "to introduce a higher class of nursing." The idea was initiated by three of the hospital's eminent physicians with the intention that the Sisterhood would undertake the training, staffing and administration of nursing at Kings College Hospital. To the extent that the scheme was prompted by the medical staff, it nonetheless had to come under the sponsorship of the Church of England, requiring an array of bishops among its promoters (Tooley, 1906, pp. 56-57).

The purpose of the Sisterhood at St. John's House

was to create a community of women, all members of the Church of England, who would be trained to "act as nurses and visitors to the sick and poor" (p. 57). Because the work was basically a religious undertaking they sought women of good character and better qualifications than would ordinarily be found in hospital nurses. Unlike their Roman Catholic counterparts, however, the new Protestant orders did not require the taking of vows, monastic obedience, or celibacy, nor would they live in cloistered seclusion.

Members of the community were divided into three categories: probationers, nurses and Sisters. The incoming student underwent a trial period of six months; if she was found satisfactory she moved into a probationary period for two years which prepared her to serve as a nurse. Successful completion of the probationary period brought with it a medical certificate of competency and a place on the list of nurses of the community. At this point they could nurse in the hospital, with a private family or engage in work with the sick poor.

The St. John's Sisters were drawn from the upper classes being distinguished by "superior birth," nonetheless they had to undergo the same scrutinization

of character as did the probationers. The Sisters functioned to assist the chaplain and the Lady Superintendent (who was akin to a matron) in the training of the probationers, and to manage the domestic arrangements of the community (pp. 58-62).

Mary Jones, a friend of Florence Nightingale, was appointed Lady Superintendent and under her guidance the order was able to progress successfully. Six of the nurses accompanied Nightingale to the Crimea on October 23, 1854. Although four of the first party returned unable to sustain the privations and harsh discipline and a fifth died from fever while serving, a few months later a second detachment of twenty nurses, prepared by Mary Jones was sent out.

As a result of the Crimean experience the Sisterhood was encouraged to expand its work: in 1856 it assumed total responsibility for the nursing services at Kings College Hospital. Eventually it would make similar arrangements in three other major hospitals (pp. 65-66). In 1861 St. Johns House was subsumed under the All Saint's Sisterhood which had been founded ten years earlier (Shryrock, 1959, p. 270).

There is evidence that St. John's House Sisters attempted to modify the old ward system, which left the

matron essentially powerless to enforce any hospital regulations over the heads of the ward Sisters and the authority of the physicians and surgeons who governed the wards. When the Sisters took over a hospital they established the lady superintendent as a powerful manager. All probationers, nurses and Sisters reported directly to her and, in turn, she could pass instructions to the nurse without going through the ward sister. The Sisters centralized the system even further by rotating nurses from ward to ward rather than having them remain permanently in one place. Supposedly this arrangement would be a factor in "breaking the power of the old sister and the medical officer over the nursing staff in the individual wards" (Helmstadter, 1993, p. 57). Historically, this change may be seen as a return to an earlier system as was the case at St. Bartholomew's Hospital in the 1770s whereby the matron ruled supreme in terms of retention and assignments of all nursing staff (p. 56).

Nonetheless, the basic curriculum at St. John's House was not ambitious in attempting to promote anything by a very practical education for its probationers. This limited view of nursing can be attributed to the system of placing them under Sisters

who brought with them only the "skills in domestic management appropriate to their upper middle-class backgrounds." However, the carefully chosen Sisters were responsible for setting the spiritual tone during the entire educational process (Dingwall, Rafferty, & Webster, 1988, p. 29).

Nursing orders like St. John's House did not change the class of nurses at the bedside of the patient; like the voluntary hospitals of England they recruited working-class women to work under supervision. By and large, the distinguishing feature of the Sisterhood reform was the strong reintegration of the spiritual dimension within the ordinary duties of the nurse. To carry this goal to fruition the nurses whom they certified were held to higher standards. Hence, as time went on the Sisterhoods would break, as did Nightingale, the cultural link between the unreformed nurses and their patients (p. 29). It is also essential to consider here that St. John's House gave the status of probationer new meaning and dignity; no longer cast in the traditional role as permanently subordinate to the ward sister, she began to be seen as "a candidate for higher status" and "expressly valued as an individual and a member of the community of Sisters equally with

its own members" (Williams, 1980, p. 67).

Unlike the Nightingale system, St. John's House did not create a theory of nursing. The instruction of its students remained pragmatic and, perhaps even more significantly, it was directly analogous to the traditional arrangements of the old establishment. In essence, even with the decentralization of the nursing staff, its nursing practice took its form based on "the relationship between the ward physician or surgeon and ward sister . . ." (p. 68). Moreover, the only written formal direction given nurses by the Sisterhood was confined to a four page pamphlet entitled "Hints For Nurses" which specified "loosely formulated" knowledge and carried "more moral than scientific instruction in nursing . . ." (pp. 68-69).

The teaching of the probationer comprised practical instruction from the sister in the sphere of the ward. . . . There existed no source of nursing knowledge that was external to the sphere of the ward. In this way, the status of hospital nursing as a set of practical duties pertaining to hospital wards was unchanged, as was its status as subordinate in this respect to medical control. (p. 69)

Anne Summers (1988) reminds us that their aim was

"Spiritual rather than medical improvement" (p. 20).

The early English philanthropists can be credited with bringing nursing to the prelude of professionalism.

This was achieved for the first time by establishing the nursing candidate as worthy of higher status through stringent requirement of character and successful completion of a training period. Moreover, the Sister's system of hospital nursing was unique for being the first to arrange for ladies, or non-working class women, to work in hospitals, even if unpaid, thus helping to reestablish nursing in the minds of the public as a respected occupation with a strong, religiously motivated, altruistic service orientation.

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CHAPTER III

The "Nightingale System"

Although Nightingale was not the first person to implement the idea of nursing education, she became the leading and influential voice largely because of her charismatic qualities and the fact that her system provided the means for the transmission of reforms, as she designed them, to diverse sites and settings (Davies, 1980, p. 103).

As we have established, other institutions for training nurses were already in existence in England and Germany prior to the inception of St. Thomas school, however the Nightingale model is singularly regarded because it

restored to women, in a secular framework, a measure of autonomy they had lost in Protestant countries with the decline of the religious nursing orders. In response, nursing in England had begun to regain status and to attract more intelligent and dedicated women. (James, 1979, p. 206)

Nightingale's experience with the various religious orders during her army experience in the Crimea, especially as is dealt with conflicting authority between their own heads and official administrators, as well as the need for some to proselytize to patients convinced her that nursing must be non-sectarian (Woodham-Smith, 1951 p. 124; Baly, 1991, p. 23). Her

concern was that the methods of nursing be used to prevent and cure sickness, not as a means to save souls (Summers, 1988, p. 23). Subsequently, she presented a secular model for nursing education that became the archetype for schools of nursing throughout the European continent and abroad. Although Nightingale's scheme would eventually dominate early American achievements in nursing under the auspices of hospital-based training schools, there were significant modifications that will be examined later.

While recognizing that it is essential to apprehend the dimensions of her "system", such an inquiry would be incomplete without first noting that Nightingale was foremost a renowned nineteenth century social reformer whose interests and accomplishments in other socio-political arenas have, at various times, paralleled her contribution to nursing. The focus of this study does not permit an examination of the many facets of Nightingale's character nor does it allow for an in-depth examination of her works outside nursing. But an appreciation of the scope of her talents, motivation and genius must be addressed, especially as they have affected her power to resolutely pursue significant goals for nursing.

Nightingale's character and beliefs have the distinctive mark of the culture in which she was born and died, yet the pattern of her life betrays on extraordinary woman who dared to transgress the mores of her class in keeping with her deep spiritual convictions. Underlying all of Nightingales' achievements is a woman who possessed and used a strong intellect culled by a religious idealism that drove her to seek perfection.

Of no small importance was Nightingale's possession of an exceptional liberal education for a woman of her era. Born into the privileged upper class of British society, she was taught by her father who agreed with Unitarians on the importance of educating women, an idea that was not commonly held at the time (Schyler, 1992, p. 14). She not only became fluent in Italian, French, Latin and Greek, (Smith, F.B., 1982, p. 18) she was "informed in the arts" and was "perceptive about politics, economics and government" (Palmer 1977, p. 84). Nightingale delved heavily into history and philosophy and was "a serious student of the Bible." Considered one of the best educated women of her era, her formal education was enhanced by extensive travel with family and friends through Europe and Egypt where

she became acquainted with "outstanding intellectuals of the time" (Schyler, 1992, pp. 14-15). "It is a measure of the family's intellectual and fashionable standing . . . that they knew not only the best of the English intelligentsia but also cultivated such foreign luminaries as Sismondi, de Tocqueville, Thiers and Elie de Beaumont" (Smith, F.B., 1982, pp. 18-19).

Nightingale's expertise as a statistician afforded her the means to conduct scientific research using statistical methods to demonstrate the need for improving sanitation and health care (Schyler, 1992, p. 4). Her ability to generate irrefutable statistical data allowed her to assume authority in advancing each of her causes (Palmer, 1977, p. 88).

She accomplished reforms in health and sanitation in the British Army, in civilian hospitals, in workhouses, and in the homes of England and other parts of the world. She worked to change the laws in England and India to improve the health of their populations . . . (Schyler, 1992, p. 4)

Nightingale's sense of mission was rooted in the rich environment of the Victorian era. She was

. . . educated at a time when leading thinkers were proclaiming the virtues and potential of mankind. Having discarded the fatalistic view of man previously predominant, nineteenth century philosophers advocated the optimistic belief that men could shape their own destinies and improve the circumstances of their lives . . . the central . . . belief of the Victorian Era was the idea of progress. (Schyler, 1978, pp. 34-35)

In 1844, as a young adult of 24 years, Nightingale was firmly convinced she was called by God to do hospital work; however the intense opposition of her family, which mirrored the strong societal prohibition against upper class women engaging in hospital based nursing, restrained her from following through on her calling for nine years (Schyler, 1992, p. 4). During this time "she studied hospital reports, sanitary reports, books on public health, and the yearbook of the Kaiserwerth Institute. . . . She soon had a greater understanding of hospitals and the care of the sick than almost any of her contemporaries, male or female" (Bullough & Bullough, 1978, p. 86).

In 1851, while facing the antagonism of her family, Nightingale went to Kaiserwerth for a short period to study its system of nursing. Although she was deeply impressed with the strong integration of spiritual values with the daily duties of nurses, her private correspondence highlighted her disgust with the filth of the hospital and the absence of any degree of mastery in nursing. Nonetheless the experience at Kaiserwerth served to solidify her resolve to pursue a career in nursing (Woodham-Smith, 1951, pp. 60-61).

In later years Nightingale would recount her

frustration in searching for what she considered valid examples of high quality nursing care. Her brief start with the French Sisters of Charity was ended abruptly when she was summoned home to care for her dying grandmother (Bullough & Bullough, 1978, pp. 86-87). But she found no reason to return, citing that she saw "nothing to be learned there except shelling peas, peeling potatoes, and that principle of stupid unintelligent obedience" (Schyler, 1978, p. 39). In Paris she visited the Augustinian Sisters "who were not so good as the best trained English nurses are now . . ." and she managed to live under the Sisters of St. Vincent DePaul who worked in the community with the poor (Letter to Julia Ann Elizabeth Roundell on August 4, 1896 quoted in Vincus & Nergaard, 1990, pp. 433-435).

In August 1853, following much negotiation which she initiated, Nightingale assumed the Superintendency of the Institution for the Care of Sick Gentle Women in Distressed Circumstance (also known as the Harley Street Nursing Home). The hospital committee was initially reluctant to take her because of her social standing, but later relented when they learned that Nightingale had her father's full permission. His support is demonstrated in the generous yearly allowance he

arranged for her.

Nightingale's accomplishments at Harley Street were largely organizational, although she was both brilliant and shrewd in implementing her ideas. For instance, in the face of deep rancor she was able to convince the governing body to have all religious requirements for admission abolished, a value she held firmly. Her greatest disappointment was the inability to supply the patients with the level of care she felt they deserved because her staff was inadequately prepared as nurses (Bullough & Bullough, 1987, p. 87, Smith, F.B. pp. 11-16, Vincus & Nergaard, 1990, p. 63).

There is some evidence that Nightingale once considered using the Institution as a training school for nurses, but later rejected the idea because the variety of patient experiences needed for clinical education would have been inadequate.

I have not effected anything towards the object of training nurses—my primary idea in devoting my life to Hospital work for, owing to the small number of applications. The Committee have not been able to select, in all cases, proper objects for Medical & Surgical treatment—and accordingly the results have not been satisfactory to me. (1970, p. 35)

The demand for better nurses in all hospitals became a major concern for Nightingale (Bullough & Bullough, 1987, p.87). While still under contract at

Harley Street, she actively explored the feasibility of applying for the superintendency at the new Kings College Hospital for the purpose of establishing a training system for nurses, a goal that, at the time, she never lost sight of (Vincus & Nergaard, 1990, p. 77). But radical change in events that thrust her in the center Nightingale's plans were abruptly interrupted by a national calamity: March 28, 1854 marked the beginning of the Crimean War which started when Britain joined France to halt the expansion of Russia into Turkey. While Russia and France had members of religious orders to administer humane care to their troops, England was reduced to using untrained men to care for the sick and wounded. When the public became aware of the abject handling and neglect of British casualties, it angrily remonstrated against the government. Seven months later, in an effort to quell the disastrous public outcry, Nightingale was appointed by the Parliament to the position of Superintendent of the Female Nursing Establishment in the English General Military Hospitals in Turkey.

Sidney Herbert, the Secretary of War and a personal friend, sent her a letter which was published in the Daily News on October 28, 1854, after she had already

departed on her assignment. It expresses the immense confidence he had in her ability to ameliorate the situation at the war front:

There is but one person in England that I know who would be capable of organizing and superintending such a scheme. . . . My question simply is, would you listen to the request to go out and supervise the whole thing? You would of course have plenary authority over all the nurses, and . . . cooperation from the medical staff, and you would also have an unlimited power of drawing on the Gov't. for whatever you think requisite for the success for your Mission. . . . I must not conceal from you that I think, upon [your] decision, will depend the ultimate success or failure of the plan. Your own personal qualities, your knowledge and your power of administration, and among greater things your rank and position in society, give you advantages in such a work, which no other person possesses. . . . (quoted in Goldie, 1987, p. 24; see also Cook, 1913, Vol. 1, p. 153)

On October 21, 1854 thirty-eight nurses, selected from a group of volunteers who came from religious institutions and hospitals, set sail to Scutari with Nightingale. From the onset of the massive undertaking Nightingale was hampered by the lack of a unified system of nurses training from which qualified nurses could be drawn. The ability to predict each nurse's performance, especially under the precarious conditions of war, was almost impossible. She would discover that the nurses were "extremely varied in their skills and devotion. Some were clearly unequal to the task and living conditions, while others fulfilled the stereotype of the

drunken nurse" (Vincus & Nergaard, 1990, p.92).

Nightingale remained there with various groups of nurses and lady volunteers who would arrive and depart, until she returned home in July 1856. Meanwhile the vivid accounts of her work in the Barrack's Hospital became universally legend.

Nightingale's deep grief for the horrible conditions she witnessed developed into an obsession in which she felt a need to rectify the memory of the young British soldiers left behind in their graves.

No one can feel for the Army as I do . . . I have had to see my children dressed in a dirty blanket and an old pair of regimental trousers, and to see them fed on raw salt meat, and nine thousand of my children are lying, from causes which might have been prevented, in their forgotten graves. But I can never forget. (Cook, 1913, Vol. 1, p. 314)

Eventually her political activities would confront the whole military system of medical care, including the education of its physicians. The years 1856 to 1861 were consumed by her efforts to enact long-term reform in the army, primarily through her work on the Royal Commission on the Sanitary State of the Army (Baly 1991, pp. 23-24; Vincus & Nergaard, 1990, p. 159). Besides working with the Commissioners, Nightingale spent over six months writing, for the information of the latest Secretary of War, Lord Panmure, her extensive private

report Notes on Matters Affecting the Health, Efficiency and Hospital Administration of the British Army Founded Chiefly in the Experience of the Late War, which has become recognized as the "least known, but most remarkable of her works" (Seymer, 1960, p. 7). This report proved conclusively that more men died from the unsanitary conditions in the army hospitals than from battle wounds (Schyler, 1992, p. 5).

These pressing national projects prevented Nightingale from turning her attention to opening her own school until July 1860. Significantly, it was her heroic stature and fame, resulting from her service during the war, that granted her the requisite publicity and authority as a nursing expert to successfully inaugurate the Nightingale School.

The history of the school actually began in November 29, 1855. While Nightingale was still serving in the Army hospitals in Turkey and the Crimea, a large meeting was convened in London by Nightingale's friends and admirers in order to find a means to honor her. The fate of the project was sealed when Queen Victoria's first cousin implored them "to enable Miss Nightingale . . . to make use, unfettered, of a sum of money to establish a school for nurses . . . who when trained by

her may be sent forth to various hospitals which shall require their services. . . ." Prophetically, the Queen's physician pronounced that the educational project Nightingale would establish would become "a national blessing" as well as a "model for similar institutions throughout the country" (Seymer, 1960, pp. 1-2).

A gift of 45,000 pounds (possibly the equivalent of over \$1,000,000 in today's currency) was eventually collected from every class in English society. The amount of money solicited was not as significant as the fact that it began to foster the notion in the minds of the citizens, especially middle class groups, that nursing "was a suitable occupation for respectable educated women and that nurses needed to be trained" (Baly, 1986, p. 18).

At the age of 39, Nightingale returned from the war in a much weakened physical state. Within a relatively short period of time, while working on the Royal Commission she collapsed, never again regaining sufficient vigor to return to her former active life. All that Nightingale would achieve hereafter, including the seminal work in nursing, was accomplished while living her life as reclusive invalid (Baly, 1987, p. 35).

It has been widely argued that Nightingale deliberately chose to remain behind the social scenes of British society: this vantage point afforded her the opportunity to orchestrate her will in civil affairs more successfully than if she were not physically incapacitated (Cope, 1958, pp. 159-160).

From 1857 to 1910 she lay in bed or on a couch or sat in an invalid-chair most of the time, interviewed relatives, friends and visitors one at a time. . . .

. . . she did an immense amount of work, reading blue books, collecting volumes of information, writing countless letters, often of great length, putting together elaborate memoranda and tables of statistics, and penning innumerable notes, many of which are preserved in the one hundred and fifty large volumes in the British Museum, not to mention other documents elsewhere. Her correspondence [and visitors] kept her in touch with statesmen, eminent doctors, matrons of hospitals, nurses, relatives, friends, and showed the working of an alert mind. The work she did has left a permanent mark on the medical and surgical professions in this country [England], on the sanitary condition of India, and on the Army Medical Service. (pp. 151-152)

When it became apparent that Nightingale's health would not permit her to personally undertake the task of organizing and managing a hospital for nursing on a special plan, the fund collected by Sidney Herbert was placed in the hands of trustees and a Fund Council was named to administer it. Nightingale reserved for

herself "the power to advise" and the Council supported her opinions and details in designing the project (Tooley, 1906, p. 94).

Nightingale eventually selected St. Thomas Hospital, which originally stood near the London Bridge, as the site for the training school. It is widely reported that she was drawn to St. Thomas because of Mrs. Roberts, who was one of the best nurses to serve in the Crimea and through her admiration for Mr. Whitfield, the Resident Medical Officer at the hospital. Ultimately, however, she was impressed with the reputation of its matron, Sarah Wardroper, a disciplinarian, who had already gained recognition for raising the standard of nursing at the hospital (Tooley, 1906, p. 95). Both she and her predecessor, Martha South, appointed "a better quality of woman as ward sister rather than . . . promoting the existing nurses" as other hospitals traditionally did (Howlett, p. 1). The choice of St. Thomas proved to be an astute move since its "capable and experienced sisters" would comprise the first nursing faculty (p. 2).

The Nightingale school, unlike others at the time, was independently funded, consequently nursing students enrolled in the program contracted their loyalty to the

Fund Council (also referred to as the Nightingale Fund), and not the hospital. The probationers underwent training for a year and agreed to work for the Fund for an additional three years. It was this unique arrangement that gave Nightingale and her trustees a supply of nurses trained to their stipulation "to send, in groups, to implement the Nightingale System" (Davies, 1980, p. 104).

The Fund provided free tuition for students who were drawn primarily from the working class although some "members of the most prosperous families in Britain" were among the early probationers (Abel-Smith, 1964, p. 66). They were given room and board, uniforms and a small allowance. In addition an annual salary was paid to the Matron as Superintendent of the Nightingale Training School, and to Mr. Whitfield for his medical instruction. Each doctor who lectured received an honorarium and a small payment was made to the ward sisters who gave the probationers practical instruction (Howlett, 1993, p. 2; Seymer 1960, pp. 20-21; Smith, F.B., 1982, p. 159).

Nightingale approached the new training school as an experiment, knowing full well that some plans were yet untried and others would have to be guided by

experience and compromise. The efforts of gender would always warrant special attention. For instance, working within the Victorian, male dominated society Nightingale realized that if she attempted to give women positions of authority, a lot of public agitation would ensue, therefore she perspicuously used the same hierarchical organizational structure that was peculiar to the English voluntary hospital (Palmer 1983b, p. 231). In effect, she "grafted her system" on to the existing model. There are four main features she introduced at St. Thomas Hospital which were adopted by other hospitals and training schools. These features became the hallmark of the "Nightingale System":

- (1) The Matron is supreme. She is responsible for the nursing in the hospital, for the kitchen, laundry and domestic staff, for the nursing school and for the appointment and dismissal of the nursing staff. She is answerable only to the Hospital Board.
- (2) The student-nurses "live in," for their educational and moral good as well as for discipline, their home being attached to the hospital and under the charge of a "Home Sister."
- (3) Theoretical teaching is given to the nurses, including instruction in the basic sciences.
- (4) The ward "Sister" occupies a place of great dignity and importance: she is under the Matron's direction responsible for the practical teaching of the nurses.

Besides these four fundamental points Florence Nightingale laid great stress on the above-mentioned special distinction of her school, its economic independence due to endowment. (Seymer, 1932, p. 117)

Probably the most salient feature of the entire design is the edict she enjoined "that the entire control of the nursing staff, its discipline and instruction be taken out of the hands of men and lodged in the hands of a women who must herself be a trained and competent nurse" (Stewart & Austin, 1962, p. 11).

Nightingale had a distinct plan to use the graduates of St. Thomas to promote her reforms. They were admonished not to take positions in private nursing, as did the graduates of the earlier English's schools, but rather to fill posts in hospitals and public institutions in order to raise the standards of care (Woodham-Smith, 1951, pp. 234 and 350).

As vacancies occurred in the regular staff of . . . [St. Thomas] hospital they were filled by Nightingale nurses, so that, eventually the old style ward nurse was replaced by the new. It would probably be impossible to record all the hospitals that were regenerated by the Nightingale nurses. . . . (Nutting & Dock, Volume II, 1907 & 1912, p. 183)

Although Nightingale garnered popular support when she sought to rectify nursing and hospital care for soldiers during the Crimean campaign, she suffered scorn and scoffing when she introduced her scheme for establishing a system for trained nursing. "People still shook their heads over the idea of making nursing

a calling for women of gentle birth, and of the exclusion from it of the uneducated, unskilled, and unfit women" (Tooley, 1906, p. 93).

Acutely aware that secular nursing would never become a "socially accepted profession" until its practitioners were "socially accepted women" Nightingale gave first priority to upholding the character requirements for probationers (Barritt, 1973, p. 30). "Strictness was necessary. The Nightingale nurse must establish her character in a profession proverbial for immorality. Neat, lady-like, vestal, above suspicion, she must be the incarnate denial that the hospital nurse be drunken, ignorant and promiscuous" (Woodham-Smith, 1951, p. 236).

The best nurses in Nightingale's view were those who chose the work from a sense of a calling by God. Throughout her public life she maintained that although education was indispensable, it was the character of probationers and nurse that became the essential factor in determining the success of her plan.

Because the moral integrity of probationers was a key factor in reforming the care of the sick, no student could be admitted without a certificate of good character. Correlatively, constraints were built into

the curriculum to help insure their spiritual and moral probity as well as their cognitive development (Bullough & Bullough, 1978, p. 95). For, although Nightingale sought to recruit women with the highest moral standards and principles, she was keenly aware that the education of probationers need assume that these traits be developed and routinely evaluated.

The inference experience suggests is, that even if you can be sure . . . that the woman has learnt her trade of nurse, you cannot risk her as a character by sending her out to such a very responsible situation . . . as that of a hospital nurse till you have trained and tested her as women in moral and also mental qualities. (Nightingale quoted in Schyler, 1975, p. 166).

She insisted that probationers be supplied with comfortable living quarters in a closely chaperoned home where they were under the supervision of a home sister. A total institutional environment was planned in which they were obliged to follow a rigid schedule of guided study, meals, recreation, worship and Bible study. Strict standards of behavior extended to their free time including regulations that forbade going out unless accompanied by another classmate (Barritt, 1973, p. 31). Underscoring the emphasis on character, Nightingale drew up a comprehensive list of duties for students that began with the requirements that they be sober, honest, truthful, trustworthy, punctual, quiet,

orderly, and clean and neat (Howlett, 1993, p. 3). A review of records for the probationers admitted during the first decade of the school indicated a significant number were indeed dismissed for causes such as "insubordination", "insobriety", "disobedience" or for being "unsuitable" (Baly, 1987, pp. 47-59).

Arrangements For Practical Education

In contrast to the arrangements for nursing instruction at Elizabeth Fry's Institute and the Sisterhood of St. John's House Nightingale offered profound and enduring change in the way nurses would be educated. In Nightingale's plan "the status of the hospital nurse as pupil" was established "not only in principle but, more importantly in practice." For one, she removed the province over the ward nurse from the ward sister "to a sphere that was external to the ward," thereby severing the "exclusive control of the sister in allocating ward duties to the pupil nurse" (Williams, p. 69).

In 1867, Henry Bonham-Carter, Nightingale's first cousin and secretary to the Fund Council, published a pamphlet entitled "Suggestions for Improving the Management of the Nursing Department of Large Hospitals" which succinctly lays out the premise behind

Nightingale's design: good nursing could not be learned merely within a context of chance experience in a hospital. Heretofore nursing was never seriously accepted as an art with its own body of knowledge worthy of systemic instruction. Carter acknowledged that while most large hospitals "had a considerable number of skilled nurses" good nursing grows out of "study, training, teaching, and practice," lending itself to "a sound tradition" which can be "transferred anywhere." Until this happens, he warned, the prevailing system could not be reformed. He proposed that the only way to institute lasting change was to "substitute trained for untrained nurses" (Carter quoted in Williams, 1980, pp. 69-70).

Nightingale defined the training of the probationer as a year of service on the wards of the hospital as Assistant Nurse. What the student was obliged to learn was specified before she engaged in the learning process and was laid out as a list of ward duties. In essence, while Nightingale did not explicitly spell out a theoretical perspective in her curriculum, neither did she simply offer advice to her students as the pamphlet of St. John's House Sisterhood had done. Rather, Nightingale formalized what each probationer was

expected to learn and master.

Although this was to be a major step in standardizing the education of nurses, Nightingale realized it was not enough to insure compliance. Consequently, as her curriculum evolved she held both the students and their teachers accountable for implementing the learning process from their perspective roles. With this intent, Nightingale arranged for the ward sister to receive a book which listed the duties to be learned by the probationers. Each month the matron was to examine the book to determine student progress. At the end of the year the Nightingale Council Fund itself participated in the overall evaluation of the probationers' training.

Nightingale designed the course of study in this manner to constrain the ward sister from allocating duties to the probationer "in any arbitrary fashion, as she was able to do in the established system." Nightingale also acted to prevent the matron from undermining the pupil's primary role as learner rather than worker by proposing a separate position of matron whose traditional task was overseeing the domestic and household functions of the hospital; the supervision of students then could fall under a specially appointed

matron/superintendent of nurses. If this was not feasible, she counseled that the matron or superintendent have an assistant as housekeeper to free up the position for nursing supervision, particularly as it pertained to the training of nurses (pp. 70-72).

The Nightingale training school emerged amidst burning antagonism from the medical staff at St. Thomas.

Although Nightingale's Fund amassed a huge list of supporters, only three physicians and one surgeon from one London Hospital and one physician from a second can be found among those championing the cause (Woodham-Smith, 1951, p. 233). Nightingale envisioned an ideal nursing system, whether military or secular, in which the matron or superintendent was free of outside interference in administering her staff (1910, pp.1-3).

But she was forced to superimpose her ideas at a time when hospital physicians had taken control of nursing vis-à-vis the ward sister to accomplished their ends.

[The] form of nursing education [she built] was a compromise based on the existing institutional framework of the hospital. It neither challenged the doctors' status nor made demands on the hospital administrations for resources. It could probably only have worked in world where women were prepared to be so self-denying, so hard-working and so amenable to discipline. (Davies, 1980, p.104)

The lack of employment opportunities for women at mid-century made them ripe to accept these conditions as

normative. The Nightingale model proved to be an attractive alternative at a time when voluntary hospitals were becoming financially strapped. In coming to terms with the need to provide an expanding array of services to treat the growing population of inpatients with acute illnesses, the system of education she conceived "made political and economic sense in the hospitals." The matron, driven to prove the value of the new nurses, maintained strict discipline. Ostensibly the cost of the living quarters the hospitals were obliged to provide for probationers was more than offset by the small stipend they were paid in exchange for having a reliable workforce that was accessible and available (p. 105).

Confounding as this turn in admission policy might seem, Nightingale's eventual success in institutionalizing her system of education and nursing reform is closely tied to the introduction of paying probationers who underwent the same rigorous training as the regular students. Paradoxically, when she launched her program she deliberately solicited "women of the upper servant class such as daughters of small farmers or tradesmen, who had received some education but were accustomed to earning their own living" (Howlett, 1993, p. 2).

Nightingale had misgivings as to whether aristocratic women of her class would be suitable for the regimented life of the reformed nurse. In 1858, two years before she opened her school at St. Thomas, Nightingale remonstrated that although she believed ladies of the upper classes had important contributions to make they would, more often than not, be remiss in complying with the dictates that nurses be humble, subdued, disciplined and subject to legitimate authority. From a practical standpoint, she predicted it would be far more difficult to dismiss upper class women for dereliction than it would be dismiss other nurses (Palmer, 1983b, p. 231). Undoubtedly, Nightingale's experience with lady volunteers in the Crimea only served to underscore her concerns. Basically she characterized their performance as indifferent to hard work and more focused on benign flirting with the soldiers (Howlett, 1993, p. 2).

However, the new attractiveness and respectability of nursing inspired ladies to importune for training. In 1867 the increasing demand for trained nurses and the limited financial resources of the Nightingale Fund paved the way for the establishment of a grade of "special probationer" which was designed to accommodate

financially independent women. The specials paid a annual fee for their room and board. Although they received the same training as the ordinary probationers they were expected "to be appointed to superior positions as ward sisters or matrons or lady superintendents" (p. 2).

Nightingale was adamant that all the nurses she sent out in leadership positions be educated according to her methods. She provocatively pronounced at one point that the situation was analogous to a lady being trained along "with her cook." However she firmly believed "that ladies would rise to the position of superintendent, not because they were ladies, but because they were educated." Eventually a third category of probationer called Free Specials, was created comprised of women who were ladies by birth and education, but who were unable to pay the annual fee for their maintenance (p. 2). In contrast to the two class system of probationers at St. Thomas, in 1855 the nursing Sisters at St. John's House did not receive a training and were expected to regularly contribute to the funds of the Institution from an annual [family] income (pp. 2-3).

During the Victorian era it was assumed that women

of means were better equipped spiritually than those of the working women and were also qualified to teach nursing to those of the lower classes without themselves having had any practical preparation. Nightingale used to ask, "in exasperation, many times in the 1850s and 1860s—why a group of women of independent income and religious inclination, but without any formal training of any kind, should have been considered competent to perform these functions" (Summers, 1988, p.21).

"There is no such thing as amateur nursing," [was Nightingale's] response to those who felt that any woman of the "better" classes could do nursing. She further emphasized her point with the comparison: "as a woman could undertake hospital management, or the management of a hospital ward . . . without having learnt anything about it, any more than a man can undertake to be, for example, professor of mathematics without having learnt mathematics." (quoted from Una and Her Paupers, Memorials of Agnes Elizabeth Jones, introduction by Florence Nightingale. New York: George Routledge and Sons, 1872, pp. XV, XXXI, in Monteiro, 1985b, p. 184)

Nightingale would remind her regular probationers that "perhaps here only" nurses are "on a footing of equality with educated gentlewoman" (1874a).

Other hospitals were willing to duplicate the nursing system Nightingale started. Administrators readily sized upon the advantage of having probationers deliver a higher standard of bedside care while they

could be paid less than the traditional nurses. Their willingness to copy what was being hailed a successful program at a prestigious London hospital helped pave the way for Nightingale to inculcate her methods on a wide scale. Many of her pupils became matrons of other hospitals spreading new order "by geometric progression as each trained nurse trained others" (Abel-Smith, 1964, p. 67).

Nightingale purposely set in motion a movement to secure an "autonomous female role" in the hospital. Her plan was that upper class women with sensitivity and breeding would take over the superintendency of the institutions and be answerable only to the governing boards. She rightly calculated that the "prerogatives of female sensitivity and class identity" would legitimate her requirements, however she also knew that these traits alone would never be enough to achieve her aims. It was for this reason that all recruits, regardless of their class origins, were mandated to share the same technical training and abide the same rigorous standards of discipline.

The Nightingale program wedded intuitive moral capacity and intellect, piety and efficiency, and promised hospital trustees and administrators a stable and relatively inexpensive labor force along with improved internal discipline and lower mortalities. It constituted a powerful and well-

calculated appeal for public and medical support.
(Rosenberg, 1987, p. 218)

English physicians initially balked at the goals of early reformers under Nightingale, preferring instead to retain the older style ward nurses whose careers they sponsored and who could be relied on to remain subordinate to members of the attending staff. They were particularly exasperated by the prospect of having a female superintendent (matron) with direct access to the governing board of a hospital. When the trained matrons impinged on the traditional hospitals' administration fundamental changes had to occur, but not without its share of conflicts. No longer was the matron to be content in playing a minor role in the affairs of nursing. As we can recall under the old system she was largely concerned with the domestic efficiency of the hospital; when she hired nurses it was always in consultation with the medical staff responsible for the ward. Similarly, whatever training a nurse needed was primarily the responsibility of the physician under whom she worked.

In order for the matron to commence what she saw as her rightful place in superintending the nursing service and in many instances establishing a training school she had to proceed quickly and decisively "to carve out an

empire of her own". Not only would she be taking over some of the responsibilities of the medical staff, but that of the administration, as well. What is perhaps critical to see here in relation to the study of nursing autonomy is that in centralizing the administration of nursing affairs, the matron had to necessarily lower the prestige of her sisters.

Within a relatively short period of time the matrons succeeded, taking over "positions of undisputed authority between the medical staff and the lay administration." By 1880 most of the leading voluntary hospitals in London had adopted this tripartite system of administration. The swiftness of this change was largely due to "the pressure [that] came from the top of the social hierarchy: the ladies who sought power in the hospitals moved in the same social circle as the committees that ran them" (Abel-Smith, 1964, p. 68).

The domestic experience which supposedly entitled [a lady] to dispense advice and comfort to the poor was not just the bringing up of children, but the management of servants . . . subordinate and submissive as she was to her husband and her male relatives, [she] nevertheless exercised managerial skills, and the power to hire and fire, within her own female domain. . . .

Many of the women associated with the reform of hospital work in Britain brought this domestic experience to their work . . . they were more accustomed to giving orders than taking them. They accepted that men exercised authority in their own sphere . . . [but the] ladies would brook no

interference in theirs. . . . Ladies wished to enter [hospitals] on privileged terms. They showed every deference, in principle, to the superior knowledge of the medical men; but they refused . . . to allow medical men to interfere in their own supervision of nurses. (Summers, 1988, pp. 3-4)

In retrospect the Nightingale School at St. Thomas may have been more effective in its production of matrons than of nurses.

Nightingale did not allow the "trained" matrons whom she engineered into the hospitals to delay in undertaking reforms. She showered them with advice both solicited and unsolicited. She coaxed them and bullied them until many of them attained the heights of uncompromising ruthlessness of which she herself was capable. The changes involved conflicts with the old nurses, the doctors, and the lay administration. For the introduction of trained matrons and probationer nurses meant a major change in hospital administration. (Abel-Smith, 1960, pp. 24-25)

Nightingale innovations were given prominence over early reforms because she was able to change "not only the conduct of nursing but also . . . the relationship between nurses and other hospital workers." Moreover, in carrying out these early principles, built on a system that selectively recruited women for training, Nightingale "supplanted the established definitions of nursing" and laid the foundation for a separate public identity (Williams, 1980, p. 50).

Once the advantages of nursing reform were widely recognized, the opposition it first encountered began to

diminish. Around 1867 administrators increasingly sought trained nurses to staff their hospitals, workhouse infirmaries, and district nursing associations, leading to a problem of a short supply (Bullough & Bullough, 1978, p. 98).

As we shall explore in succeeding chapters, there were many hidden problems in these arrangements that would inadvertently subvert the professional ambition of nurses who would follow. For although Nightingale was successful in institutionalizing particular changes for nursing practice and its system of education there were looming issues threatening the integrity of the whole experiment Nightingale set in motion.

Of particular importance was how the practice of nursing and its relationship to medicine would be defined and how it would evolve, particularly as each occupation competed for practical experience in a clinical setting that was increasingly more technical and complex. The tripartite system of administration embodied a hierarchy of power arrangements imposing a harsh discipline on the rank and file nurses. But insuring their subordination only stifled the intellectual growth Nightingale felt was essential to the developing profession. The lack of standardization

among the schools that followed Nightingale and the growing exploitation of students by the hospitals that purported to train them would become major concerns for future generations. All of these questions were necessarily subsumed under the aegis of Victorian expectations about gender and class. Lastly, even at St. Thomas, Nightingale would bitterly discover that without her ability to physically superintend her program she was deceptively undermined in her educational prescriptions by the school's matron, Mrs. Wardroper and the medical lecturer, Mr. Whitfield.

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CHAPTER IV

Case Study: Nightingale in the Crimean War

The following case study can illustrate circumstances that mitigated decisions Nightingale made in establishing the relationship between nurses and physicians during the Crimean War. These decisions would be major determinants of a philosophical basis for a shared ethos upon which nursing reform in England and the United States was fashioned.

The Crimean War began in March 1854 when Great Britain and France came to the defense of their ally, Turkey, then under Russian attack. The British army, ill prepared for the fierce fighting that ensued, suffered large numbers of casualties that flowed into makeshift hospitals in Scutari, Turkey.

Reports of callous "treatment" of military patients reached the people at home through The Times of London. On October 12, war correspondent William Russell described the acute lack of basic supplies, surgeons, dressers and nurses in the hospitals. On October 14, a pivotal letter was published in The Times that asked, "Why have we no Sisters of Charity [as do the French soldiers]?" The letter noted that surely there are "able-bodied and tender-hearted English women" who would

fulfill this function if "placed under the proper protection" (quoted in Schyler, 1975, p. 5).

The resulting public outcry prompted the government to act. Following investigations and heated debates in Parliament, Sidney Herbert, the Secretary of War, requested Florence Nightingale to recruit and supervise a party of nurses for service in Scutari (Berges & Berges, 1986, p. 812). On October 18, Nightingale was unanimously confirmed by the British Cabinet as the Superintendent of the Female Nursing Establishment of the English Hospitals in Turkey. Her broad authority governed "Everything relating to the distribution of the nurses, the hours of their attendance [and] their allotment to particular duties . . . subject to the sanction and approval of the chief medical officer [emphasis added]." However, the selection of the nurses was solely Nightingale's responsibility (Woodham-Smith, 1951, p. 90).

Before Nightingale left England, she was repeatedly reminded "how much depended on her success." There was great concern among other supporters that she not only live up to the expectation of improving the conditions of the sick and wounded at Scutari, but that she not fail in "the experiment of using women nurses in the

Army." Facing threatening opposition from physicians and military men before she departed, Nightingale was keenly aware that if she did not succeed it would reflect on her old friend Sidney Herbert's prestige and would give cause to the anti-feminists in the government "for saying they had been right when they objected to her going" (Goldsmith, 1937, pp. 143-144). Nonetheless, Herbert took the chance that Nightingale could "pacify the public," in spite of the resistance she would encounter (Vicinus & Nergaard, 1990, p. 81).

First hand accounts describe Nightingale and her nurses' entry into the "living hell" of the Barracks Hospital in Scutari. Military patients were crowded by the thousands in filthy beds or on the floor, often naked and lying in their own excreta covered with vermin and suffering from bedsores. Beds were placed in a row extending nearly four miles with a space of 18 inches apart. High mortality rates resulted from preventable hemorrhage following amputations, malnutrition and rampant communicable diseases brought about by the squalid and inhumane environment (Taylor, Vol. I, 1856, pp.70-72; Goldsmith, 1937, pp. 145-146; Schyler, 1992, p. 5).

While these deplorable conditions existed, a

military medical officer flatly declared to Nightingale that they were in want for nothing. (Nutting & Dock, Vol. II, 1907 & 1935, p. 122). Nightingale commenced her work in an atmosphere of unrestrained hate emanating from Sir John Hall, Chief of the Medical Staff, and Mr. David Fitzgerald, the Deputy Purveyor in Chief, on whom she was dependent for her medical and other supplies (Goldsmith, 1937, p. 160).

Nightingale's first offers of help were refused; rather than rebel or assert her discretionary powers, Nightingale's strategy involved gaining the confidence of the medical officers, "her designated superiors." Whatever her personal opinions, "Nightingale believed in . . . obedience to those in authority" (Vicus & Nergaard, 1990, p. 83). Consequently Nightingale and her nurses kept busy preparing supplies, setting up a kitchen for special diets and organizing a laundry. On November 9th, the hospital became inundated with casualties and acutely ill soldiers so that, at last, the medical officers turned to her for assistance.

Although Nightingale was given permission to enter the ward with her nurses, obstacles were present to prevent the total administration of basic nursing care. These obstacles will be explored to arrived at an

understanding of how Nightingale negotiated a role for female military nurses as forerunners of the modern nursing reform that will begin in 1860.

Following the terms of her limited authority, a document under Sidney Herbert's Instructions dated 1854 in the London Public Record's office reveals:

. . . the number of nurses admitted into each division of a hospital depended upon the medical officer of that division who sometimes accepted them, sometimes refused them, sometimes accepted them after they had been refused, while the duties they were permitted to perform varied according to the will of each individual medical officer. (quoted in Palmer, 1983a, p. 230; see also Nutting & Dock, Vol. II, 1907 & 1935, p. 157)

In a private letter written to Sidney Herbert on November 15, 1854 describing the conditions she found, Nightingale describes the lack of hygienic facilities for patients: no soap, towels or basins in the wards. She reports that Dr. MacGrigor permitted only 30 patients to be bathed per night "but this does not do more than include a washing once in eighty days for 2,300 men." One sponge is used to clean all wounds resulting in "Fever, Cholera, Gangrene, Lice, Bugs, Fleas and may be [sic] Erysipelas." Nightingale reminded Herbert that "all [this] is written in obedience to your private instructions." She admonished Herbert not to let her appear as a government "spy" which "would destroy all my

usefulness . . ." (Vicinus & Nergaard, 1990, pp. 88-89). Ironically, it was precisely this private channel to a high government official that both gave Nightingale a significant power base, yet it was a constant source of enmity between her and many of the military officers (Woodham-Smith, 1951, p. 146; Smith, F. B., 1982, p. 36).

Incomprehensible by today's standards, the military purveyor at Scutari refused to give Nightingale shirts for the wounded who lay naked in the bitter cold hospital (Woodham-Smith, 1951, pp. 101-102). However, a brief examination of the structure of military authority with its agenda, hidden and overt, to minimize costs gives insight to what would now be considered an aberration.

The British Army's health depended on the collective responsibility of the Commissariat, the Purveyor's Department and the Medical Department:

Commissariat-	Controlled the procurement and dispensation of supplies and transportation.
Purveyors-	Worked through the Commissariat to supply the hospital with equipment and invalid food.

At the "bottom of the pyramid of authority" was the Purveyor who was dependent on the Chief Medical Officer for his promotion; "he had been ordered to govern by

thrift and no emergency would alter his position" (Vicinus & Nergaard, 1990, pp. 86-87). To compound the bereft system of procuring needed supplies and food, other conditions mitigated against the probability of obtaining what was needed. For instance, physicians were required to order what they wanted on requisitions from the Purveyor, but they rarely followed them up to see if their orders were filled.

All requisitions, including those for diets, had to be signed by two medical officers, one of whom had to be a "senior official who was inundated with paperwork" (p. 87). As a result, the chances of not meeting this prerequisite were high. Moreover, although the Purveyor and the Commissariat had executive powers, they could experience serious consequences for dispensing any "unwarranted" articles.

Supplying hospitalized soldiers with eating utensils and shirts when needed was forbidden because these articles fell into the category of "unwarranted." Presumably the reason was that shirts were part of the military pack given to the soldiers with their uniforms; however, for reasons unclear the soldier's pack did not accompany him to the hospital (p. 87).

Junior medical officers were very cognizant of the

problems, but no one would voice criticism for fear of jeopardizing his military career (pp. 82-83). In a letter written to Sidney Herbert on January 8, 1855, Nightingale's outrage is apparent. "You will never know the whole truth . . . except from one independent of promotion. . . . I have no compassion for the men who would rather see hundreds of lives lost than wave one scruple of the official conscience" (quoted in Cope, 1958, p. 44). The system of army administration held the officers to a narrow interpretation of their duties. All action had to move through established channels, "even the principal medical officer had little executive power outside his strictly medical duties" (p. 50).

The prevailing tone of the military hospitals at that time is poignantly described by a lady volunteer who worked under Nightingale: "Amid all the confusion and distress at Scutari hospital [sic], military discipline was never lost sight of, and an infringement of its smallest observances was worse than letting twenty men die of neglect" (Taylor, 1856, Vol. 1, pp. 82-83). To illustrate this point, it was reported that Dr. Cummings, the Inspector General, threatened to arrest an assistant surgeon for allowing a patient too many extras on his diet (p. 82).

A private letter to a friend from Sir Anthony

Cunningham reveals:

When a soldier goes into the hospital the Government stops 10d. a day out his pay to pay for his physic [medical care] and food; the difference between the expense and the 10d. goes to the Government. So that doctors are encouraged to keep the men on a low diet, in order to gain credit for economizing, i.e., expending men instead of pennies (quoted in Goldsmith, 1937, p. 147).

According to a letter printed in The Times of London on October 24, 1854, the public was informed that Nightingale and her nurses were to work "in strict subordination to the medical officers." However, after examining all of the events that have transpired it is clear that this directive referred only to medical orders for the direct management of patient care. In other tangential circumstances Nightingale's powers to circumvent regulations in order to implement her reforms were fully backed by the government (Nutting & Dock, Vol. II, 1907 & 1935, p. 126).

Nightingale used her powers to pursue options that would have resulted in a court martial for other medical officers (Goldsmith, 1935, pp. 149-150). It is recorded that she commanded the orderlies to break the door of the storerooms and distribute supplies for want of which the patients were suffering (Nutting & Dock, Vol. II, 1907 & 1935, p. 166). Another time, when infectious

diarrhea was rampant in the hospital causing the pipes to clog, "Nightingale forced the orderlies to open wooden tubs which were substituted for privies" (Vicinus & Nergaard, 1990, p. 91). At first Dr. Menzies, the Chief Medical Officer at Scutari, initially refused to allow the clogged lavatories to be cleaned out " because there was no military order for such work" (Schyler, 1975, p. 66; Woodham-Smith, 1951, p. 115). Nonetheless, Nightingale continued to be a "strong believer in regulations; she broke the rules [only] when she saw no other way" (Vicinus & Nergaard, 1990, p. 91).

Within ten days after her arrival at Scutari, Nightingale had a kitchen set up with a capacity to serve special diets for nearly one thousand men. This project was followed by the establishment of a "laundry in a private house, which she rented for the purpose." The laundry provided the first clean linens for the hospital.

To support projects such as these Nightingale had at her disposal 7,000 pounds raised by The Times as well as her own annual allowance of 500 pounds which she donated to provide necessities for the men. Ten thousand shirts were distributed during her first three months at the war front (Nutting & Dock, Vol. II, 1907 & 1935, pp. 125-126; Vicinus & Nergaard, 1990, p. 82).

Nightingale's ability to work around established protocols by using her privileges as the Lady-in-Chief (her title) as well as her access to extensive funds further aggravated her relationship with some of the ranking military authorities. This became particularly apparent when she attempted to pay local workers in order to expedite the rebuilding a "condemned part of the Barrack Hospital to accommodate another influx of soldiers" (Vicinus & Nergaard, 1990, p. 91). It should be noted here that because Dr. Menzies would not publicly admit the deficiencies that existed at Scutari, he had refused to accept the money "which The Times and the English public collected for the care of the British wounded" (Woodham-Smith, 1951, p. 105).

At the time of her assignment in London, probably no one anticipated that Nightingale would quickly determine that the "utter chaos of the Scutari Hospitals could not be resolved by female nursing alone. . . . [Ultimately] Nightingale drew the attention of the government to problems that went far beyond her specific purview; in the process she exposed the administrative incompetence and disorganization of the British military . . . she faced—and created—enemies" (Vicinus & Nergaard, 1990, p. 81).

Nightingale was not without powerful allies, yet seemingly insurmountable problems continually surfaced. For instance, Lord Ragland, the Commander-in-Chief of the Army referred to Nightingale as an "auxiliary general." At the same time, Nightingale faced deep resentment by the "bureaucratic underlings" (Nutting & Dock, Vol. II, 1907 & 1935, pp. 164-165).

Many ward surgeons regarded Nightingale as a powerful support; these "overworked and harassed surgeons used her name as a menace" when the bureaucratic army regulations made it impossible for them to obtain what they needed in the performance of their duties. Other accounts tell how junior medical officers and orderlies were informed that "the less they had to do with Miss Nightingale and her people the better it would be for them" (p. 165).

In another case, Dr. John Hall, Chief of the Medical Staff of the British Expeditionary Army, made it clear that "no Nightingale power, no Sidney Herbert could save those [who offended him]." Consequently in spring of 1855, when he appointed his friend Dr. Lawson as Senior Medical Officer of the Barrack Hospital, "terror" swept over the Scutari medical staff. The doctors began to succumb to Lawson's influence, and

avoid Nightingale (Woodham-Smith, 1951, pp. 145-146).

As a result of sanitary improvements* and the provisions of nursing care, Nightingale is credited with reducing the mortality rate to two percent (Dolan, 1978, p. 162). In February 1855, the rate was 427/100 whereas in June 1855 it fell to 22/1000**. Although she won the wide respect of the surgeons, the soldiers and the public, her hardships continued.

Nightingale would pressure the physicians to attend to serious cases. A letter from a soldier tells of his wounded sergeant who had to wait "seven days without seeing a Doctor" but he referred to Nightingale and her "attendant angels" who "were everywhere among the sick doing more good than any Doctors" (quoted in Schyler, 1975, p. 70). Nightingale's sister Parthe wrote in August 1856 that Nightingale endured insults from assistant surgeons "because she would not allow a man

*Nightingale was successful in persuading the government to convene a Sanitary Commission. When the commission arrived in March 1855, it confirmed Nightingale's reports about the abominable conditions in the hospitals at Scutari. A thorough cleaning of the water supply, sewage system and hospital environment by the commission was the major factor in the drop in mortality rate (See Woodham-Smith, 1951, pp. 138-140).

**To have some idea of the enormity of the patient population at Scutari, some figures are provided. On January 2, 1855, 1,200 men arrived at the hospitals due to an outbreak of cholera. There were 12,000 men in the hospitals compared to only 11,000 in the army camp at Sebastopol (Schyler, 1975, p. 68-69).

with a bullet in his eye to be left with his wound undressed, untouched all night. . . ." (pp. 72-73). The same letter exposed that a purveyor in the Crimea (where Nightingale later traveled to inspect the military hospital on the peninsula of Russia) refused her rations for her nurses for ten days (pp. 72-73). The reason was cited as an attempt to prevent her unwanted intervention as had occurred at Scutari; however, these actions failed to deter Nightingale, who anticipated hostility and perspicaciously brought her own supplies (Goldie, 1987, p. 241).

The facts above paint a picture of a woman with an indomitable spirit who never wavered in fulfilling her responsibilities to the sick and wounded as she perceived them. Furthermore, there is no solid evidence that Nightingale was ever intimidated by a person's rank, professional status, or by the fact that she was female. Instead, Nightingale used her wit, intelligence, authority, and every conceivable support system to meet her goal amid a series of unending calamities.

It is generally accepted that Nightingale drew from her military experiences in constructing the parameters of modern nursing as well as the social relationship

that governs the physician and nurse. As mentioned earlier, Freidson and others look at the decisions she made at Scutari as a major factor in defining nurses' work as subordinate to physicians, thus relinquishing an opportunity to establish a clearly delineated autonomous role for nursing.

Freidson (1970) posits that the act of feeding the military patient should have been uncomplicated enough for Nightingale to initiate without a doctor's order.

Through her decisions:

Nightingale thus required that what a nurse did for the patient was a function of what the doctor felt was required for the care of the patient. Even such unskilled tasks as feeding a patient were . . . defined as part of the medical regimen. All nursing work flowed from the doctor's orders, and thus nursing became a formal part of the doctor's work, a technical trade. . . . Nursing thus defined as a subordinate part of the technical division of labor surrounding medicine. (p. 61)

To test the validity of this premise it is important to examine the whole arrangement for feeding patients in military hospitals to determine how Nightingale interacted with the organization in existence at that time. Undoubtedly, Nightingale's wealth of knowledge about the different systems of hospital care made her acutely aware that the environment of health care is rife with opportunities for conflict yet she carefully avoided unbridled contention that didn't honor basic

traditions and established lines of authority believing it would be counterproductive.

Feeding the Military Patients

During the Crimean War, there was a set of very regimented regulations that dictated procedures to be followed in requesting and securing particular diets for British military patients. These procedures, cumbersome as they were, probably did not pose any major problems in ordinary circumstances. But given the extraordinary situations at Scutari with the excessively large influx of casualties and men suffering from infectious diseases,* the system was at best incompetent; at its worst it became a life-threatening risk for many patients.

So jealously did the medical military command guard the system of dispensing diets, a junior surgeon could be court marshaled for deviating from the normal regulations to allow a patient extra food (Taylor, 1856, Vol. 1, p. 82). As mentioned earlier, the overriding concern was economy at the expense of the health of the men (Goldsmith, 1937, p. 147).

A lady volunteer who worked with Nightingale

*Out of the 97,800 British troops sent to the East, 2,700 were killed, 1,800 died from wounds, while 17,600 died from disease (Baly, 1986, p. 6).

described the standard procedures as they existed in military regulations. As she tells it, while on daily rounds the assistant surgeon dictated the patients' diets to sergeants or corporals who were appointed as ward masters. The ward masters in turn transcribed the diets in a special book called a "diet roll" with a separate page for each day. The diet as transcribed would not be given to the patient until the following day. According to the lady volunteer, the procedure thus far was similar to those practiced in English civilian hospitals at that time, the exception being in "London hospitals [where] a diet card for each patient hangs at the head of his bed" and the diet is prescribed or altered almost always by the "house-surgeon" (Taylor, 1856, vol. 1, pp. 73-75).

For the situation at Scutari, the bureaucratic regulations became problematic when we move to the next level in the overall military procedures. Special diets for the seriously ill patients had to be placed on separate pieces of paper. They constituted urgent requests and could be prescribed at any time. Furthermore, diet requests required two sets of signatures: that of the assistant surgeon in charge of the patients and then a countersignature by the staff

surgeon of the division.

Irregularities in the system abounded; the diet orders were often transcribed incorrectly thereby causing patients to forgo or delay their food. Moreover, the purveying department could decline to honor any request with impunity, while the food that was supplied frequently was either inedible* or delivered very late. Not uncommonly, pressing duties kept assistant surgeons from filling out all the necessary requisitions for any urgent changes in diet and, even if they did, there was even a larger probability that the staff surgeon could not be located to sign the order (pp. 73-77).

Under the category of urgent and special diets went ordinary liquid nourishments such as beef tea and lemonade. These fluids were extremely important in the treatment of dehydration arising from conditions such as massive diarrhea of cholera and the fevers that were prevalent. We must remember that intravenous fluids so commonplace today were not available in the mid-nineteenth century.

Before she and her nurses ever set foot in the

*The food not issued from Nightingale's kitchen was reported to be of "such a bad quality . . . and so wretchedly cooked," that the men often would refuse to eat. (Taylor, 1856, Vol. 1, pp. 81-82)

hospitals of Scutari, Nightingale anticipated that the nutritional and fluid management of the patients was in disarray. Her immediate priority was to set up a kitchen intended to dispense special diets (called spoon-diets)* for the more acutely ill patients.

"Nightingale and her nurses introduced . . . beef broth, custard and other [foods] appropriate for convalescents" (Vicinus & Nergaard, 1990, p. 91); however, adhering to the protocol in existence, she stipulated the proviso that they "could only be obtained by a requisition signed and countersigned" (Taylor, 1856, Vol. 1, pp. 77-78). Nightingale would write after the war in Notes on the British Army that the nurses would never dispense any extra diets or other medical supplies "except by the order of the superintendent, which order was consequent upon the requisition of a medical officer, and that only, with few exceptions" (Nutting & Dock, Vol. II, 1907 & 1935, p. 158).

*The military patients were placed on one of four diets listed:

Full diet: consisted of one pound each of meat, potatoes, and bread, two pints of tea and a half pint of porter. (Alcohol was considered to have important therapeutic value.)

Half-diet: was exactly half of a full diet.

Low-diet: was half of a half diet.

Spoon-diet: consisted of one pound of bread and two pints of tea, but the surgeon could allow the men on a spoon-diet two or three "extras" such as chicken, milk, lemon for lemonade, egg, etc. This diet was reserved for the sickest patients. (Taylor, 1856, Vol. 1, p. 74)

Although the extra diet kitchen was highly successful in bringing much needed nourishment to patients, Nightingale's insistence upon following established protocols was a source of distress for the ladies and nurses she directed. Busy surgeons would give "verbal permission" for extra feedings and fluids but frequently would not write out the required requisitions so that the necessary supplies could be obtained (Taylor, 1856, Vol. 1, pp. 78-79).

Lady volunteers and nurses would actively pursue the surgeons for the requisitions, most especially for ingredients to make beef tea and lemonade for patients in acute stages of illness. In order to get the drinks prepared for the suffering men, it was necessary to boil the local water directly in the hospital wards since the potable water was highly contaminated. For reasons not recorded, Dr. Cummings, the Inspector General, ordered that cooking (boiling water) in the wards cease. Without the availability of the clean water, dehydrated patients were deprived of their sole source of fluids. It is recorded that nurses had to ignore their insistent pleas for water; meanwhile, the assistant surgeons dolefully declared that they could not help for "their duty was to obey [emphasis added]" (pp. 79-82).

There is no evidence that Nightingale ever intervened to circumvent Dr. Cummings' order. More illuminating is her reference to the incident in a letter to Sidney Herbert dated February 5, 1855 in which she adamantly states her intention to maintain cordial rapport with Dr. Cummings in order to secure his cooperation in larger matters. Imputing more importance to her own plan she writes:

[These projects are] not so amusing as pottering and messing about with little cookeries of individual Beef Teas [*sic*] for the poor sufferers personally. And my ladies do not like it. . . . I acknowledge it. At the same time, it is obvious that what I have done could not have been done, had I not worked with the Medl. Authorities [*sic*] and not in rivalry of them. (quoted in Goldie, 1987, p. 86)

Significantly, her report in Notes on the British Army reveals she believed it was important to protect the authority of medical officers.

"To take anything from the authority of the medical officers, or to reduce their responsibility, would never be contemplated by any one convinced of the paramount importance of the promptitude of action resulting from unity of government" (Nutting & Dock, Vol. II, 1907 & 1935, p. 160).

Rather than directly challenging all the injustices within the system of the military hospitals while she

was serving, Nightingale waited until her return from the Crimea. Giving testimony before a royal commission, she recommended executive responsibility be separated so that "A principal medical officer, and his staff, [be] relieved of all administrative duties. . . ." She wanted physicians to attend solely to professional matters (pp. 144-145).

Nightingale was also deeply concerned that the nurses not lose any approbation they acquired by accomplishing reform in sanitation and basic nursing care without causing major disruptions in the structure of military authority. In September 1855, after recovering from Crimean fever from which she nearly died, Nightingale discovered that Mother Brigdeman, a Roman Catholic nun, "had assumed command of the General Hospital at Balaclava in the Crimea without orders." Previously Mother Bridgeman and her Sisters were involved in a scandal "when they had issued lavish amounts of wine, food and clothing without orders at another hospital at Koulali, in Turkey." Nightingale was particularly worried that the Sisters "would ruin the order of the General Hospital" (Schyler, 1975, pp. 74-75; see also Woodham-Smith, 1951, pp. 158-161).

Nightingale's way to achieve change was not to

engage in or encourage defiance. She firmly believed that authority "must not be flouted, but converted. Regulations were to be observed because they "were essential to organization. If regulations were bad, they must certainly be changed, but until they were changed they must be observed" (Woodham-Smith, 1951, p. 309). Writing to a rebellious nurse in 1869, Nightingale was unequivocal in stating that she countenanced working within the prevailing system to accomplish reform.

Do you think . . . I should have succeeded in doing anything if I kicked and resisted and resented? . . . I have been shut out of hospitals . . . obliged to stand outside the door in the snow, have been refused rations for as much as 10 days at a time for the nurses I brought by superior command. And I have been as good friends the day after with the officials who did these things-have resolutely ignored these things FOR THE SAKE OF THE WORK. (quoted in Woodham-Smith, 1951, pp. 309-310)

Other examples of Nightingale's compliance exhibit her stance. On one occasion she requested an orderly to obtain a hot-water bottle for a critically ill man with "stone-cold feet." When she was refused because there were no directions from a medical doctor she "accepted the correction, found a doctor and obtained a requisition in proper form" (p. 108). Another time she was severely chastised by a Sellonite nun, Sister Elizabeth Wheeler, because she refused to dispense any

nourishment from her supplies not prescribe by the physician. Labeled by some of her nurses as "callous" and indifferent to the patient's needs (pp. 119-120), she remained steadfast in her plan to gain full acceptance for her nurses.

Nightingale's decision to require physicians orders before she would permit her nurses to feed patients in the Crimea cannot be regarded, as Freidson asserts, as a retreat from an opportunity to assume nursing autonomy.

Clearly the sociocultural setting under which she assumed her military duties should help us to dispel notions that she had any other choice than to abide by the traditions and regulations that governed military protocol, as well as the relations between physician and nurse. It must not be forgotten, either, that the whole idea of using female nurses in the English army hospitals was an experiment that many wanted to fail.

But, certainly Nightingale was not to sit by passively. She set a powerful example for all nurses in being prepared to choose her battles and ultimately to achieve her goals in furthering health care incentives in which nurses were to play key roles. The men who received the nourishment from her kitchen were ultimately better served than those who didn't. Had

Nightingale used her nurses to assert themselves in the name of moral superiority, it is doubtful that the British public would have been ready to accept such a bold challenge to its notions of proper behavior for ladies; in the last analysis, neither would the medical officers.

Ostensibly Nightingale wanted change, her influence was considered transforming in some respects, but the legacy she left nurses from the Crimean experience was not one of desiring or attempting to usurp the physician's authority in matters of medical care. In the context of her era, one would be hard pressed to discern any other feasible alternative. Concomitantly, underlying the entire argument is the fact that Nightingale, as a member of the privileged class of Britain, was imbued with the notion that societal order had to be maintained. Preserving the time-honored authority of superordinates, while working to ensure the integrity of their functions, was in her mind, the way to move society to perfection.

In hindsight Nightingale's decision in the Crimea may have had immeasurable success in hastening the acceptance of nursing reform. In 1912, the prominent

American leader, who graduated from Bellevue Hospital, asserted in her book, Nursing Ethics,

. . . after physicians had once begun to realize that with the trained nursing it was possible to have their orders intelligently carried out, that chaos and dirt gave way to order and cleanliness, and the percentage of deaths decreased and of recoveries increased; lastly, when once and for all they had learned to recognize the fact that their own particular province was in no danger of invasion [emphasis added], they finally accorded the trained nurse . . . recognition. (Robb, p. 28)

Nightingale seemed to understand from the very beginning of her involvement in nursing that anything she hoped to achieve could never happen at the expense of curtailing the parameters of medical practice.

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Chapter V

Theoretical Underpinnings of Nightingale's Plan

Nightingale's spiritual beliefs provided the central philosophical basis for all her aspirations for reform. The perpetuation of her educational system and her writings insured that her ideas would penetrate the motivation of forward thinking reformers in health care. Perhaps nowhere are they more salient than in her conceptualization of nursing and medical practice as both complimentary and disparate as well as in her desire to ameliorate the unhealthful condition of hospitals.

Nightingale's spirituality permeated everything in her life; her religious persuasion guided all her major decisions and provided the force and motivation to sustain her extraordinary life as a reformer and activist. Widerquist (1992) found that at the core of Nightingale's spirituality was a belief in perfection. "Nightingale considered God to be Absolute, the Perfect, the Spirit of Truth. To Nightingale, one pursued communion with perfection [God] with a goal of remodeling the world, or as Florence Nightingale frequently stated 'Mankind creating mankind'" (p. 49).

The two dominant spiritual influences in Nightingale's life were the Unitarianism passed on by her father and the prevailing religious character of Victorian society. And although she would remain formally an Anglican (a member of the Church of England) her eclectic beliefs prevented her from fully embracing any one institution (Winderquist, 1992, p. 51). Nightingale had a highly developed personal sense of religion and maintained a tolerant mind for any faith that issued good works. Her scorn was reserved "for any that did not. . . . It is for this reason that she seemed to be all things to all people in religious matters" (Cook, 1913, Vol. I., p. 54).

Unitarians, like other dissenting religious sects of this period, "paved the way for social reform and social progress" at a time when England was undergoing a transformation from an agrarian, religious society to one that was urban, industrial and secular. The spiritual fervor that arose permeated the entire Anglican Church (Winderquist, 1992, p. 52).

Men, and some women—in spite of Victorian repression—sought to share their spiritual renewal in concrete acts of charity towards their fellows, expecting nothing less than moral regeneration to follow. Nightingale was one of these who felt such spiritual fervor and the resulting zeal for renewing society. (p. 50)

To Unitarians, salvation had a technical meaning involving both health and wholeness. "Belief in 'progress onward and upwards,' especially through education became for Unitarians, and Nightingale, a belief in a perfectibility of mankind within history" (p. 50).

Nightingale is frequently described as a mystic who spent her life seeking a deep personal relationship with God. She saw Him, not as a savior who responds to intercessory prayer, but rather "as a noninterventionist being who, having put laws in place, let consequences occur according to them" (p. 51).

Influence of Nightingale's Spiritual

Beliefs on Nursing Practice

Understandably, while Nightingale's spiritual beliefs were embedded in the whole philosophical scheme she created, the pieces of her framework that have survived and created an enduring legacy are, for all intents and purposes, devoid of the religious fervor that inspired them. This is largely explained by the decline in the authority of religion and the rise in the authority of science that occurred at the turn of the century (Baer, 1991). Nonetheless the structure of

modern nursing is, at its roots, unmistakably a product of her design.

To implement the mission of the modern secular nurse Nightingale constructed what is recognized in hindsight as a conceptual model of nursing, an important step in the development of nursing theory. Her belief in the immutable laws of health and nursing lay at the heart of its foundation. Within this framework she described relationships between the concepts of nursing, person, environment and health (Reed & Zarakowski, 1983, p. 11). These four concepts were found in the metaparadigm of all subsequent nursing models that followed (Chinn & Jacobs, 1987; Fawcett, 1984; Reed & Zurakowski, 1983).

Nightingale called upon nurses to "acquire and apply knowledge about God's laws of health and, thus, move mankind closer to perfection" (Reed & Zarakowski, 1983, pp. 11-12; see also Nightingale, 1859/1992, p. 15). She acknowledged that, while the "laws of nursing" were yet unknown, its practitioners had to be "truthseekers" and continue discovering the "great laws of nursing" (Monteiro quoted in Reed & Zurakowski, 1983, p. 20). Using the patient as the focal point, Nightingale challenged nurses to "concern themselves

with disease prevention, health promotion, the physical environment, and psychosocial processes" (Dennis & Prescott, 1985, p. 66).

Nightingale's Notes on Nursing (1859/1992) and later writings present the essence of what she envisioned to be the core of nursing practice: the divide between nursing and medicine. She acknowledged that nurses would operate within a structure granting them the obligation to accept delegated functions of the physician, referred to as "orders;" this aspect of their practice had a long tradition in English hospitals predating Nightingale (Abel-Smith, 1960, p. 9). What Nightingale hoped to do within the parameter of these physician-dependent functions would be to insure, through her emphasis on character and theoretical training, that nurses could be relied on to be ethical and trustworthy.

However, there is a major contribution Nightingale made which set her apart from other contemporary reformers in nursing: she created an independent, discipline specific function for nurses that drew on her understanding of the state of sanitary science. Using this as the theoretical underpinning of her plan, Nightingale developed specific principles which she

called laws, sometimes referred to by others as canons or doctrines, to guide practitioners. These principles directed nurses to promote health and prevent illness primarily (but not exclusively) by altering the environment of persons sick or well.

Nursing proper [nursing of the sick] means, besides giving the medicines and stimulants prescribed, or the surgical appliances, the proper use of fresh air (ventilation), light, warmth, cleanliness, quiet, and the proper choosing and giving of diet, all at the least expense of the vital power of the sick. And so health-at-home nursing [health nursing] means exactly the same proper use of the same natural elements, with as much life-giving power as possible to the healthy. (Nightingale, 1893/1949, p.29)

The details for carrying out each of these elements are expanded on in her Notes on Nursing (1859/1992); the instructions include advice on managing sick patients in terms of their psychosocial needs; i.e.: allaying anxiety, conserving energy, preventing excessive environmental stimuli, observing for signs of mental depression, employing appropriate communication techniques—all included in current day concepts associated with professional nursing (Dennis & Prescott, 1985). Because of her beliefs about the primacy of polluted air and water in determining disease states she placed large emphasis on activities

designed to alter a person's environment (Fitzpatrick & Whall 1983b, p. 324).

Nightingale challenged societal assumptions that every woman by her nature is instinctively led to be "a good nurse." The very word "nursing," she said, had come to represent a shallow description of its function, namely "little more than the administration of medicines and the application of poultices." While she felt bound to use the word: "nursing" because of its historical roots, she would have preferred to use another that embraced the expanded direction she was about to lay out (Nightingale, 1859/1992, p. 6).

In establishing a new order for nursing, Nightingale began by defining nursing in relationship to health and illness (1859/1992), later elaborating on this subject in subsequent writings (1882/1954c, 1882/1954d, 1893/1948). At the same time she was aware of an impending conflict between physicians and nurses associated with a realigning of their respective roles, therefore she gave particular attention to distinguishing the domains for the two occupations.

Bearing in mind Nightingale wanted a clear delineation between medicine and nursing she was cognizant of the fact that if proper deference was not

provided medical men, they had the power to obstruct her work. In effect she needed the political and social power and skills of medical men who came to believe in her causes to promote and enhance projects that were important to her. Illustrating this point, she used Dr. John Southerland to critique her manuscripts while she was preparing Notes on Nursing for publication. It was he, a trusted friend and advisor, who "warned her against using language that might be viewed as inflammatory by the medical community," fearing that if she offended the doctors they would rise against her (Henry, Woods & Nagelkerk, 1990, p. 203; Cope, 1958, pp. 38-39).

There is little doubt Nightingale continued to be influenced in what she said and wrote by the political climate of her time, especially as it related to advancing the status of women in the public arena, and to the prospect of encroaching on the power of the doctors. Nonetheless, she enunciated principles over the last fifty years of her life concerning her central beliefs about what nursing could and should be (Marks & Beatty, 1972, p. 173).

The reparative processes of nature are inherent at "some period" in the course of all disease, Nightingale

wrote, consequently it is incumbent upon caregivers to assure that the healing work of nature not be impeded "by some want of knowledge or attention." Otherwise, she warned, pain and suffering might arise and healing is interrupted.

In watching diseases, both in private houses and in public hospitals, the thing which strikes the experienced observer most forcibly is this, that the symptoms or the sufferings generally considered to be inevitable and incident to disease are very often not symptoms of disease at all, but of something quite different—of the want of fresh air, or of light, or of warmth, or of quiet, or of cleanliness, or of punctuality and care in the administration of diet, of each or all of these. . . .

If a patient is cold, if a patient is feverish, if a patient is faint, if he is sick after taking food, if he has a bed-sore, it is generally the fault not of the disease, but of nursing. (Nightingale, 1859/1992, pp. 5-6.)

After saying this Nightingale was quick to assert that the absence of competent nursing alone could not account for these lapses, but rather that nursing requires environmental arrangements and efficient management to assure its efficacy. "Bad sanitary, bad architectural, and bad administrative arrangements often make it impossible to nurse" (p. 6).

When Nightingale charted the beginning of a theoretical foundation for modern nursing practice she was aware that the knowledge base it commanded was

still in the infancy phase of development: "The very elements of nursing are all but unknown" she noted (p. 6). Yet, she had enough confidence in the principles she outlined to warn its adherents not to let them be devalued in lieu of unproven medical remedies. She referred to the existence of evidence to support the effects of good nursing while particular medical interventions lacked similar backing. ". . . so deep-rooted and universal is the conviction that to give medicine is to be doing something, or rather everything; to give air, warmth, cleanliness, etc., is to do nothing" (p. 6). Undoubtedly her success in lowering the high death rate that prevailed in the English military hospitals in the Crimea was foremost in her mind when she wrote this. There she sought clean dressings, clean bedding, good nutrition, clean drinking water, proper sanitation and adequate ventilation which culminated in favorable statistics (Dietz & Lehozky, 1967, p. 63).

Nightingale refers to the independent function of nursing as "sanitary" nursing and the physician delegated and technical aspects of its work as the "handicraft" of nursing (1859/1992, p. 71). Knowing how to maneuver and set priorities within the meshing

of these functions calls for expertise in clinical judgment.

. . . let no one think that because sanitary nursing is the subject of these notes, therefore what may be called the handicraft of nursing is to be undervalued. A patient may be left to bleed to death in a sanitary place. Another who cannot move himself may die of bedsores, because the nurse does not know how to change and clean him, while he has every requisite of air, light, and quiet. (p. 71)

Conversely Nightingale maintained that "thousands" of patients die who have been deprived of sanitary nursing, in spite of the fact they received faultless technical care following surgery (p. 72). No doubt she was referring to the high infection rate among surgical patients.

According to Nightingale, sanitary nursing (or health nursing) relies on the laws of health and the laws of nursing: which "are in reality the same" (1859/1992, p. 6). All women who had the charge of caring for someone were to practice health nursing, "which required some practical teaching, and the goal of which was prevention of disease" (Reed & Zurakowski, 1983, p. 13). In this respect Nightingale created an inclusive rather than an exclusive model for its adherents. She railed against notions that knowledge

pertaining to health and illness were the exclusive commodity of physicians. In this respect she fell short of accusing her medical colleagues of expropriating this knowledge at the expense of public health. After highlighting the excessive infant mortality rates in England she asked ". . . did Nature always intend for mothers to be accompanied by doctors?" (1859/1992, p. 7).

Nightingale observed that medical emphasis on pathology did little to advance knowledge of health: "Pathology teaches the harm that disease has done. But it teaches nothing more. We know nothing of principles of health, the positive of which pathology is the negative, except from observation and experience" (p. 74). She consistently asserted that no pathology need be present before a person could benefit from nursing care (Reed & Zurakowski, 1983, p. 22). The essence of all nursing, be it health nursing or sick nursing, "is to put the patient in the best condition for nature to act on him" (Nightingale, 1859/1992, p. 75). Within this definition Nightingale subsumed broad ranged goals including "maintenance of health, prevention of infection and injury, recovery from illness, health

teaching, and environmental control" (Reed & Zurakowski, 1983, p. 14).

Notes on Nursing was intended to promote health/sanitary nursing or what professional nurses today refer to as wellness nursing, the emphasis being on the promotion of optimal health of individuals and groups and the prevention of illness. The publication was subsequently used as a textbook in the Nightingale school, thus integrating its concepts in the care of sick patients (nursing proper). Here nurses were to acquire "specialized knowledge in addition to the laws of health for their wider scope of practice" (Reed & Zurakowski, 1983, p. 13). Eventually, Notes on Nursing would serve for decades as the standard text on nursing (Kalisch & Kalisch, 1986, p. 51).

In more precise terms, Nightingale created a broad based discipline in which designated laws of nursing provided not only a theoretical foundation for its practitioners but also gave them moral direction. The theoretical foundation which incorporated principles of sanitary science allowed Nightingale to claim that nursing was both a science and an art (Nightingale, 1893/1949, p. 24). The activities of the nurse, directed toward implementing God's laws of health,

served as the "art form through which spiritual development might occur" (Reed & Zurakowski, 1983, pp. 11-12). Through its emphasis on health promotion and illness prevention Nightingale hoped to preserve the new order of nursing as a discipline with undisputed goals and functions, some of which would be independent of and distinguishable from medicine.

Influence of Nightingale's Spiritual Beliefs
on Reform in Health Care Delivery

Nightingale's spirituality is evident in the principal ideas she generated in reforming health care delivery systems in England. The hospital as a microcosm of society occupied a large part of her effort to rationalize health care in concert with her beliefs. She collected an enormous amount of data in the form of statistics, reports and anecdotal information to demonstrate correlations between human behavior and the outcomes resulting from decisions to comply or contradict God's laws governing health (Woodham-Smith, 1951, p. 43; Cope 1958, pp. 18-19). Rosenberg suggests she implied that "health lay not in prayer, not in hoping for miracles, but in obeying the dictates implicit in those unyielding laws" (1987, p. 131).

Her credibility as an expert on hospitals was built on a matchless knowledge of their conditions. In 1857, while she was only thirty seven years old, she told members of the British Sanitary Commission on which she served that she had

. . . visited all the hospitals in London, Dublin, Edinburgh, many county hospitals, some of the naval and military hospitals in England; all the hospitals in Paris and studied with the [Sisters of Charity]; the Institute of Protestant Deaconess's at Kaiserwerth on the Rhine where I was twice in training as a nurse; the hospitals in Berlin and many others in Germany, at Lyons, Rome, Alexandria, Constantinople, Brussels; also the war hospitals of the French and Sardinians. (quoted in Cope, 1958, pp. 18-19)

Nightingale was an astute observer who took into account not only the system of nursing and medical care as it was constituted in these institutions but also the physical layout and construction of the hospitals along with their hygienic practices and administration (Cope, 1958, pp. 18-19; Henry, Woods & Nagelkerk, 1990, p. 204).

Nightingale applied a nineteenth century understanding about the role of sanitation in disease prevention to construct her laws of health: principles that were widely accepted but largely ignored or ineptly applied even in the most prestigious institutions of her era (Rosenberg 1987, pp. 128-131).

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Her prescriptions, prominently laid out in Notes on Hospitals (1858/1863) and Notes on Nursing (1859/1892) brought her universal recognition as an expert in hospital and nursing reform. Within a short period of time, she would become the leading consultant when plans were being drawn for hospitals in England, Canada, Australia and the United States (Cope, 1958, p. 19). The foregoing will help to illustrate that her contributions were not directed to developing the general theory of sanitation, as many believe, but rather to its implementation (Vicinus & Nergaard, 1990, p. 5).

Nightingale was urged on in propagating her sanitary reforms by the critical situation of hospitals. During the 1850s and 1860s hospitals in England, France and America were showing alarmingly increasing rates of "hospitalism" identified by fevers and infections associated with hospital admissions. "[Medical] care in even the best known urban institutions [became] more perilous than treatment in a cotter's simple hut. . . ." Similarly, a poor woman had a better chance of survival by issuing a midwife in her own home rather than be exposed to the deadly childbirth fever prevalent in hospitals of every grade.

In Philadelphia's Pennsylvania hospital death rates following amputations rose to almost 267 in a thousand; in other instances in the medical community post-operative deaths following major procedures ran as high as twenty-five percent (Rosenberg, 1987, pp. 122-123).

Antecedent arguments had been in existence for close to a century about the sources and remedies of hospital acquired infection; by the 1840s, almost twenty years before Nightingale first published Notes on Nursing administrators had developed a set of procedures for combating their occurrence in the institutions serving the sick and infirm.

Normal practices following an outbreak of erysipelas or childbed fever involved removal of patients to isolated wards or rooms. The contaminated ward was then fumigated, scoured, and whitewashed, and bedding burnt or otherwise discarded. The room was then to be thoroughly "aired" so as to remove or substantially dilute any disease inducing materials that might remain in the atmosphere. (p. 126)

In order to prevent epidemics of infection there were general policies

. . . to avoid crowding, another to enforce cleanliness, a third to promote ventilation. Servants were. . . to . . . change linen and empty bedpans frequently, and never allow food to remain on the wards, for any decaying organic matter . . . could contribute to the aggregate contamination of an institution's atmosphere. (pp. 126-127)

Every detail concerning the minimization of dirt

in the interior structures and the promotion of clean air was considered. Smooth, hard floors, metal instead of wood bedframes, properly placed sewers and drains, routine removal of garbage were considered essential sanitary precautions. Hospital architecture assumed particular importance at this time. It was believed that hospitals should "be located in a healthful site and then designed to maximize the circulation of fresh air". Accordingly, the correct placement of windows, doors and fireplaces was critical to this plan, as was the necessity of minimizing air circulation among potential sources of infection. Thus the ideal building isolated "every ward from every other ward" (pp. 126-127).

But descriptions of the civil and military hospitals of this era provide evidence that these safeguards were generally unheeded. Nightingale captured the imaginations of the public when she dramatically drew attention to the issue of needless hospital deaths by using statistical analyses and examples from her own experiences in observing the care of patients.

For instance, Nightingale's practical views about the patient and his environment were drawn primarily

from her Crimean experiences (Welch, 1986, p. 8). In 1855, while at Scutari she created a system of medical statistics to demonstrate that the majority of deaths were due to preventable infectious diseases acquired in the military hospitals. In order to "sway public opinion and pressure governmental officials" to institute policies for hospital reform she arranged at her expense to have a pamphlet printed in 1858; two thousand copies were circulated one of which she later sent to Queen Victoria.

Another publication: Introductory Notes on Lying-In Institutions, resulted from a three year study of postpartum women which she conducted. Nightingale corresponded with "physicians, nurse administrators, and sanitary engineers throughout the world" gathering information in three volumes. Her data analysis confirmed "the relationships of infection, sanitation, and hospital design." A significant finding indicated that at a time when puerperal sepsis was a major threat, mortality "was far lower for women delivering at home" (Henry, Woods & Nagelkerk, 1990, pp. 204-205).

In her Notes on Hospitals she asserted that high mortality rates resulting from hospital conditions were unacceptable, and she offered practical and plausible

methods of remediation that integrated procedures not unlike those outlined above (Rosenberg, 1987, p. 128). In essence she advocated improved construction, better management and sanitation to insure the therapeutic mission of the hospital (Bullough & Bullough, 1978, p. 94).

Perhaps it is a tribute to her genius that no one before Nightingale had taken on the mammoth task of systematically investigating sources of hospital acquired infection. Until this time the absence of uniform hospital statistics and records rendered such an undertaking impossible. Without the data physicians and hospitals were prevented from identifying the probable causes behind the high mortality rates (Goldsmith, 1937, p. 230).

With empirical evidence such as this it is not difficult to understand how Nightingale's ideas and examples became the principal influence on the organization of nursing schools and the reform and reconstitution of hospitals. By and large, she saw a direct connection between the interaction of human behavior, environment and health; the atmosphere of the hospital was affected as much by the actions of the people who inhabited and worked in it as it was on the

design and construction of the physical plant. (Rosenberg, 1987 pp. 130-131). For this reason, Nightingale incorporated two other essential ingredients in her plan for reform: she considered "the need for formal nurse training coupled with a vision of administrative order" as important as the need to alter "the hospital as physical artifact" (pp. 128-129). And while Nightingale saw the reform of hospitals as an important step in remedying and preventing major sources of health problems, she believed that as society progressed other superior modes of care would emerge. She wrote, "Hospitals are only an intermediate stage on civilization, never intended, at all events, to take in the whole sick population" (1893/1947, p. 37).

A convincing argument has been made that Nightingale's success in propagating her ideas was in no small measure related to the fact that she didn't create anything entirely original, but rather that she used to advantage "the contemporary prestige of science and [the] moral certainties of a more traditional sort" (Rosenberg, 1987, p. 135). She wrote for select audiences as well as for the general public, carefully adapting her style of writing as required. For

instance, Nightingale was a forerunner of her time when she "popularized" her Notes on Nursing in its last printed edition, insuring that it would be readable for persons with less education. She titled it Notes on Nursing for the Laboring Classes and made it available at a low price. Seymer (1954) suggests her actions were in keeping with her belief that the ultimate responsibility for health does not rest with professionals but rather is "everyone's responsibility," a notion that is now commonplace (p. 123).

Nightingale's doctrines were well served by the language she used which "communicated the perceptions of a particular class and time" (Rosenberg, 1987, p. 135). Moreover, by adding two consequential dimensions to older ideas of sanitary science she made them difficult to ignore; Nightingale elevated them to the status of spiritual laws, the carrying out of which became a moral imperative (p. 131); secondly, she gave the doctrines force by using empirical data to which persons of all classes could identify.

Nightingale's Understanding of
Sanitary Science

A look at Nightingale's ideas on the subject of health promotion and disease prevention lends significant historical insights into traditions that have become identified with modern nursing practices. Taking off on this theme it is important to recognize that although she rejected the notion of microbic origins of disease some of her "views on medicine were many years ahead of her time" while others were in direct conformity "to the medical doctrine then current." Cope observed that in matters of sanitation she well exceeded her contemporaries (1958, p. 14).

Nightingale integrated her understanding of the causation of illness with her conception of God's laws; from her perspective this combination of beliefs was incompatible with the emerging germ theory of disease. And although mounting scientific evidence began to eclipse the older paradigms of medicine, she would cling tenaciously to her views (pp. 14-15).

During most of the nineteenth century two fundamental conceptions of health and disease shaped the thinking of physicians and educated laymen alike: (1) ideas that disease producing poisons contaminated

the environment (Shryock, 1959, pp. 256-257) and (2) ideas of a more ancient history that viewed the body as a uniform whole (Rosenberg, 1983, pp. 7-8). In examining Nightingale's postulates for nursing and health care, both these views form the bedrock of her assumptions. Nightingale adapted sanitary reform because she could call upon empirical evidence to show that it was effective (Reed & Zurakowski, 1983, pp. 18-19). Consonantly, she assured that modern nursing would be founded on principles of holism: under her direction nurses were consigned "to meet the holistic needs of mankind in sickness and in health" (Barritt, 1973, p. 45).

Rosenberg argues that Nightingale's "ostensibly medical rationale for institutional reform [can only] be understood [in] relationship to contemporary social ideas and values on one hand, and, on the other, to centuries-old explanations of infection" (1987, p. 124).

Like most physicians and sanitarians of the nineteenth century, Nightingale believed that the atmosphere played a major role in transmitting diseases which were characterized as "zymotic" or ferment-like. Infections, they thought, could be spread in

individuals, hospitals or whole communities through a process analogous to the role of yeast in fermentation. Consequently they came to accept the idea that minute particles carried by the air could "induce potentially pathogenic changes in a far larger quantity of material" (p. 129). Although the medical community argued about whether these noxious elements were organic or chemical, there was a general consensus, to which Nightingale wholeheartedly subscribed, that they were produced spontaneously by "decay, fermentation, overcrowding and filth" (Pernick, 1985, p. 10).

Such concerns were sparked when England found herself caught up in major public health problems stemming from the growing industrial civilization. Because of changes in the Poor Law policies in 1834 huge segments of the working poor and paupers were deliberately drawn to the urban communities to fill jobs in factories: within a short time health conditions deteriorated to the point of escalating death rates and recurrent epidemics that threatened the entire population (Rosen, 1974, pp. 191-192).

In 1842 Edwin Chadwick, "the father of modern public health," published the compelling Report on Sanitary Condition of the Laboring Population of Great

Britain—that highlighted the need for environmental intervention. It was he who is credited with moving the impetus of public health into the arena of the central government, stressing the need for major systemic change in the total environment of the individual (Bourdillon, 1988, pp. 30-31; Galdston, 1981, p. 113; Rosen, 1974, p. 195,).

The Sanitary Report, as it is generally known, sold record numbers of copies and had a huge impact in terms of sensitizing the privileged classes to the abominable conditions under which the laboring population existed. It cited the ". . . foul odors of open cesspools, the garbage, excrement and dead rats rotting in the streets, the filth and scum floating the river, [and] the sewage that passes as drinking water."

From these observations it was Chadwick, who created the theory of miasma which he claimed emanated from the decaying matter and the "fluid effluvia" which poisoned "the atmosphere". Miasmatic contamination was ultimately charged as the prime source "of the physical, moral, and mental deterioration of the poor" (Himmelfarb, 1984, pp. 356-357).

Chadwick would declare that the solution of these problems was in the province of civil engineers, not

physicians. He reasoned that medical men might identify the disease and prescribed remedies to help alleviate the symptoms, but they did not have the resources or expertise for prevention (Rosen, 1974; pp. 196-197). Within this context lies at least a partial understanding of why the movement for sanitary reform did not start in the medical community, although some physicians played a significant role in calling attention to the environmental sources of ill-health. Pointedly, Nightingale, as a powerful ally of Chadwick, would insist that syphilis, small pox and cholera were not carried by infection but rather were the result of poor sanitation, contaminated water and foul air (Himmelfarb, 1984, p. 357).

During this time physicians lacked conclusive scientific knowledge about the manner in which communicable diseases were transmitted. It is precisely this point that sparked the great battles between those members of the medical community who either subscribed to or opposed ideas of contagion. (Rosen, 1974, p. 197). Those who propagated ideas of contagion believed that "specific disease-causing substances could be transmitted by touching a sick person." Hence they prescribed quarantine procedures

for infectious diseases that engendered "social stigma, moral blame and economic costs of disease on merchants, travelers, immigrants, and seamen." Noncontagionists sought remedies in the form of traditional concern about the health practices of individuals including their diets, exercise, hygienic habits and emotional states. However, they also saw factors in the environment beyond the control of individuals as major sources of disease, so that in addition, they stressed the importance of sanitation projects.

Until around 1870, when the germ theory of disease causation began to pick up momentum, most physicians in America and Europe regarded contagion as less important than personal hygiene or community sanitation in explaining and preventing the majority of serious illnesses (Pernick, 1985, pp. 10-11). Eventually modern medical science would confirm that both explanations had validity in the overall phenomenon of disease communicability.

Paradoxically, while medical science was moving in the direction of addressing the major source of sickness in the nineteenth century: infection and infectious diseases, it continued to rely on antiquated techniques and medications to treat its symptoms (p.

12). The therapeutics it employed arose from centuries old ideas about the body and its physiology—assumptions of a holistic nature that were generally shared by educated persons as well.

The body was seen metaphorically as a kind of equilibrium system in constant interaction with the environment. Food, air, exercise, and rest were variable environmental forces impinging on the body: excretion, perspiration, and defecation were outputs necessary to the body's particular equilibrium. Balance constitutes health, imbalance illness, and the symptoms of disease could be thought of as efforts by the body to restore itself to a proper balance [emphasis added]. . . . All such symptoms could be regarded as evidence for the existence of what many physicians had since classical antiquity termed "The healing power of nature". (Rosenberg, 1983, pp. 7-8)

Furthermore, this "shared heritage of intellectual assumptions" (p. 7) tended to view sickness as "a particular state of a particular organism," leaving "comparatively little place for specific disease entities and specific causative agents" (p. 8).

Bloodletting: blistering on the skin: drugs to induce vomiting, diarrhea or perspiration—all were ancient remedies by the second century A.D., when Galen systemized their use for restoring a harmonious balance among the four elemental body fluids ("humors"). These and other time-tested remedies remained the cornerstones of therapy of well into the nineteenth century, long after the demise of the particular medical systems from which they emerged. (Pernick, 1985, p. 12)

Physicians' prescriptive patterns during the nineteenth century showed they selected drugs on the basis of their ability to produce specific physiological effects on the body rather than because of their specificity in curing particular diseases. The goal of drug therapy was to modify the body's "ongoing efforts to maintain or restore a health-defining equilibrium" (Rosenberg, 1983, p. 8). Thus, mercury in various forms could be used as a bowel stimulant in conditions causing constipation as well as to deliberately bring on diarrhea and profuse salivation in the treatment of "bilious" pathology (Pernick, 1985, p. 12). Similarly, bleeding and the related practices of cupping and leeching, were "efforts to help the body restore itself to health by relieving it of some component present in excess" (Rosenberg, 1983, pp. 8-9).

Some drugs deemed highly therapeutic by modern medical standards were available at that time, but they were mainly employed to produce general effects on the body rather than for the clinical specificity for which they are known today. For instance, quinine, derived from chicon bark is routinely used for malaria, however physicians in the last century prescribed it as

a tonic or as a treatment for fevers. Correspondingly, foxglove, the source of digitalis, commonly prescribed for congestive heart failure, was used to relieve edema of body tissues, regardless of the causes (Pernick, 1985, pp. 12-13).

The relative ineffectiveness of traditional remedies in the face of rising infectious illness rates induced physicians to recognize the increasing effect of environmental conditions on disease. And while pharmacological intervention remained conspicuous, scientific doctrines augmented opinions linking social causes with both the etiology and cure of sickness.

This turn in interest to the environment and the behavior of individuals as major detractors of health pressed physicians to assume an "invasive and paternalistic" attitude in their relationship with patients; consequently, their judgments about what constituted "healthy, natural living" influenced the advice they dispensed— notions that were colored by their personal biases, cultural norms, and largely middle-class Protestant values (Pernick, 1985, pp. 15-18).

From the foregoing outline it is fair to deduce that sanitary science, as it was understood and

practiced in the last century was, in fact, a loose conglomeration of scientific evidence and conjecture, philosophical beliefs about health and disease, coupled with efforts to inject a particular moral viewpoint on society through the administration of health care.

It is relatively easy to understand why physicians and laymen alike were attracted to environmental and moral solutions to the serious health problems they faced; on one hand recognizable scientific studies could demonstrate "real correlation's between environment and health" thus offering "new hope" in what seemed to be hopeless situations. And on the other, the therapies they addressed "provided a safe substitute for the excruciating and lethal remedies of earlier medical systems" (p. 17). Later scientific findings would dispute and eventually discredit ideas of miasma and spontaneous generation of disease causing agents, however, it is noteworthy that these "erroneous theories" hit upon a remarkable number of "right solution[s]" that are essential to public health today (Rosen, 1974, p. 197).

Actually, there was to be a blending of environmental approaches with elements of the older style of medical practice. In the 1820s and the 1830s

American physicians who studied in Paris were exposed to the "therapeutic skepticism" of the French (Starr, 1982, p. 55). Many such as Boston's Dr. Jacob Bigelow began to subscribe to beliefs about a natural healing force that "was sufficient to cure most diseases." It was he who would first begin to use the term "self-limiting" to describe ailments that would eventually heal themselves if nature was not impeded in its work. Hence a dichotomy in medical practice and ethics evolved that set those who advocated the "art" of medicine against those who viewed the laws of nature as the only rational choice.

Natural healing methods found the old style bloodletting, blistering and purging anathema to its premises. Its adherents assumes "laws of nature" comprised scientifically predictable causal relations such as links between bad living conditions and bad health (Pernick, 1985, pp. 19-20). Their positions were predicated on widely held nineteenth century beliefs in the beneficence of nature and upheld by the philosophical injunctions of Hippocrates that physicians should "do no harm." As such, they "portrayed the doctor's role as simply to help the patient avoid anything that might interfere with

nature's healing powers."

The more radical healers called hydropaths went so far as to proclaim that poor hygienic practices were a "sin" against nature; likewise, medical practices that placed obstacles in the way of nature's healing process were considered immoral. Accepting this premise, physicians could only be held ethically accountable if their interventions caused damage to the patient; meanwhile, "the ravages of untreated disease were blamed on nature" (p. 20). This attitude of passivity caused its extreme advocates to be accused of "medical nihilism."

Eventually a synthesis of the two opposing approaches emerged that made use of both forms of the therapy. Referred to as "conservative medicine" it gave the physician the obligation "to select whatever combination of active and passive measures was most likely to minimize the overall damage from either the treatment or the disease."

It was the conservative approach to medical decision making that dominated during the mid-nineteenth century at the height of Nightingale's work. Hence, physicians could still be seen using bleeding and purging to some degree while at the same time they

"touted the body's natural recuperative powers and endorsed environmental-moral therapies. . . ." (pp. 21-22).

The factors outlined above addressing the state of medical science in the last century are deeply entrenched in Nightingale's construction of health and sickness and the respective roles of physicians and nurses in the care of patients. It can be demonstrated that she rejected some ideas, tolerated others, and held some as central to her philosophical viewpoint. This attitude is consistent with her tendency to be philosophically eclectic. In analyzing some of her writings, Welch (1986) found that "she borrows from different sources and describes and embellishes that with which she is in accord and refutes or ignores that with which she disagrees" (p. 4).

Rosenberg suggests that:

Her ideas of pathology and therapeutics were rooted in a more fundamental vision of society, a way of organizing and controlling the world that transcended the specifically medical form in which the vision was projected.

Beneath her invocation of statistics and experience lay ideas much older and more traditional. Like those assumptions [underlying] early nineteenth century pathology and therapeutics, these ideas reflected a vision of the world in which volition and disease, environment and regimen, body and mind were woven together so as to create a meaningful structure

into which health, healing, and disease could be placed. (1987, p. 129)

While the sanitary reform movement was at its height in the 1850s its leading advocates sought rectification in the community through efforts applied to the field of public health; insofar as Nightingale designed its principles to adapt reform in health care and nursing she became known as one of the great sanitarians in history (Shryock, 1959, p. 283). But in her scheme she held physicians to circumscribed roles that reflected their historical position in relation to the rampant health problems of the time.

Nightingale never held a "high" opinion of the curative powers of medicine (Cope, 1958, p. 12). During the mid-nineteenth century physicians were relatively helpless in altering the course of a disease. Their situation is reflected in a letter she wrote to Lady Herbert on April 10, 1861: "Medicine is a mere matter of experience of which we do not yet know the rules" (quoted in Cope, 1958, p. 24). Nightingale was more akin to "her self-consciously forward-looking medical peers" in giving little credence to the role of "drugs and bleeding, or in [medical] therapeutics generally. . . . Drugs and bleeding were to play at

best a minor role in her ideal hospital—nursing, cleanliness, and dirt were to occupy center stage" (Rosenberg, 1987, pp. 133-134).

Although the sanitary measures Nightingale advocated were supported by some leading public health men such as Chadwick, "the bulk of the medical profession was slow to appreciate how great a reformation was needed" (Cope, 1958, p. 14).

In the days when slop water was emptied from windows, when the liquid manure from pigsties trickled into the shallow wells next to them, and when closed houses reeked of foul air, it is little wonder that Nightingale displayed intense concern about the physical environment. (Dennis & Prescott, 1985, p. 68)

To Nightingale's thinking there is always a direct link between the laws governing the physical world and the moral actions of its inhabitants. She would tell her probationers that whenever she arranged to have a drain cleaned out, ventilated a hospital ward or urged the "principles of healthy construction of buildings" she felt she was "obeying a direct command from God" (Nightingale, 1915, pp. viii-ix). In contrast, in matters concerning the "healthiness" of hospitals Nightingale would infer that "practicing physicians and surgeons" were not only ignorant but disinterested (quoted in Cope, 1958, p. 18).

Nightingale proffered that the methods of medicine were not critical to the recuperative process.

It is often thought that medicine is . . . curative. . . . It is no such thing; medicine is the surgery of functions, and surgery proper is of limbs and organs. Neither can do anything but remove obstructions; neither can cure; nature alone cures. (1859/1992, p. 74)

On the other hand she identified the primary activities of the nurse as promoting healing when she wrote: ". . . what nursing has to do in either case is to put the patient in the best condition for nature to act in him" (p. 75). Unmistakably, this "view magnified the nurse's role while necessarily de-emphasizing that played by the physician" (Rosenberg, 1987, chapter notes, p. 377).

Nightingale's reference to nature as the matrix of healing corresponds to older philosophical assumptions about the body and its interaction as a constituted whole.

In other words, all that is wanted to enable nature to set up her restorative processes, to expel the intruder disturbing her rules for health and life. For it is Nature that cures: not the physician or nurse. (1882/1954d, p. 336)

Consonantly, Nightingale frequently referred to the wholeness of the individual when she entertained ideas about health. In 1871 she sent a letter to Mr. Jowett in which she described her thoughts: "I believe that

the laws of nature [God] tend to improve the whole man, moral and physical, that it is absurd to consider man as either a body to be improved or as a soul to be improved separately" (quoted in Welch, 1986, p. 9). Twelve years earlier, writing in her Notes on Nursing, she portrayed "the body as the house of the mind" demonstrating her understanding of the mind body interaction.

Nightingale embellished concepts of holism with her empirically based insight on the needs of the sick. In this respect she was years ahead of modern day health care professionals vis-à-vis psychologists, physicians, and nurses when she recognized the powerful effect of the patient's psychological state, especially as it relates to anxiety, and the outcome of the recovery process. Her ideas on the psychology of suffering are integrated in the instructions she gave nurses to allay unnecessary anxiety:

Apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion. Remember, he is face to face with his enemy all the time, internally wrestling with him, having long imaginary conversations with him. . . . "Rid him of his adversary quickly," is a first rule with the sick.
(1859/1992, p. 22)

She would lament: "How little the real sufferings of illness are known or understood. How little does

anyone fancy him or even her self into the life of a sick person" (p. 57).

Nightingale's ideas about holism explained the way she perceived the relationship between persons and the incidence of disease as a consequence of willful dissonance with God's laws. From her perspective illness and suffering resulted when individuals or a whole society chose to neglect or thwart the laws of health that were known (Rosenberg, 1987, p. 131). But she also saw common ignorance as an evil to be overcome. Nightingale felt that educated persons such as physicians, sanitarians and eventually trained nurses had not only an obligation to continually use empirical methods in discovering those laws which were yet unknown, but also to teach laypersons about health and avoiding sickness. It was in this sense that she also spoke out against the paternalism of medicine that served to create dysfunctional dependence on its knowledge and practice.

. . . how . . . extraordinary it is that, whereas what we might call the coxcombries of education—e.g., the elements of astronomy—are now taught to every school girl, neither mothers of families of any class, nor school-mistresses of any class, . . . nor nurses of hospitals are taught anything about those laws which God has assigned to the relations of our bodies with the world in which He has put them. . . . Not but that these laws . . .

are in a certain measure understood, but not even mothers think it worth their while to study them—to study how to give their children healthy existences. They call it medical or physiological knowledge, fit only for doctors. (1859/1992, p. 7)

To Nightingale's contemporaries her accomplishments signaled an end to prevailing perceptions that sickness, being a product of fate and sin, was inevitable. At a time when mortality and disease dominated daily life, she sought to put the locus of control for health into every person's hands. She was astute in associating nursing with the advance of science as it was being heralded, co-opting "sanitary science, the science of health," to demonstrate dramatic changes in hospital and health care (Taylor, 1856, Vol. I, p. 170). Her ideas did propagate a new attitude toward sickness—in effect, dispelling much of the stigma that tended to characterize the patient when she continued to assert: "Sickness or disease is Nature's way of getting rid of the effects of conditions which have interfered with health. It is nature's attempt to cure . . . " (1882/1954d, p. 335).

As long as the principles of environmental sanitation and holistic prescriptions formed the dominant science addressing the scourges of diseases

and epidemics, Nightingale reigned as an expert and leader in health care reform. These same principles undergirded her work in renewing and reconstructing institutional forms of hospital care and nursing. She relied heavily on the tenets of sanitary science to provide the authority upon which nurses educated in her methods could carve out a unique and independent role in implementing change. It is important to keep in perspective that their ultimate goal was the perfectibility of society implemented by the continued growth in knowledge and application of God's laws of health.

Nightingale contended that a trained nurse's capacities must be ultimately spiritual: the technical skills she might acquire were, if not precisely subordinated in her moral endowments, at least subsequent to them. That same holistic pathology and hygiene that explained the incidence of health and disease also explained the numerous ways in which a nurse could help bring about the patient's recovery. (Rosenberg, 1987, p. 133)

The medical profession, paradoxically, spent most of the nineteenth century in frustration over its attempts to secure effective remedies and public confidence in its ability to prevent and control disease (Brown, E. R., 1979, chapter 2). With the advent of "scientific medicine," however, its prospects were dramatically transformed.

CHAPTER VI

Scientific Medicine Dominates Over Nightingale's Intentions

The ascendancy of scientific medicine began at the same time Nightingale was enjoying success in implementing her sanitary reforms. The clash between her underlying assumptions about disease causation and health would eventually drive a wedge between her aspirations for nursing and the goals of the traditional medical community.

The germ theory "in its modern form" was ushered into medical thinking in the 1860s by Louis Pasteur, a scientist who long disputed the notion of spontaneous generation of disease-producing substances. In 1876, Robert Koch demonstrated that a cattle-borne disease, anthrax, resulted from a specific bacterial organism. It wasn't long before a multitude of illnesses like tuberculosis, cholera, typhoid, diphtheria, gonorrhea, pneumonia—the dreaded scourges of all people—were found to have a microbacterial origin.

It didn't matter that the effective remedies for treatment or cure might be a decade or more away, the excitement of the new medical science being heralded brought with it the imminent promise of good health and

long life. "So powerful was the sweep of the germ theory that it gave rise to hopes . . . that perhaps all diseases might be one day found to have a microbial origin" (Ludmerer, 1985, p. 76).

The euphoria engendered can be understood in light of the fact that in the late nineteenth century life expectancy had not yet reached fifty years and most individuals considered suffering and premature death as inevitable accompaniments of life (p. 77).

The germ theory of disease brought with it "indisputable practical benefits," most particularly in the area of preventive health care. In the surgical arena it validated the need for antiseptics and paved the way for aseptic (sterile) procedures (p. 76). The magnitude of its imperatives is perhaps best understood when we recall that as late as the 1880s a surgeon might use an unwashed jacket for his operating gear for as much as a year—and when an instrument fell on the floor it was acceptable in many cases to simply wipe it on the jacket sleeve before proceeding with the surgery (Rosenberg, 1987, p. 148).

When the implications of the new theory were applied to public health "it provided scientific direction to the sometimes flagging and ineffective

efforts of old-fashioned hygienist and sanitationists." Up until that time "the boundary between medicine and public health was never distinct" (Ludmerer, 1985, p. 76). For the first time specialized medical knowledge rather than sanitary science took the lead in disease prevention by "enabling more accurate diagnosis and identifying how diseases were spread." This point is made particularly salient when typhoid fever eventually came under control. Once the causative organism was discovered in 1884, an incontrovertible urgency manifested the need for cleaning up the sewage contaminated water where it was found (pp. 76-77).

At first, exactly what defined the new science was still largely unknown, yet the question failed to impede its mass appeal and the promise is held for future application.

In demonstrating a connection between particular infectious ills and particular microorganisms, the germ theory underlined and explained the unity of disease patterns already demonstrated by three generations of clinicians and pathologists. But this new knowledge did more than just that. It changed public attitudes toward the medical profession and raised expectations, even before laboratories could do much to transform the shape of everyday [medical] practice. (Rosenberg, 1987, p. 151)

Paul Starr (1982) observed that although curative agents were sparse, the new science spawned diagnostic

techniques that greatly enhanced the authority of the physician. In the mid-1800s they had at their disposal the stethoscope, ophthalmoscope, laryngoscope, and later x-ray capability to enlarge their "sensory powers in clinical examination." In addition, they began to routinely incorporate physiological indicators such as body temperature, blood pressure, and characteristics of the pulse in their patient assessments. By the 1890s laboratory tests were already in existence to detect prominent infectious diseases that were only isolated during the previous decade. Meanwhile, medical practice was becoming increasingly reliant on analysis of urine and blood for diagnostic purposes (pp. 136-137).

These innovations were not serendipitous. They were the result of progress in basic science that made it possible to duplicate successful applications more rapidly than ever before. The earlier advances . . . like smallpox vaccination, had been purely empirical discoveries and were not quickly repeated. Microbiology, for the first time, permitted physicians to link causes, symptoms, and lesions systematically. (pp. 137-138)

Whereas objectivity had always been the goal of medicine, now that it had the means to realize "that elusive ideal" (Rosenberg, 1987, p. 153).

By the 1890s medicine made a noticeable impact on health largely through its ability to provide more

accurate diagnoses, identify and disseminated knowledge on the modes of disease transmission, and by relating the need for personal hygiene in prevention. Equally important were the new antitoxins against diphtheria and typhoid that were developed in time to cause a dramatic drop in the death rate.

In contradistinction to this idea, however, some scholars dispute the notion that advances in medical science played a central role in improving health by the turn of the century. An argument can be made that better standards of living, improved nutrition, and other earlier public health initiatives that fostered cleaner air and water were in themselves key elements of change (Starr, 1982, p. 138).

However, belief in the authority of science grew when people of all classes recognized the sweeping changes occurring in everyday life. The "new order of urban life" spurred by industrial capitalism necessitated an increasing dependence on specialized education and skill. Older traditions that enforced self reliance and drew its resources from a common fund of knowledge became outmoded. As might be expected, professional workers found their occupational interests served in the pervasive transformation that was taking

place (p. 142). In medicine, the rapidly expanding knowledge base contributed to a permanently widening gap between lay and medical understanding of disease and therapeutics (Rosenberg, 1983, p. 12).

As the main emissaries of science, physicians benefited from its rising influence. The continuing growth of diagnostic skills and therapeutic competence was sufficient to sustain confidence in their authority. And with the political organization they achieved after 1900, doctors were able to convert that rising authority into legal privileges, economic power, higher incomes, and enhanced social status. (Starr, 1982, p. 142)

Ostensibly, the growing role of science in medicine permanently altered its traditional styles of practice. This observation, not unlike that repeatedly made by Nightingale, is tersely summed up by Rosenberg when he wrote: "doctors began to treat diseases . . . not patients." Insofar as the "pathology-based and legitimated picture of disease grew increasingly prominent in medical thought," older methods derived from holistic beliefs that took into account "the patient's physiological individuality" became "less and less" relevant (Rosenberg, 1987, p. 152; see also Rosenberg, 1983, p. 11).

More precisely, to the extent that medical science directed its energies toward understanding disease patterns contributing to specific diagnostic categories,

"patients were inevitably seen in terms that transcended their individuality, as instances of more abstract, yet somehow more real syndromes that manifested themselves in countless other men and women" (p. 152).

The field of public health mirrored almost exactly the paradigmatic change that was occurring in medicine. Although not totally unopposed, the new public health leaders became "medical men" who were trained in laboratories and educated in the newly developed bacteriological institutes of Europe. Galdstone (1981) relates that they belonged to the school of thought labeled "Etiological"—signifying their opinion "that disease—notably infectious and communicable diseases—is due to specific causes which, science . . . will undoubtedly prove amenable to control by specific therapies." Ultimately they turned away from older "humanistic" traditions that emphasized social concern for the total environment of populations, directing their attention instead to a preoccupation with "germs, vaccines, serums, fumigation, sterilization, and quarantine" (p. 11).

Among the opponents to this stark shift in direction were the old anticontagionists, many of whom did understand "the pathogenic powers of bacteria" and

although their philosophical viewpoint would not prevail, they campaigned bitterly to retain a holistic outlook toward disease causation and intervention. In short, they rejected any notion that gave microbial organisms credit for being "the ultimate and determinate agents of disease" (pp. 137-138).

E. Richard Brown (1979) recounts how modern scientific medicine rescued the medical profession from an extensive lack of public confidence in its effectiveness. For the purpose of this study selected arguments are called to demonstrate this point. For one, its assumptions mirrored the ideology of the dominant groups in society associated with industrial capitalism. Taking off on this theme, parallels can be made between the increasing specialization in scientific knowledge and technological innovations that increased the success of business interests, and the growing assurance people felt in the advances being made by medical science.

Discoveries in bacteriology, made possible by a rationalized approach to basic science, conjured up ideas that disease, like any other highly technical difficulty, "could be seen as an engineering problem, surmountable with sufficient talent and resources" (pp. 71-77). In effect, medicine was increasingly portrayed

as an "exact science" while individual physicians become cast in the role of an "inquiring and skeptical scientist" who carefully tests all evidence before pronouncing his conclusions (pp. 77-78).

It is apparent that Nightingale considered the generations of new knowledge as important to the survival of modern nursing as it was to medicine. The point of departure, however, was in the way each occupation determined the principle methods by which its knowledge should be pursued.

To Nightingale's thinking the acquisition of new knowledge in nursing signified tapping into God's laws of health and nursing and to laws of life and death (Nightingale, 1959/1992; Welch, 1986, p. 8). In this respect, she was acting in conjunction with some early nineteenth century philosophers who were influenced by the Enlightenment era—especially John Stewart Mill who believed that "general laws exist a priori; and all phenomena act in accord with them. In principle, these laws are confirmable and can be empirically substantiated. They provide predictability and stability to man's existence" (Welch, 1986, p. 5).

Although Victorian philosophers like Mill tended to subscribe to the notion that universal laws existed,

they rarely attributed them to "God as the Lawgiver, the or the Originator." Because of her strong beliefs Nightingale could be seen reacting, as Kant did, against the view that "Science, through its casual determination left no place for freedom of human action or for a government by God . . ." (Reichenback, 1951, p. 65).

Nightingale was persuaded that practical, workable theories could only originate from empirical observations by those who were involved in situations rife with relevant data. In her Suggestions for Thought published in 1860 she wrote: "In all things, however, be not satisfied with thinking, do; by doing, and accurately observing at once, experience is gained. By thinking only, ideal theories are gained, brought to the test of no experience, and generally far astray . . ." (quoted in Palmer, 1983, p. 231).

From the foregoing one can begin to see how Nightingale arrived at the position that nurses had to build a knowledge base for nursing primarily by engaging in the practice of care of patients. The stance is consistent with her tendency to draw empirical generalizations based on her extensive experience in observing and participating in different systems of health care delivery. Nightingale's perspective

notwithstanding, Reed and Zurakowski (1983) point out that her approach would be unacceptable according to current standards of theory development in nursing. Using contemporary methods entails separating the goals and activities concerned with acquiring new knowledge from those of its application or use. However, Nightingale did not have a highly developed theoretical foundation upon which the future profession could claim legitimacy, nor did she have nurses academically prepared to organize research (p. 20).

Nightingale was unassailable in her determination that nursing could only be properly taught at the bedside of the sick where clinical competence was constantly being generated, applied and passed on from one practitioner to another (1893/1949). Her rationale for centering education and knowledge accretion at the site of patient care is clear: nurses do not learn the art of "nursing sickness," rather, they engage in "nursing the sick" (p. 24). She wrote this in dogmatic terms for nurses attending the World's Fair in Chicago thirty-three years after the establishment of the training program at St. Thomas, affirming her commitment to the apprentice system of nursing education. Nightingale had deep concerns about the

possibility of blurring the boundaries between medicine and nursing, thus she distinguished medicine as centering its focus on the disease while nursing focuses on the affected person in a more holistic sense. She argued that if nursing is learned primarily at the bedside this perspective can be maintained (p. 24).

Irene Sabelberg Palmer questions why Nightingale chose the hospital setting as the prime setting for nursing education when in her earlier life she had desired a university education for herself. Palmer concluded that perhaps Nightingale did not believe that her own extraordinary education was a key factor in her success. Perhaps, more importantly, it was her deep disappointment in the incompetence of many physicians she had observed that drove her to insist upon a strong clinical training for nurses (1983, p. 232).

Nightingale steadfastly referred to nursing as an art derived from a scientific foundation: what is commonly referred to today as an applied science. Viewed in this light she lamented that a curriculum driven "by lectures or by books" without correlated participation in real clinical situations results in the accumulation of sterile facts lacking any meaningful conviction. If this were allowed to occur, she

predicted that "what is in the book [would stay] in the book" (1893/1949, p. 24).

It is significant to note here that once scientific medicine made significant progress, Nightingale would allude to the legitimacy, and perhaps the superiority, of its knowledge. She recognized that the science of medicine and surgery is created by the medical community while nursing must, within the bounds of its own particular discipline and philosophy, convert medicine's continuing advances into the art of nursing.

Nursing the sick is an art, and an art requiring an organized, practical, and scientific training; for nursing is the skilled servant [of the science] of medicine, surgery and hygiene. . . . The physician prescribes for supplying the vital force, but the nurse supplies it. Training is to teach the nurse how God makes health, and how He makes disease. Training is to teach the nurse to know her business. . . . (p. 26)

The question of whether Nightingale disdained a strong theoretical knowledge base for nurses never fails to arise. What may be at the heart of the problem was her frequent injunctions against putting preeminence in conceptualized knowledge, as described in the literature, in lieu of knowledge that is derived from clinical practice (Worchester, 1920, pp. 193-194). She saw the medical, surgical, and hygienic and later pathological sciences as giving direction to nursing,

but the art and science of nursing proper was advanced and refined in the process of administering care.

Her system of education allowed for novices or probationers to learn under the direction of experienced nurses, thereby implying that practitioners with clinical competence were the most qualified educators in nursing practice. Indeed, the recent work of Benner and Tanner supports the notion that clinical experts in nursing have an important function in moving the novice practitioner to higher levels of clinical judgment (1987, p. 31): their research has demonstrated that fundamental aspects of expertise "cannot be taught in lectures nor broken down into procedural rules" but that they can be developed through case studies, enriched feedback, by perception and validation of expert nurses (p. 31). There is a lot of evidence that Nightingale attempted to structure of all three modes of learning in her system. Not only were nursing students expected to do case studies, but Nightingale insisted that their formal teaching be constantly reinforced at the bedside of the patient by their physician and nursing instructors. Such reinforcement called for open communication whereby students were to receive critical feedback on their progress at regular intervals.

Nightingale drew up a program of formal classroom instruction and ward practice in a hospital under the tutelage of a medical instructor (physician) and qualified nurses; moreover, she established a rigorous training schedule for the special probationers who were learning how to train other nurses.

Nightingale did encourage the development of intellectual skills leading her to recommend that all schools of nursing provide a library of high quality with professional books which were, at the onset, probably all medical in nature. She instructed that these books were "to be made careful use of, under the medical instructor and class mistress [nursing instructor]" (1882/1954c, p. 323). In addition, she was a strong proponent of continuing education, believing that the basic curriculum merely helps the student to learn "how to go on learning for herself . . ." (p. 322).

Perhaps Nightingale's perspective of nursing is best summarized by her contention that a nurse "must have a threefold interest in her work—an intellectual interest in her case, a much higher hearty interest in her patient, [and] a technical interest in her patient's care and cure" (1893/1949, p. 34).

As late as 1893, Nightingale reiterated her firm belief that nursing care could only be learned within the system of apprenticeship.

Book-learning is useful only to render the practical health of the health-workshop intelligent, so that every stroke of work done there should be felt to be an illustration of what has been learnt elsewhere—a driving home big an experience not be forgotten, what has been gained knowledge too easily forgotten. (1949, p. 36)

She reminds us continually that nursing is an applied science and as such requires creativity in transforming conceptual knowledge into practical knowledge. "Look for the ideal, but put it into the actual. 'Not by vague exhortations but striving to turn beliefs into energies that would work in all details' of health" (p. 36).

Nightingale's Conflict With Scientific Medicine

Although Nightingale had an unusual education for a woman of the mid-Victorian era, except for her undisputed expertise in statistics, it is not recorded that she had any basic scientific education, leading some, such as Palmer, to infer that "she rejected scientific knowledge" (1983b p. 232). Even Cope (1958) suggests her lack of a scientific background was a major

deterrent in her ability to adapt to the changing status of medical science (p. 16).

But overarching influences of a deeper magnitude caused Nightingale to reject the germ theory of infection. If she could be pigeonholed in the controversies surrounding the origin of disease in the last century, Nightingale would be categorized as sympathetic to the anticontagionists. As we can recall, members of this group had apprehensions about the social effects that would follow once public health shifted to a single, rather than a multifaceted perspective on disease causation. Her letter on November 8, 1858 to Chadwick reveals her judgment on the issue: "Sanitary experience has so completely disproved the invisible 'seminal' contagions. . . . I never knew a case of infection but there was gross mismanagement and carelessness" (quoted in Cope, 1958, p. 15).

Nightingale worried that the well being of persons, sick or well, would be jeopardized by the abandonment of hygienic measures. Glaring evidence of these concerns were expressed in 1873 through the instructions she gave to Health Missioners—philanthropic women of the upper classes who were formed to teach health promotion to the rural poor. She expressed fear that the germ theory was

propagating a false sense of security because disinfectants and antiseptics were being advocated in lieu of sanitary measures and hygiene. Nightingale once lamented:

Ill informed medical men aid in sustaining this delusion, by laying the blame on "current contagions." Badly constructed houses do for the healthy what badly constructed hospitals do for the sick. Once insure that the air in a house is stagnant, and sickness is sure to follow.
(1859/1992, p. 15)

Similarly, she pondered whether the "doctrine of 'disease germs'" may lead one to infer that infection is inevitable. To this she countered "that there is no such thing as 'inevitable' infection is the first axiom of nursing" (Nightingale, 1882/1954d, p. 338). She may have been challenging the hypocrisy of the medical men of her time when she wrote "That patients are 'accustomed to the filth and it does them no harm' is not only thought but said when in the present years of grace (or disgrace). . ." (p. 340). A bit later she specifically indicts surgeons for unnecessary deaths related to their failure to use cleaning and disinfection when attending to surgical wounds and performing surgical procedures (p. 345).

Nightingale's last reference citing the carelessness of surgeons in employing disinfectants

points to what Goldie observed to be her ambivalent attitude toward infection—for although she resolutely rejected the existence of germs, her actions were always inconsistent with her articulated beliefs (1987, p. 65). In pre-Listerian days she insisted that absolute cleanliness was essential in preventing infection, yet as an anticontagionist she fearlessly worked with smallpox infected patients without ever feeling the need for barrier protection (Nightingale, 1859/1992, p. 19; Cope, 1958, p. 14).

Although there are many instances of such inconsistencies in her work, Goldie asserts that Nightingale "warmly embraced Lister's antiseptic technologies, and later aseptic theories" (1987, p. 65). The following passage, written for nurses perhaps is a reflection of her continuing ambivalence:

All disinfectants are more or less a "mystic rite," as a great surgeon said. Absolute cleanliness is the true disinfectant; but chlorinated soda, if disinfectants are to be used, is about the best. Always have chlorinated soda for nurses to wash their hands, especially after dressing or handling a suspicious case. It may destroy germs at the expense of the cuticle; "but if it takes off the cuticle, it must be bad for the germs" said a [great] surgeon. (Nightingale, 1882/1954d, p. 342)

Her statement may also be an example of diplomacy for, as we shall soon demonstrate, Nightingale was well aware that probationers were being lectured on the latest medical theories by physicians at the time when scientific medicine was beginning to dominate the thinking of forward looking practitioners. Had this not occurred, it well may be that the very same schisms that were occurring in medicine would have plagued and irreparably hurt the growth of modern nursing.

It is entirely open to question what her motives were in rejecting the germ theory. Writers have suggested that perhaps Nightingale's huge investment in sanitary reform caused her to reject the possibility that living microbes might be the actual source of infection (Stewart and Austin, 1962, p. 119). But there is a lot of evidence indicating that she wasn't alone in her thinking—even among distinguished medical men who were her contemporaries. For instance, her close colleague and secretary Dr. Sutherland, a noted sanitarian, had remained opposed to the idea of germs and contagion (Cope, 1958, p. 15).

Ludmerer (1985) recalls that during the Civil War (1861-1865) physicians themselves propagated much of the infection that was rampant among the injured. It was

not uncommon for surgeons to probe battle wound with their fingers and to clean their hands merely by wiping them on pus-stained aprons (p. 10). Most physicians in America at this time did not understand the importance of clean hands. Yet, in 1854, while treating the wounded in Scutari during the Crimean War, Nightingale's efforts in implementing sanitary measures succeed in sharply reducing morbidity and mortality among the military patients.

But even in a more enlightened time of medical knowledge physicians initially reacted to developments in bacteriology with hostility; in New York prominent physicians were known to get up and leave a meeting when papers were read that gave credence to the germ theory (Rothstein, 1972, p. 262). As late as 1904 members of the profession who were not educated in the new scientific tradition opposed the notion that tubercle bacillus caused tuberculosis and the treatment of diphtheria with antitoxin (Ludmerer, 1985, pp. 130-131). Meanwhile in London, many surgeons continued to vehemently oppose the use of antiseptics (Bordley & Harvey, 1976, p. 301).

A significant number of physicians and scientists did acknowledge the existence of specific microbes but,

preferring to play Devil's advocate, they argued that the presence of microbes could merely be the result, rather than the cause, of infection (Shryock, 1959, p. 257). It was Koch's work in replicating disease patterns by the introduction of particular organisms that was essential in convincing many skeptics of the authenticity of the germ theory (Kalisch & Kalisch, 1986, p. 143; Ludmerer, 1985, p. 76).

There is a semblance of logic that seems to explain Nightingale's position in opposing the germ theory. For one, she could never bring herself to accept microbiology as a respectable science (Stewart and Austin, 1962, p. 119). According to Reed and Zurakowski (1983), her intransigence grew out of her basic assumption that knowledge could only be verified by observation using the senses. Therefore, to her thinking, investing one's belief in unseen organisms bordered on superstition (p. 16). Yet, in the older, traditional ways of speculating about disease, no one "saw" the elements that were considered to bring about infection from dirt and decaying organic matter. Unlike the medical men teaching her students, Nightingale refused to acknowledge the specificity of diseases that were the outcome of the new medical sciences (Baly,

1986, p. 23). Significantly, her viewpoint did not hold sway over the new generation of nurses, some of whom would become authors of manuals on microbiology before Nightingale's death (Robinson, 1946, p. 127).

Ultimately, Nightingale may have been guided in her opinions by the entire mission to which she dedicated her life. As Baly remonstrates:

Improved nursing was but one small cog in the sanitary wheel in which she was interested and "sanitary" was of course used in its wide nineteenth century interpretation. . . . This new science [had to be] first applied to the army because it suffered most, then to the Empire, particularly to India because its need was the greatest, and finally to the population as a whole. (1986, p. 22)

In a letter to Dr. Pattison Walker in 1866 she expressed her view that the aim of the medical profession should be to implement ways for the public to care for its own health. Nurses, meanwhile, were to be the sanitary missionaries (p. 23).

Significance of Nightingale's Opposition to the Germ Theory

Nightingale's formulation of God's laws of health and laws of nursing have proved to be timelessly salutary in expediting a safer environment for patient care; her emphasis on the humane aspects of the patient nurse relationship and insistence that nurses be moral

and ethical in the totality of their responsibilities placed secular nursing on a plane previously reserved for respected nursing Sisterhoods. Still, nursing would not be able to enter any serious discussion about its legitimacy as a profession were it not for Nightingale's unyielding insistence that all its candidates, regardless of their class or previous educational background, successfully complete specific academic and clinical requirements.

A case could be made that Nightingale's early departure from progressive members of the medical community in respect to the new clinical approach to pathology served as a metaphor for defining the characteristics by which each occupation came to be known. Both occupational groups sought enduring change through educational reform; however, each built systems for socializing students on different paradigmatic schemes. This is not to infer that nurses and physicians learned a different medical science, but rather that there came to be, at least philosophically, disparate areas of emphasis.

Medicine's acceptance of the germ theory was a watershed in its transformation to a technical, mechanistic concept of illness and health. Within this

paradigm the role of the nurse's character as being the prime moving force in assisting nature to heal was necessarily reduced in importance. Nightingale initially perceived this threat from the onset, believing the drive of her personality, her connections in high places, and her conviction of the rightness of her laws would be enough to insure that the foundations she laid down would prevail.

The scientific base for medicine placed a larger emphasis on the cognitive development of its practitioners, in a profession with a long standing academic culture among its elite members beginning with European medieval institutions. During the Classical Age, or the Renaissance, medicine made a dramatic break from its association with "superstition, theological dogma, and metaphysical speculation." Moving to a rational approach to disease it began to systematically study the body from a perspective of its structure and function. Although patients would have to wait centuries before they could derive any substantial medical benefit arising from this dynamic shift, it provided the "intellectual tradition on which modern medicine would be based" (Vogel, 1979a, p. viii).

Concomitantly, medicine gave paramount importance to the creation and acquisition of new knowledge on a large scale while it continued to use to its advantage the normative traditions that grew out of older patterns of relating to patients. Grounded in the privileges attached to the time-honored profession of law, divinity and medicine, these traditions insured that the physician would maintain cultural authority in the healing art.

As medicine shifted from a holistic model of health and illness to one in which the patient is viewed primarily through the prism of physiological structure and function, it found itself continually reinforced in this direction. For as long as this remained the nidus of the activities it drew increasing prestige, economic rewards, and a deepening dominance in health care.

In contrast, modern nursing, during its early development, never felt the urgency to embrace the highly scientific, academic model of education for all its practitioners, as had medicine, to justify the heritage it adopted from its founder: promoting healing, preventing illness, attending to the psychosocial processes, and utilizing a more integrated holistic approach in managing patient care.

Nursing's inclusiveness and its espousal of a supportive, assistive role towards its [patients] created difficulties and disadvantages in the increasingly reductionist, science-oriented atmosphere of the first half of the 20th century. (Lynaugh, 1988, p. 34)

In order to secure its standing in the new order of medical care that emerged medicine assumed a proactive role while nursing was necessarily reduced to reacting in terms of adapting its practice to the revolutionary changes that were taking place. Meanwhile nurses had to subsume their discipline specific goals, as specified by Nightingale, under the mantle of the perceived superiority of the new medical science.

CHAPTER VII

Nightingale's Apprentice Model of
Education Prevails

Nightingale was an intellectual whose deep religious and philosophical beliefs undergirded all her actions. Her writings indicate she gave much thought to the "nature of the universe, men's purpose in life, and God's laws and expectations for mankind," yet the basic curriculum she proposed and used appears almost devoid of these concepts. Perhaps she failed to identify her strong background as an essential element in forging a philosophical commitment to the reconstruction of nursing. It is not surprising that it has taken more than a century before "the unifying theory Nightingale proposed as operational in the universe would be incorporated in the development of a science of nursing" (Palmer, 1983a, p. 17).

It may be that Nightingale subsumed all her aspirations for nursing under her goals for sanitary reform.

The language in which she expressed her ideas is less marked by sectarian religiosity and owes a greater debt to secular scientific work on public health. But she saw the laws of health as the Divine ordering of society which it was her duty to interpret and sustain. Thus her vision of who nurses should be and what they should do contained the same elements of discipline as those adopted

by the sisterhoods. What was new was the emphasis on the hygienic aspects of this practice. (Dingwall, Rafferty & Webster, 1988, pp. 40-41)

Under the influence of Nightingale, nursing came to define itself, not so much by its intellectual roots, as by its claim to professionalism based on an altruistic service model that had as its basis the propagation of the laws of health. The standards of sanitary science coupled with the rigid requirements of character in its new practitioners were culled in an apprenticeship education setting that shaped the massive movement of modern nursing reform. Within this exemplar of education and practice there was, in contrast to the medical profession, no recognized role for the nurse as a developing scientist in the pursuit of knowledge to guide nursing care. Many would see this as the crucial impasse in the later attempt to secure full professional status (Bloom, 1963; Christman, 1991; Katz, 1965; Kelly, 1987; Montagna, 1977; Strauss, 1966).

It is difficult to reconcile this seemingly unintended outcome of Nightingale's mission for the new generation of nurses. Her basic premise had never changed. Nightingale remained firmly committed to her belief that nursing's responsibilities were distinct

from those of medicine, therefore nurses had to develop and use their own knowledge (Chinn & Kramer, 1995, p. 33). From this standpoint she placed a high value on education; all her "educational efforts and exhortations were directed toward the development of the nurse's intellect which she perceived as a life-long process" (Palmer, 1983a, p. 16). "Nursing is an art," she stressed at age 72, "and an art requiring an organized practical and scientific training" (1882/1954d, p. 335). She emphasized the uniqueness of nursing in terms of the knowledge base nurses need to acquire and the nature of its practice (Rogers, 1992, p. 59).

What is problematic in attempting to discern her specific ideas about curriculum development is the fact that Nightingale "never set down in print" exactly what she wished to include in the curriculum of every school for nursing.

Her best known book, the famous Notes on Nursing cannot be included in the [official] category of textbook. . . . Instead it lay down the principles on which all good nursing should be founded, and outlines . . . what one might term [her] philosophy of nursing.

It is considered enigmatic that Nightingale, who was prolific in other areas, never wrote a textbook. Yet it is obvious from her early works that she considered the minute details of how nurses should be trained and how their work should be organized. (Seymer, 1954, pp. vii and viii)

Lucy Seymer (1954) suggests that Nightingale deliberately refrained from capturing in written word her vision of the wide range of developing content in nursing, fearing that future educators might give preeminence to theory at the expense of learning practical application in what is now referred to as the clinical setting (pp. viii-ix).

When Nightingale introduced disparate goals for medicine and nursing, she was intent on maintaining a separate identity for nursing as the business of women. Wanting to guarantee this separation, she structured the work of nurses so that they would be singular in their responsibility for promoting sanitary principles in health care. By pursuing this course she intended to prevent the co-optation of the developing profession by medicine and preserve for posterity an independent role for nursing. The ultimate effect resulted in nursing's initial association with Nightingale's sanitary mission and the laws of health as the scientific basis for legitimization (Christman, 1991, p. 210).

Despite Nightingale's dictum that her system of training required a strong theoretical component to develop a competent practitioner (Barritt, 1973, p.

45), the experience at St. Thomas reveals she was disenchanted with her ability to direct a nursing curriculum that consistently supported her ideas. She found herself confronting the prospect that her educational system would inadvertently circumvent her highest aspirations by producing graduates performing as medical assistants whose primary role would culminate in enhancing the outcomes of medical therapy rather than advancing nursing practice (Baly, 1986, p. 221).

Nightingale's inability to directly supervise what and how students were taught proved to be an enormous disadvantage. But, even if she possessed the full capacity of vibrant health, during the early years of the school she remained deeply involved in other humanitarian projects of crucial import. These included the care of the sick in the British workhouses, improving the sanitation of the army and the indigenous population in India, and decreasing the death rate from Puerperal Fever (Schyler, 1992, pp. 9-10). Actually, before the 1870s nursing occupied a small part of her time (Vincus & Nergaard, 1990, p. 206).

Undoubtedly the abiding problem had to be the fact that the curriculum would be directly influenced by the state of nursing in the 1860s. According to the account of a former student, Rebecca Strong, who trained in 1867, nurses had not yet assumed many of the advanced technological tasks; instead medical students took the temperatures and pulses while dressers managed the serious wounds (Baly, 1986, pp. 54-55). In fact all the early schools that followed based their curricula on a simple job analysis of hospital nursing. From this compilation students were directed to master the lists of bedside functions that Nightingale had drawn up at the start of her program (Murdoch, 1986, p. 16).

But as medicine became more scientific Nightingale became more conflicted about how much "pure medicine" students should learn, fearing that nurses would lose sight of the wider parameters of their domain.

. . . Miss Nightingale was not in favor of teaching nurses too much pure medicine, for she thought it would make them either intolerable from their knowledge, or miserable, presumably from seeing methods adopted which were not in keeping with the methods which they were taught were the best. In March 1873 she wrote . . . "The one extreme danger in these days is that nurses shall fancy themselves "medical women." (Cope, 1958, p. 23)

Nightingale envisioned nursing strictly as a gender specific discipline in the sense that she believed women of intelligence and high moral values were the best qualified to carry on its mission. As its acclaimed leader she jealously fought to maintain nursing as the one occupation women could excel in and achieve recognition without having to compete with the prerogatives claimed by other male dominated professions. She declared:

Hospital nursing is the only calling in the world where a woman is really in charge of a number of adults, men or women as if, nay, still more than if they were babies. For purposes of life and death they are as much in their power. (quoted in Schyler, 1975, p. 166)

For this reason Nightingale remonstrated upon learning that eligible women she hoped to recruit into nursing aspired instead to become physicians. When women were attempting to enter medicine on equal status with men, she interpreted this as a direct threat to her plans to bring educated women into nursing (Vincus & Nergaard, 1990, p. 361).

Nightingale was constantly facing two major challenges to her vision: how to constitute the structure and function of nursing as the highest order of feminine work and, the second interrelated factor crucial to her ideology, how to forge an identity that

would pose minimum conflict with physicians, yet be able to control distinctive areas of practice. In 1869 she wrote to her friend, Sir Henry Acland, a professor of medicine at Oxford, "Experience teaches me that nursing and medicine must never be mixed up. It spoils both . . ." (quoted in Baly, 1991, p. 68).

Patently Nightingale held the opinion that physicians had inadequate knowledge about the totality of patient care, rendering them unqualified to "control" nursing, but she came to face the fact "that the changing hospital situation made physician domination of the nursing profession something she had to accept" (Bullough, V. L., 1993, p. 256). The educational model Nightingale designed actually drew on a minimum of educational resources in terms of output from affiliating institutions; the hospital staff was used to form the part-time faculty. To the extent that the lectures had no specialized body of knowledge in nursing "available and ready to transmitted," it fell on the medical men who taught to develop the content (Davies, 1980, p. 104).

Nightingale knew what she didn't want: nurses whose education would simulate that of physicians, especially as it referred to the theory of bacterial

infection. Although she desired to keep an integrated nursing focus she had to acknowledge the circumstance of the paucity of formalized nursing knowledge and educational theories. What developed then was absolutely anathema to Nightingale's intentions: women educated in a medical mode who began to transfer its model as teachers to the less educated nurses and pupils (Baly, 1986, p. 24). But the differences between the two perspectives were not only difficult to explain they were not fully grasped by Nightingale's staunchest disciples either (p. 26).

Paradoxically as medicine grew more scientific nurses had to understand the increasingly complex treatments that were being transferred to them: "This need was met by more doctor's lectures, which were often modified lectures of medical students." Since the apprentice system of education was the primary mode of learning the Fund Council contract with St. Thomas consigned the probationers to fulfill roles as assistant nurses in the hospital wards. But the nature of their assignments would often negate their ability to understand the relationship of theory to practice. This happened because, as the schools that would follow this system, "Most of the ward instruction was

conducted through these ward experiences, and little attention was paid to either their sequence or the relative proportion of each of the experiences within the total curriculum" (Murdock, 1986, p. 17).

Seeing this "danger" to their education, Nightingale wanted to place a mistress of the probationers on the wards who would help the students to make this connection. To her dismay Mrs. Wardroper, the matron, and the hospital authorities foiled her plan. It became clear that the Nightingale [Fund] Council was powerless to enforce independent teaching for its probationers" (Baly, 1986, p. 222).

Other evidence suggests the mounting confusion surrounding interpretations about what should constitute nursing practice as it traversed the developing core curriculum of a training program. This notion is perhaps best illustrated in Nightingale's stark criticism of Mr. Whitfield, the school's first lector. When he created an elaborate plan to guide students in assessing medical and surgical patients she denounced it as suitable for medical students rather than nurses. The ensuing correspondence between Nightingale and Whitfield demonstrated the difficulty he had in determining the extent to which nursing and

medical histories should be distinctly different (p. 55). As early as 1863 the apparently exasperated Whitfield would go so far as to express direct opposition to the whole notion of introducing a nursing perspective when lecturing on medical cases (Cope, 1958, p. 112).

But this of course is what nurse training was meant to be about, dovetailing the nursing procedures with the symptoms of disease. Although Miss Nightingale was unclear about how to obtain her objective, she alone [emphasis added] seems to have had in mind a "nursing model." (Baly, 1986, p. 56)

It is curious that Nightingale initially tolerated these clashes but, as Cope (1958) illustrates, by the time Whitfield "took over the supervision of the medical part of the education of the probationers" he held a position of seniority within St. Thomas (p. 112). From the onset he seemed to undermine her plan for written assignments, having decided that the "combination of diary keeping and case note taking was impossible and beyond the mental powers of probationers who only needed simple instruction" (Baly, 1986, p. 56).

Gradually Whitfield would become more critical of Nightingale's training plan. His underlying attitude

was betrayed in a letter in which he conveyed "that for nurses 'on Sunday there might be a Bible class—all other classes should be ignored.'" (Cope, 1958, pp. 112-113). This was the last straw for Nightingale who, in 1872, was being privately informed about his neglect of teaching probationers. Interestingly, this information was supplied to her mainly through the educated lady probationers who were introduced later in the program (Baly, 1991, p. 81).

In frustration, the Fund Council let it be known that it was exploring the feasibility of taking the Nightingale school elsewhere. The possibility of withdrawing the probationers' service from St. Thomas gave them leverage to strike a compromise in selecting another medical lecturer and to finally create the position of home sister as Mistress of Probationers which could be filled with their own person (p. 81). The home sister acted as a tutor for the students, but she was forbidden, as Nightingale wanted, to enter the wards where the students were administering care (Baly, 1986, p. 179).

It is speculated that Wardroper, in essence turned down her request to have a qualified clinical instructor supplied by the Fund Council because it

would have exacerbated the tensions with the staff physicians who were focused on upgrading medical education.

Mr. Whitfield, for example, was probably reflecting his colleagues when he said that teaching probationers about case histories was objectionable. Under the old system the sister was accountable to the doctor, who taught her enough to carry out his orders, and there was appropriate male domination of women's work. . . . (Baly, 1986, pp. 172-173)

But to the extent that Lady Superintendents were already operational in many institutions, physicians viewed their authority to move nursing students from ward to ward as a conflict with the clinical training needs of medical students. Introducing a home sister in the wards would have meant that there was another woman not accountable to the physician in charge. They would not be perturbed if the goal of nursing education ended with making nursing "noble and womanly" work, however, Nightingale proposed that the women she arranged to educate understand the rationale for their practice. ". . . this invited questioning and was a challenge to medical power" (p. 173).

Henry Binham Carter wrote Nightingale in 1878 that the physician

. . . thinks his telling the nurse what she ought to do is nearly enough to perfect her . . . he requires to be told more distinctly than ever why

this is not enough and that no training can be sufficient where he is the principal. (quoted in Baly, 1986, p. 173)

Whitfield was forced to tenure his resignation by the Fund secretary and was quickly replaced by John Croft who had been elected to the senior surgical staff at St. Thomas.

Mr. Croft was enterprising and enthusiastic in his efforts to instruct the nurses. He drew up a proper curriculum and submitted it to Miss Nightingale for her approval. He not only lectured, but he arranged for other members of the staff also to give lectures. He advised the nurses what books to read to supplement the lectures. He used to ask them questions, though, as Miss Crossland [the home sister] reported to her chief, the questioning was not always to the point or vigorous enough. (Cope, 1959, pp. 113-114)

According to Baly, this was, to Nightingale's consternation, the true beginning of a medical rather than a nursing model as the theoretical basis for nursing education. Overall she feared the emphasis on pathology would deflect nurses from valuing those aspects of patient care that symbolized their legitimacy as a separate and necessary agent of health, namely the individualized holistic approach to patients, careful attention to sanitary principles and the raising of the "moral tone" of the hospitals (1990, p. 13).

While accepting the inevitable dominance of

medical science in nursing education, Nightingale was intent on maintaining as much control of the curriculum as she could. The correspondence between Croft and Nightingale confirms that he did consult with her on the smallest details which seemed to please her immensely. On March 24, 1873 she wrote an effusive note thanking him for the "Course on Reading" which he drew up conveying, "I entirely 'approve and more than approve.'" She indicated that the Fund would order whichever books were not already available.

Mr. Croft's Notes on Lectures (1873a) indicated he adopted an integrated system of learning that included Nightingale's sanitary principles as well as the technical aspects of nursing care. On the first page he lays out his plan.

A nurse is by thinking and acting for a sick person to help him or her get well. . . . You are to think for and act for your patient. Nursing does not simply mean making a patient neat and tidy, giving food and medicines and putting on poultices . . . and that sort of mechanical work.

In order for you to think and act for your patient you require knowledge, knowledge of a special sort. I shall try and impart some of that knowledge in this course of instruction—knowledge such as anyone standing between the doctor and the patient should possess. A knowledge of how to observe the sick. A knowledge of the art of fresh air, of cleanliness, of light, warmth, food. A knowledge of some medical subjects, and of some surgical subjects, besides a knowledge of the manual nursing which will

take up a great deal of your time. (Croft, 1973a, p. 1)

But the whole issue about the direction the curriculum should take was multifaceted. Consequently Nightingale became inconsistent in her views about what nurses should be taught. She expressed concerns that the better prepared applicants who were coming into nursing would choose other schools which were competing by offering more advanced lectures.

Hospitals were attracting the new middle classes who appreciated the new smart . . . probationers [while] young and ambitious doctors saw nurses as their assistants to be trusted with new treatments, measuring, testing, and observing, thus leaving doctors free for higher things. (Baly, 1990, p. 13)

Effects of the Hospital Apprentice System

It is an unremitting fact that the history of modern nursing is inseparable from the soaring expansion of hospitals as both submitted to and were inexorably influenced by the exigencies of scientific medicine. The early generations of nurses following the Nightingale era were bound to a work ethic that stressed duty and submission to authority. Administrators and trustees of hospitals looked to the establishment of training schools to provide a ready nursing work force that was once economically

parsimonious and efficient in meeting a higher standard of patient care.

The domineering influence of the hospital left an inheritance that would grieve Nightingale when she realized the success of her program become in reality a double edged sword. The structural changes she programmed through her educational system simultaneously elevated nursing and inadvertently predisposed its practitioners to the exploitation and harshness of hospitals as they acted to serve their own best interests. Still, because the new training schools she inspired reproduced ironhanded discipline and supervision, succeeding graduates, formed in "an atmosphere of obedience and conformity" became "the greatest obstacles to change" (Helmstadter, 1993, pp. 43-44).

Concern for mitigating and standardizing the behavior of probationers in the first training schools was determined in large measure by the entrenched class system in Britain. Victorians adhered to a traditional belief system that extolled the superiority of the upper classes from whom the chief sponsors of the early reform movement were drawn (Howlett, 1993, p. 2).

The students were to be thoroughly socialized into middle class values which have the effects of permanently separating them, not by class, but by virtue of their training, from the nurses of the old order and from the customary class links between nurses and patients of the mid-nineteenth century hospitals. "All the reformers shared Nightingale's view of the unsuitability of the lower class morals and behaviors of hospital nurses" (Helmstadter, 1993, p. 52). For this reason moral training became as important as the technical training of the new nurses. While our concern here is primarily on nursing education it is significant to understand that Victorians had an intense preoccupation with building a "popular character" which "permeated virtually every field of human nature, society, and public policy" (Wiener quoted in Helmstadter, 1993, p. 53).

From their perspective lower classes lacked sufficient moral discipline to bridle the primal instincts that were inherent in all persons. Victorians were specially concerned with the rise of illegitimacy and prostitution as increasingly large numbers of young people from the working classes filled jobs created by the expanding industrial economy. The

problem was attributed to the freedom with which the sexes could intermingle in factories and other workplaces, a situation that "undermined the old social controls of apprenticeship and other forms of youth dependence." The young in particular were seen as lacking self mastery over their passions. A strikingly similar predicament existed in hospitals where nurses were subjected to seduction by "not only the male patients but [also] porters, medical students, and house doctors." According to Victorian traditions more was at stake, however; they bemoaned the relative "freedom of action" women were experiencing as wage earners which placed "patriarchal authority in all classes" at peril (pp. 53-54).

In no area did the teaching of moral restraint and character building . . . have more importance than in elementary education designed for working classes. . . . The teachers approached their pupils in the same way missionaries approached the heathen in the empire—they wished to civilize them by teaching them Christian morality. . . . The ultimate aim . . . was the preservation of social order . . . teachers aimed at increasing church attendance, decreasing crime, preventing strikes and riots, and implanting the virtues of self-help, thrift, sobriety, and cleanliness in their pupils. Above all, the poor were to learn with the importance of submission to established authorities.

The new trained nurse received this type of education [emphasis added]. (p. 55)

Nightingale's keen appreciation for an ordered society was shaped by her Victorian belief in the virtues of obedience to superordinates which was markedly apparent in her leadership style as Lady in Chief during the Crimean War. Within the context of the social era in which she lived obedience was regarded as an important virtue by members of the educated classes. It was feared that if society was to survive the confusion and turmoil of rapid industrialization and urbanization, a strong respect for this virtue had to be inculcated in the working classes.

Religious orders promoted this principle by "enforcing blind, unconditional obedience through the fears and promises of the Church" (Nightingale, 1915, pp. 10-11). However, in contrast to the orthodox formation of nursing Sisters, Nightingale was steadfast in adhering to definition of obedience for nurses that was anything but blind or obsequious. What she desired was conformity to high standards of care which, she believed, could only occur when students of nursing are educated to understand the underlying rationale for directions given (Schyler, 1978, pp. 38-39).

Her address to probationers on May 6, 1881
underscores this point.

We need to remember that we come to learn, to be taught. Hence we come to obey. No one is able to teach who is not able to learn. The best scholars make the best teachers—those who obey the best rulers. We have to obey as well as command all our lives. (quoted in Vincus & Nergaard, 1990, p. 385).

To Nightingale's mind, because secular nurses have more freedom than their peers in religious life they are called to execute "greater individual responsibility, greater self command . . . greater nobleness . . . more discretion, and higher, not less, obedience. For the obedience of intelligence, not the obedience of slavery, is what we want" (1915, p. 11).

Nightingale hoped her system of education would prepare nurses to both collect empirical data on patients' health status and to make accurate inferences necessary to properly manage their care. Moreover she expected that if, in the nurse's judgment, the physician's orders were not reasonable, given the nature of the health problem or because of the changing effect of the sickness, the nurse would take appropriate action in the patient's behalf.

But, significantly, Nightingale never indicated in writing what nurses should do nor did she provide any

anecdotal information to illustrate how nurses could handle conflicts of this nature—although they were probably numerous. If anything, she leaned in the direction of conformity to orders, implying that the nurse's judgment in these matters had to be formed according to the standards of medical practice at that time—a paradox considering her own lack of confidence in the therapeutics of the mid-nineteenth century.

In this respect she may have used the word "obedient" to indicate that under her system it would be anathema for nurses to willfully defy medical orders or the instructions of their nursing superordinates in deference to their own individual and uninformed ideas—a frequent criticism of the lower class women, lacking formal education, who worked in hospitals and in the home as nurses.

But other scholars believe she wanted to maintain equanimity with physicians while specifically preserving areas of health care specifically under the control of nurses—thus insuring "autonomous nursing practice" (Rogers, 1993, p. 59). In her Notes on Nursing

Nightingale used "concise and precise" decisions as a means to exert her authority and control over

nursing practice and to hold her own with physicians. She used detailed recordings and observations as well as instructions to physicians as a means to control nursing practices. (Leininger, 1992, p. 34)

In 1897, when she was 77 years of age, Nightingale alludes to the proper way to handle conflicts.

If it is something which [the nurse] knows or fancies by experience disagrees with the patient, let her respectfully explain to the Doctor. There are very few doctors who will not listen to a nurse who talks gently and cautiously, like a woman who knows what she is about. . . . A Hospital Doctor constantly desires the Sister to report to him upon this or that. That is because she knows what she is about. (p. 13)

Parenthetically, there is another way of looking at the persistent injunctions to obedience that were repeated by early educators, matrons and sisters. Probationers from the working classes posed their own special problems, as well.

When one sees the magnitude of the problems that the nursing reformers were trying to solve, it is easy to see why they chose the system of nurses' training with which we are all so familiar. They had to fashion an efficient but low paid nurse out of an ill educated and undisciplined work force. The nurse had to be able to function in the new world of scientific medicine, and she had to meet the new demands of Victorian respectability as well as the stricter, more orderly, time-oriented discipline of an industrialized society. Even more important, she had to be able to meet all of these conditions in what was an unpredictable environment, namely, a hospital ward of acutely ill, unstable patients. (Helmstadter, 1993, p. 44)

The Nightingale model for revitalizing nursing and reordering the hospitals "was built on an uneasy alliance among concepts drawn from the sexual division of labor in the family, the authority structure of the military and religious sisterhood, and the link between her moral beliefs and medical theories" (Reverby, 1987, p. 41).

Two qualities set the new trained nurse apart from her contemporaries: she could be counted on to be educated to the latest techniques of contemporary medical practice and secondly, she would have undergone a rigid preparation in character formation.

The home motif, the family imagery, which permeated [the hospital] discipline was based on the middle class construct of the family with its divisions of roles and spheres, rights and duties, and clear distinction between the sexes. In the hospital world the doctors assumed the role of the father and in his absence . . . the functions of the new father were subsumed under the functions of the mother, the senior nurse. Obeying the senior nurses, ward sisters, nurse-tutors, matrons . . . meant that the trainee was the doctor's daughter. (Maggs, 1983, p. 15)

Nightingale deliberately cast the new order of nurses within a "hierarchy of authority and duties." She began by insisting that the nurses in training at St. Thomas work with, or in some cases subordinate to, the senior nurses of the old order at St. Thomas; "these women were actually to carry out the

instructions of the 'nightingales,' [sic] relieving them of every medical duty and freeing them for instruction by the sister and the matron and, of course, the doctors" (Maggs, 1983, p. 26).

As this arrangement evolved, the trained general nurse would become topmost in the hierarchy while the ward scrubber and the junior probationer were assigned the most menial ward duties that included cleaning washbasins, lavatories and sputum pots. Using the student in this manner was justified by the requirements that she demonstrate allegiance to the science of hygiene which became a salient feature of the new nurse (p. 26). As could be predicted hospitals eventually institutionalized these tasks exclusively within the domain of junior probationers rather than employ wardmaids.

But loftier aims fueled this new hierarchical arrangement and, ironically it began with Nightingale. Her dictum that the new trained nurse is trained to train and to lead axiomatically infers a system of control.

Control of others, be they patients, wardmaids or nurses-in-training, was the major role of the new trained nurse, but before she could control others by virtue of her training, she had to learn to control herself through that training. (p. 29)

In the sense that "[self] control was equated with moral character" the assignment of non-nursing duties were used to develop self discipline in the probationer (p. 29).

In Nightingale's scheme good nurse managers earn their right to lead by having demonstrated command of all the tasks they would eventually assign to those of inferior rank. More importantly, nurses who had been through the training were thoroughly inculcated with the scientific rationale for these tasks and could demonstrate their ability to manage their assignments efficiently. The price of this arrangement had consequences for the generations of nurses who followed, for while it established the trained nurse on a higher plain in hospital nursing, simple household tasks, as they become identified with the science of hygiene, assumed a direct association with the functions of the new nurse (p. 30). Nightingale was aggrievedly aware of the dilemma it created.

The "Professional Model" Fails

By the 1880s many of the lady probationers entering training schools had been exposed to collegiate education and private schools that offered them advanced academic education. Consequently they

began to demand a longer and more scientific training. These ladies sought a means to put nursing on a parity with the medical profession and thus increase its prestige (Abel-Smith, 1960, p. 64). There was genuine concern about the inequity of standards among schools of nursing, with the sense that their own status was seriously undermined by graduates of inferior schools.

Ethel Gordon Manson (Mrs. Bedford Fenwick) became the leader who rallied to their cause. Her background is typical of the ladies: she entered the Children's Hospital at Nottingham as a paying probationer at the age of 21 and after serving as a sister in a London hospital she was appointed matron of the St. Bartholomew's Hospital by the age of 24. Following her marriage to a politically connected physician she retired from nursing and devoted the next sixty years of her life to the organization of nursing as a profession. She became the principal player in the establishment of the British Nursing Association (Abel-Smith, 1960, pp. 61-62).

Nightingale unintentionally made nursing an attractive occupation for ladies who would over time enter the field in significant numbers. Many like Fenwick, took advantage of the brief privileged courses

offered by new training schools following which they filled key positions in the nursing world. In the final analysis they would wrestle control from the founder in determining the destiny of nursing in Britain. "She favored reform by example, but they chose to impose it by regulation." Abel-Smith (1960) notes that the ladies were armed with a "ruthless leader" who sought to raise the standards of education by mandating a uniform syllabus for all schools of nursing, lengthening the training to three years, and requiring that new graduates pass a "stiff" national examination (pp. 241-242).

The long and intricate struggle to obtain registration for qualified nurses—a battle which would last over 30 years—cannot be elaborated in the body of this study. Nightingale's opposition carried enough weight to guarantee that its promoters would have to wait until after her death to see it passed. As was her style, she had worked intelligently and thoroughly behind the scenes gathering the support of the Nightingale Fund Council, executive officers, matrons, and lady superintendents of prominent hospitals, as well as members of the medical profession (Baly, 1986, p. 200).

Many matrons and superintendents were wary of registration, fearing they would lose some of their autonomy when outside organizations determined their school's curricula. More threatening to some physicians and hospitals was the prospect of raising admission standards so high that the number of students available to staff the hospitals would be severely limited (Abel-Smith, 1960, p. 67). It is ironic that Nightingale's deepest concerns about the movement for registration for nurses revolved around her conviction that nursing needed to preserve two important characteristics that would later become embedded in the description of a profession among modern sociologists.

(1) She wanted assurances that those women who were identified as trained nurses would maintain the strictest requisites of moral integrity in the service of humanity. She couldn't foresee how registration could protect this quality.

. . . you may have the most admirable circumstances and organizations and examinations and certificates, yet, if the individual allows herself to sink to a lower level, it is all but a "tinkling cymbal" for her. It is how the circumstances are worked that signifies. Circumstances are opportunities. (quoted in Palmer, 1983a, p. 19)

Nightingale was fond of saying that a "good nurse must be a good woman" (1893/1949, p. 35).

(2) She obviously believed in the complexity of nursing knowledge which would continue to expand and make demands on its practitioners to maintain equivalent readiness to use it. Nightingale proffered that a system of registration might encourage stagnation because every nurse duly recognized at a particular stage of her career could lose an important incentive to continue intellectual development and skills refinement. "No nurse can stand still. She must go forward or she will go backward every year . . ." (quoted in Palmer, 1983a, p. 19).

As an alternative to registration, Nightingale would steadfastly adhere to her older idea that each training school maintain a register of the graduates it certifies. At St. Thomas after the student completed the year of training they were obliged to remain as the hospital's employee for a salary and after a period of three years could be reassigned to other institutions.

We do not give the women a printed certificate, but simply enter the names of all certified nurses in the Register as such. This is done to prevent them in the case of misconduct from using their certificate improperly. (quoted in Nutting and Dock, Volume II, 1907 & 1935, p. 198)

Through this method each school would become the gatekeeper in setting standards for nursing practice and for safeguarding the public from practicing nurses

who had been censured. Nightingale believed that each training school should keep in touch with its trainees and should be able to supply a complete register (Baly, 1986, p. 201). This system worked for a time, especially when Nightingale was sending her hand picked graduates who had been thoroughly inculcated with her methods to fill positions, but it would eventually prove impractical. By the early 1900s most British schools were granting certificates to their graduates following a lengthened training. The special probationers received a certificate after three years of training, while those who would become the hospital nurses had to undergo four years of schooling before they were qualified (Nutting & Dock, Vol. II, 1907 & 1935, p. 199). St. Thomas was one of the last schools to expand its formal training beyond the first year principally because Nightingale justly feared that hospitals would only further exploit the students' labor (Baly, 1986, p. 195).

It is significant that the matrons who came after Mrs. Wardroper made no attempt to change the pattern of training; the superintendent of nurse training continued as the matron of the hospital responsible for supplying a nursing service as cheaply as possible. . . . Matrons paid lip-service to the Nightingale system forgetting that Miss Nightingale had fought, and lost, the battle to give the probationers their own Mistress or Director (Baly, 1986, p. 223).

Nightingale was adamant in her belief that nursing is a calling and that nurses trained to her stipulations should, above all, be "devoted to a cause" (Shryock, 1959, p. 281). It was her "deep-seated convictions about the religious nature of nursing" that helped to crystallize the notion of nursing as an occupation that could be secular yet demand the same commitment to service as a vocation to the Sisterhoods (Palmer, 1983a, p. 19).

Admittedly, Nightingale's early writings shunned any identity of nursing with the notion of a profession, however in 1865 she did assert that the "study and practice of nursing as a profession" was a universal need "second in importance to medicine itself" (1954a, p. 234). By 1900, when she was eighty years old, she wrote a letter to probationers at St. Thomas in which she declared that "nursing has become a profession. Trained nursing is no longer an object, but a fact" (quoted in Palmer, 1983a, p. 18).

Just what professional status meant to Nightingale is not clear. There isn't any evidence that she ever considered incorporating nursing education within a college or university setting. This fact is irreconcilable with her strong desire as a young woman

to have a university education for herself. Her convictions led her to become a proponent for admission of women into academics. Indeed, in 1848 while Nightingale was 28 years old, Queens College, Britain's first female college, was opened in London (Palmer, 1977, p. 87). But, in 1893, her writings would continue to affirm "the patient's bedside" as the ideal place to learn nursing (1949, p. 24).

There are many mitigating factors that could explain this. First, nursing had not yet developed its own abstract body of knowledge with teachers prepared to teach on a collegiate level. Furthermore Baly (1986) observes that physicians would have felt sufficiently threatened to oppose collegiate education for nurses—especially since Nightingale and her followers had been highly successful in assuring them that nurses would not overstep the boundaries of medical practice. Finally, nurses had been imbued with the superiority of hospital training and would have opposed any movement to change the location of their education (pp. 222-223).

During the 1890s Fenwick and her sympathizers organized a short-lived course in nursing at St. Mungo's Medical College in Glasgow (Glaser, 1966, p.

10). It ran as a three month preliminary course in theory, following which an examination had to be passed in order to gain acceptance into the hospital school. Once in the hospital, the students had no further classes during the three years' training program. This became the forerunner of various kinds preliminary courses which would be instituted throughout Great Britain (Seymer, 1932, p. 155).

At a meeting of the Congress of the International Council of Nurses in 1901 Fenwick entreated "Is it too much to hope that the wealthy will come forward and fund colleges of nursing—colleges in which the teaching power of the profession will be focused and centered?" (quoted in Seymer, 1932, p. 157).

Nightingale made her position clear regarding her opposition to the professional model for nursing that was developing on both sides of the Atlantic. In a paper she had delivered to the International Congress of Charities, Correction and Philanthropy held in Chicago in 1893 she warned of the "dangers" that have arisen "after only a generation of nursing . . ."; these she saw these as practicing nursing for pecuniary interests and "Making nursing a profession and not a calling" (1893/1949, p. 32).

There is another danger, perhaps the greatest of all. . . . It is this: as literary education and colleges for women to teach literary work start and multiply and improve some, even the very best women, believe that everything can be taught by book and lecture, and tested by examination—that memory is the great step to excellence. (p. 33)

In her summary Nightingale makes a plea not to let nursing education turn into mere "book-learning and lectures—not an apprenticeship, a workshop practice" (p. 35).

Nightingale's strong opinion about judging prospective candidates for nursing practice is embodied in a letter from Dr. Southerland in 1872 in which he indicates his support for her views:

Now in all things nursing is the most clinical of arts. The doctor is the judge no doubt of the results but he is no judge, indeed he has no knowledge of the processes by which the result is arrived at. Only the living practiced Superintendent can do this. . . . It might happen that a really good diffident nurse might not be placed on the register, while a forward glib bad nurse might pass the examination.

Although the advocates of registration and uniform standards for schools of nursing realized these victories, the professional model the ladies assiduously pursued was essentially defeated. The law that was eventually passed was actually more in line with the egalitarian ideals Nightingale held fast to at the onset. Militant lady nurses wanted to change the

demography of nurses to resemble the privileged class of women. If the ladies would have achieved all their aims the admission to approved schools would be limited to only the most educated women. They also planned to have all stipends for students suspended; that would have had the effect of eliminating the working class from the ranks (Able-Smith, 1960, p. 63).

These measures, which would not only change the class composition of hospital nurses but would have further exacerbated an acute national nursing shortage, failed to get the political support from Parliament that it needed. (See Able-Smith, 1960, Chapters 7 and 8). In essence, the Nightingale system, with an apprentice training under the direction of a strong matron, would be the prevalent education model well into the twentieth century (see Davies, 1982, pp. 125-128).

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CHAPTER VIII

Adaptation of Nightingale's Reforms

Approach in America

When the Nightingale reforms in nursing moved to America they were met with huge success in terms of transforming the care of the sick in hospitals and in the community. Physicians gained in prestige as they used the clinical skills and professional deportment of the new nurses to further their medical ambitions. The most visible and paradoxical aftermath, however, was the loss of opportunity by nurses to direct their own educational programs. Although trained nurses became unexpendable to health care, neither ample private nor governmental funds were made available to sustain their schools. Consequently the education of nurses became inseparable from the mission of the hospitals that trained them. Hospitals in turn, would, through their medical staff and administrators, carefully circumscribe the content of nursing education and practice. This was at direct odds with Nightingale's vision of autonomy for nurses in their own sphere of education and practice. The dynamic of this phenomenon was aided in no small measure by the gender and class origins of the nurses.

The emergence of the trained* nurse was credited with being a major factor in revolutionizing the care of the sick in the hospital and in the home (North, 1882, pp. 38-47). In 1911, Polk, a physician, acknowledged that three forces united to elevate the status of medical care: anesthesiology, bacteriology and the training school for nurses (p. 358). In his address to the 24th Bellevue Hospital graduating class of nurses in 1898, Dr. Samuel Alexander's comments were equally praiseworthy:

At the present time the public at large and especially those of the present generation look upon trained nursing of the sick as a matter of course, and cannot realize the wonderful change that has taken place for the relief of suffering humanity. . . .

It is difficult to appreciate the impact of educated nurses on the quality of health care without examining the antecedents in terms of early societal attitudes, patterns and norms in caring for the sick and needy. Much of the early reform movements that brought about improvements in the care of the sick were largely the work of organized state charities and philanthropic groups struggling to deal with the

*The use of the term "trained nurse" in the body of this study is drawn from the descriptive literature of the time. Contemporary usage would refer to "educated" nurses.

problems of rising indigent populations, particularly in the cities of the northeast.

The Poor in Early America

Contrary to popular belief, there were significant numbers of poor persons in the colonies who were dependent on public assistance or voluntary charity. Almost all of the colonists were of moderate means, if not poor, when they arrived in this country. Many were indentured servants shipped out of England as paupers, vagrants, or convicts. Most paupers were widows, orphans, and the sick, old and invalid persons. English courts deported demented persons and children from the poor houses who were forced into involuntary servitude for a number of years.

In the south, orphans and illegitimate children constituted a major portion of the indigent population. Many were born to African-American, Indian and mulatto women, as well as white servants, who were not permitted to care for them. In the eighteenth century, impoverished slaves and freed mulatto servants added to the number of the poor.

The principal occupation of the colonies was farming, much of it for subsistence rather than for the production of cash crops. People readily became poor

when wars created widows and fatherless children. Storms and fires occasioned other emergency needs (Coll, 1970, pp. 17-18; Friedlander, 1968, pp. 63-65).

By the 1830's the poor, who lived in East coast cities, became the objects of organized charities designed to improve their moral state, as well as their health. Energized by the notion that poverty in the United States could be eliminated, American Protestantism brought forth philanthropic projects, such as soup kitchens, dispensaries for medical care, and Bible societies (Rosner, 1982, p. 359). Up until this time private charities played an insignificant role in providing for the poor (Friedlander, 1968, p. 66).

Following the logic of the English Poor Laws Report of 1834 and the arguments of Secretary of State of New York, John V. N. Yates, Americans accepted that almshouses and workhouses were superior to giving home relief in motivating the poor to become productive and moral individuals. By 1860, owing to legislative endeavors, few localities in the country lacked almshouses (Coll, 1970, pp. 21-22; Starr, 1982, p. 150).

Admittedly, almshouses did not have the effect of improving the conditions of the poor. Indigent families who were supported in their own homes and persons who were boarded out to families could find themselves forced into almshouses. The almshouse inmates consisted of the old, sick, blind, epileptics, deaf-mutes, insane, children, prostitutes and criminals forced to live together without segregation of sexes or ages. There were no sanitary facilities; no funds were made available for the education of children (Friedlander, 1968, p. 70).

Port cities experienced epidemics of extreme proportions, largely the result of infections brought in by sailors and the fleas of ship rodents. In New York City diseases, such as yellow fever, plague, and smallpox, spread rapidly through the crowded, unhealthful environments where the poor lived, as well as in the almshouses and jails. During one yellow fever epidemic, sixteen women inmates, who performed the nursing in the infirmary of one such institution, died of the disease. Infected sailors, whose only domicile in the colonies was the ship, were sent to a pesthouse on Bedloe's Island (Giles, 1949, pp. 43-47). Eventually almshouses became the only institution to

care for the sick poor (Bullough & Bullough, 1969, p. 120).

Emigration from western Europe increased dramatically (six million between 1820 and 1860) during the pre-Civil War period. Many of the immigrants arrived ill from the overcrowding and unsanitary conditions on the boats; afterward no small number would suffer industrial accidents while building canals and railroads. For these the almshouse was, in part, a free hospital where they could stay until their health was restored. At other times, able-bodied men found themselves unemployed during seasonal slacks in some occupations. They, too, were forced into almshouses (Coll, 1970, p. 23).

Immediately following the Civil War, America was in an energizing industrial economy. The four decades preceding 1900 realized a population increase of 13.7 million. Within this increase, substantial numbers of Italian and Eastern Europeans swelled the ranks of immigrants so that nearly a quarter of the population of the industrial northern states was foreign born.

Social turbulence followed the burgeoning effects of developing industrialism. The rearrangement of family and community patterns around the industrial

imperative was particularly devastating to the sick, poor and weak. In addition, migrants from failing farms joined the ranks in factories, shops and stores.

Poverty, if not more widespread, became less tolerable as the lot of the laborer—often managing a subsistence with the help of wages from his wife and children—contrasted with the conspicuous consumption of the growing rich class. Nonetheless, Americans idealized material success. In a laissez-faire economy Social Darwinism became the prevailing philosophy of the post war period, resulting in public policies that worked against the poor, particularly the immigrant (Baer, 1985, p. 32; Brown E. R., 1979, p. 17, Coll, 1970, pp. 41-43).

Early Care of the Sick

Members of pre-industrial, small-town communities customarily possessed a wide range of skills and self confidence in dealing with their particular needs. Americans coped with problems of illness within the confines of their own families and local community; physician services were rarely required. For the most part early colonial families lived without hospitals, medical schools, or religiously inspired nursing orders. Good neighbors could be counted on to help each

other when accidents and illness occurred. Health care was self care, with much information passed on in popularly read textbooks (Austin, 1957, p. 362; Fitzpatrick, M. L., 1983, p. 7; Giles, 1949, p. 32, pp. 18 and 32).

Some early colonies engaged physicians to attend the poor. In New York the city paid for the maintenance and nursing of pauper patients who were boarded out to families (Friedlander, 1968, pp. 70-71).

Nursing Prior to Reform

In contrast to physicians, nurses had a ubiquitous presence in early rural and urban America.

As in Britain middle-class Americans did not practice nursing in the home for pay (Fitzpatrick, M. L., 1983, p. 7). Inevitably the task of caring for family members fell on women, as both an obligation and a deeply shared religious belief, that they were endowed with a capacity for self-sacrificing services to those in need. When a family member became sick any female relative, whether at home or at a distance, could be called to serve for the duration of an illness or until death ensued. But as far back as the colonial period a family could avail itself of the services of outsiders, hired for pay, to fulfill this duty when

circumstances warranted it (Reverby, 1987, p. 14).

In addition to midwives, who frequently acted as nurses, every physician had two or three nurses on his list who could be hired to care for the sick in their homes. The training of these nurses was essentially by experience (Giles, 1949, p. 32; Jones, 1902/1962, p. 71).

The idea of a nurse requiring formal training and education to care for the sick was beyond the comprehension of even progressive and enlightened minds. The nurse in colonial New York was essentially a servant, a trusted one in many instances to whom her patients might be later grateful for devotion, tenderness and faithful care. . . . If she was good she might be very, very good. If she was not good she could be as fatal as the disease. (Giles, 1949, p. 32)

Around the nineteenth century, nurses were listed in community directories in eastern United States, offering evidence of recognition of nurses as a separate occupational group (Austin, 1957, pp. 336-337).

In 1855, a Harvard-educated physician, Alfred Worcester, described a typical untrained neighborhood nurse whom he felt was sometimes maligned without justification:

. . . not only would she do the strictly nursing work in caring for the patient, but also delighted [emphasis added] in doing the family wash before breakfast, ironing in forenoon, and the mending before or after nightfall, with a baby on her lap.

Much of cooking and general housework she would do between times . . . nor were her patients ever neglected. (quoted in Austin, 1957, p. 338)

The notion of "born nurse" was prevalent during this time; the term usually designated the nurse in the country district known for selfless devotion for the sick. Born nurses were summoned for any emergency and generally served without monetary compensation. Since she was frequently called without reference to a physician, the born nurse became his colleague in some respect. This is further supported by the fact that even if a physician was involved in a case, the born nurse felt free to directly contradict his instructions. On the other hand, in the cities nurses who were employed in the home were largely reliant on physicians to call them for acute illnesses such as pneumonia and typhoid and obstetrical cases. These nurses learned to be "good" by obeying the doctors to whom they owed their living (Jones, 1902/1962, p. 72; Fitzpatrick, M. L., 1983, p. 7). Others were more independent and substituted their own treatments when they felt it was appropriate (Giles, 1949, p. 46).

One must keep in mind, however, that throughout most of the nineteenth century, medical education and practice were extremely diversified and, in some cases,

almost totally lacking in standardization. Nearly all American physicians received their training from other practicing physicians. Few physicians had prior general education. In 1800 only three schools (Pennsylvania, Dartmouth and Harvard) offered supplemental medical lectures. The graduates of these American schools, as well as those who were wealthy enough to study abroad, formed the medical elite. While the elite physicians tended to practice in eastern cities among the wealthy, most Americans consulted herbal practitioners. It is uncanny that the privileged classes were probably at a vast disadvantage because of this arrangement, for it wasn't until the turn of the century that regular medicine could offer substantial hope of curing disease. Furthermore, the heroics that were used to treat patients were vastly unpleasant and often lethal. Bleeding, violent purging with Calomel (chloride of mercury), and blistering were their standard treatment. Herbalists, at their worst, rarely caused any harm (Brown, E. R., 1979, pp. 61-62; Starr, 1982, pp. 81-82).

Up until the middle of the nineteenth century, the typical American hospital was a largely undifferentiated welfare institution whose patients

were socially marginal, overwhelmingly poor, and often without roots in society. In northeastern cities with substantial immigrant populations (Boston, Philadelphia, and New York) the vast majority of hospitalized patients were likely to be foreign born. Most health care for all other segments of the population took place in the home. Some city dwellers, who were too poor to afford medical care, could receive gratuitous service of a physician in a dispensary or in their homes (Vogel, 1979b, p. 105).

History stigmatizes the hospital . . . it evolved from the almshouse and pesthouse, institutions in which the welfare of the patient was often secondary to the well-being of society that required isolation. Further, hospital care in the pre-antiseptic stage might be life-threatening . . . (p. 106)

Historian Susan Reverby places the mid-nineteenth century nurses in America "very near the bottom" within the hierarchy of paid labor (1987, p. 22). The bulk of the care fell to nurses and orderlies who worked under the direction of a head nurse. All lived in the hospital, however extra nurses might be brought in from the outside on a daily basis if assistance was required (pp. 26-27). As in England before the reform, "nightwatchers" stayed with the patients from late evening until dawn. "Class and position linked the

hospital's patients and workers together as much as it divided them from the trustees, matrons, and physicians." For even when nurses were not the actual or former patients they shared the same poor and working class backgrounds as the patients who used the hospital (p. 27).

In an effort to save money, many early municipal hospitals used inmates from the jails and poorhouses to perform nursing duties. While planning the Pauper Hospital in New York City (now known as Bellevue Hospital), city counselors were reminded by a crusading physician that staffing needs could be met by a ready supply of women consigned for vagrancy, drunkenness and prostitution (Giles, 1949, p. 48). More often these "helpers," who included convalescing patients, were supervised by a lone untrained nurse from the lower classes (Hobson, 1916, p. 82).

Religious groups played an important part in supplying nurses with various kinds of training for the care of the sick. Most prominent were the Sisters of Charity, founded by Mother Seton in Emmitsville, Maryland, the Episcopal Sisterhood, also founded in America (known for establishing St. Luke's Hospital in New York City), the Lutheran Deaconesses from

Kaiserwerth, Germany, who settled in Pittsburgh, and the Sisters of Mercy who reached the United State in 1843 and established hospitals in various states (Austin, 1957, p. 304; Bullough & Bullough, 1969, p. 121).

Several images of pre-reform nursing in America evolve from these brief descriptions. It can be viewed as: (1) an obligatory function of females in a household, (2) an act of voluntary humanitarian community service on the part of "born nurses," (3) involuntary servitude of women criminals and paupers, (4) an occupation for lower class women, or (5) a response to a religious calling.

Nurses had various degrees of knowledge and skill based almost exclusively on information passed on from folklore, other nurses and the physicians with who they had contact. Yet in spite of their varied backgrounds, hospital nurses from this era have been notoriously maligned in history leading Reverby to counter:

. . . not all the nurses, even in the worst hospitals were the immoral and inexperienced semi-alcoholics so bitingly satirized by Dickens in Sairey Gamp and Betsy Prig in his novel Martin Chuzzlewit. Many women (and much of the hospital workforce was women) became permanent employees and stayed on their job for many years. They learned and accumulated some skills on the job and gained what one historian has called an 'ad hoc' professionalism. (1981, p. 221)

Consonantly a recorded History of the Bellevue Hospital Training School documented that prior to 1873:

The nurses appointed by the Commissioners of Charity were ignorant of the most elementary principles of nursing art, and whilst some were decent women the larger number were brought in from Blackwell Island where they were sent as vagrants, or paupers, or prisoners, and many could neither read nor write. But they were not devoid of kindness and good will, and through reports of neglect were numerous, those of cruelty were rare. Their work was hard, their service long, their food very poor. (1899)

Early sporadic attempts at nursing reform were instrumental in bringing about some kinds of formalized training to a very limited extent.

Charity Movement Lays the Groundwork for Nursing Reform

Eventually a growing charity movement in the United States created major changes in the system of nursing through educational reforms. The dynamics are examined in order to understand more clearly how this came about.

Deplorable conditions in almshouses led to initiatives by private charity societies in establishing orphanages and specialized institutions for the blind, deaf, and crippled. The intended effect separated children and invalids from criminals and the insane. Usually these societies were affiliated with

churches, fraternal orders or national benevolent associations. Together they became the leading progressive element in American social welfare. The state governments assumed responsibility for the other classes of poor by creating facilities to care for the convicted offenders and insane (Friedlander, 1968, p. 72). The rise of multiple institutions, including hospitals of various kinds, resulted in a chaotic state of administration. Eventually State Boards of Charity (and Correction) were legislated in most states to coordinate services and prevent duplication and waste (Friedlander, 1968, pp. 86-87; Giles, 1949, p. 59).

As a microcosm of public response to the needs of the poor, New York offers a rich history of voluntarism exemplified by such agencies as the Association for Improving the Condition of the Poor (AICP) in 1843, and the New York Society for the Prevention of Pauperism in 1917. The former group divided the city into 21 districts with 225 subdistricts, each of which had its own "friendly visitor." In 1873 New York organized its own Charity Organization Society (COS) based on the London COS. Later, other states would follow in an attempt to coordinate health and welfare services within the state (Friedlander, 1968, pp. 88-90).

The founders of these societies represented "bourgeois benevolence": wealthy citizens felt a moral obligation to help the poor, and by doing so, they hoped to prevent social unrest.

As one can understand, the visitors under COS were at first influenced by the prevailing philosophy that poverty was caused by personal fault. But this philosophy didn't hold up under empirical scrutiny of the poor in their own environment. Eventually the visitors reached the same conclusion as the AICP of 1843—that personal fault did not stand the test of honest analysis. As a result, organized charity moved in the direction of promoting legislation to create social change by quelling the major injustices visited on the poor; those involved became entrenched in preventive health issues, hospital reform, creating visiting nurse services, as well as establishing training and rehabilitation centers for the handicapped (pp. 90-96).

An even closer microscopic view can demonstrate how nineteenth century voluntary philanthropic groups originated, as well as their adaptive capacity to evolve into official and semi-official agencies for the purpose of institutionalizing reforms in health care. The analysis underlines the fact that major reforms in

American nursing arose on the back of hospital reform. This is in sharp distinction to Nightingale's approach which sought to reform nursing in its own right.

In December 1860, while on a sick call to Louisa Schyler's mother in Tarrytown, New York, Dr. Parker secured a promise from the young Schyler to visit the local poorhouse in Westchester County. AS the great granddaughter of Alexander Hamilton, Schyler's life, up until this point, had been the typically sheltered, protected existence of an aristocratic woman in her early 20s. Dr. Parker was a member of a committee operating under the permanent State Board of Charities whose task it was to visit the almshouses. He was deeply disturbed by the neglect of the inmates (Giles, 1949, pp. 58-60).

As it turned out, the Civil War broke out in April 1961. Responding to a call by President Lincoln, Ladies Aid Societies and Soldiers Aid Societies sprang up over the country. One particularly strong group was the Women's Central Relief Association (WCRA) organized by Dr. Elizabeth Blackwell at her New York Infirmary for Women and Children. The group, comprised of leading ladies of New York's women's right movement,

had put forth an agenda that included the training of nurses to attend soldiers. While coordinating other such women's groups in the nation, the New York Association sent a delegate to Washington, D.C. They were joined by the Board of Physicians and Surgeons of New York Hospitals, as well as the Medical Association for Hospital Supplies, in a joint appeal to President Lincoln to create an official national commission.

The Secretary of War in Washington contracted Nightingale for help, which she generously provided, in organizing the hospitals and the care of the sick and wounded. In June a Sanitary Commission was appointed with the WCRA acting as a subcommittee. It went on to duplicate many of Nightingale's accomplishments in the Crimea—including the introduction of female nurses into the military hospitals. Moreover, her writings were frequently referred to and quoted directly in the medical journals as a guide for those who were managing the northern troops (Bullough & Bullough, 1969, p. 126; Giles, 1949, pp. 61-63; Woodham-Smith, 1951, pp. 255-256).

Louisa Schyler plunged into the war work of the committee, becoming widely known as a competent organizer and director. At the war's end she was

finally able to keep her promise to Dr. Parker. Schyler visited the Westchester County almshouse and afterward she would obtain permission to visit Bellevue Hospital. Since she was accompanied by the Commissioner of Charities (Bowen) on her inspections, she was able to gain his support in undertaking beginning steps at hospital reform. The dreadful conditions of these institutions prompted Schyler to at first organize the Visiting Committee for the Hospital (also referred to as Ladies Committee for Bellevue Hospital). Later on a similar committee was formed to visit the almshouse in Westchester. Schyler drew heavily on some former colleagues of the Sanitary Commission for assistance.

With philanthropic visions broader than serving the public hospitals, Schyler organized the State Charities Aid Association (SCAA) which maintained a Committee on Hospitals. She used her social class and influence to win legislation authorizing members of the SCAA to visit all public hospitals and almshouses. Their goal was to keep a detailed account of all that was seen and heard on these visits in order to gather information that could be used to initiate improvement in the care of the indigent sick (Giles, 1949, pp. 67-

72; Hobson, 1916, pp. 79-80). With the legal threat of a \$250 penalty imposed on any person in charge who refused the visitors, their access to the institutions was secured. (Second Annual Report of the Visiting Committee for Bellevue and other Hospitals, Feb. 1, 1874, pp. 7-8.)

Another important player emerges in this crucial moment in the history of nursing reform. Young Elizabeth Hobson was invited to that fateful January 1872 meeting at the Schyler home when the Committee for Bellevue and other Public Hospitals was born. Uninitiated in the horrors of public hospitals, Hobson nearly fainted and had to leave during her first visit as chairperson of the subcommittee to visit the surgical wards for women at Bellevue Hospital. She dutifully returned the next day, and through subsequent visits, completed a report that chronicled: ill fed, ill clothed, filthy patients, putrid smells, accumulated garbage, rampant infections due to contamination of wounds by physician house staff, rats scampering over the floors at night, and unattended patients found dead in the morning because the night watchman failed to notice them and call a house doctor (Giles, 1949, pp. 72-79; Hobson, 1916, pp. 82-85).

A notation in the Visiting Committee minutes of April 11, 1872, refers to the involuntary servitude of almshouse inmates and convicted criminals in hospital service:

One, if not the chief question of difficulty to solve at Bellevue is that of the labor—people who are forced to work without pay will naturally do as little as they can—we all know that where slavery exists twice if not three times as many servants are required . . . these women are not only slaves but criminals so that there is the additional problem of immorality to contend with.

Of course these findings were the ammunition Schyler needed to begin to pressure authorities for a training school for nurses at Bellevue Hospital.

Converging Social Forces Lead to

Nursing Reform

Reform in American nursing came about through a synthesis of converging forces: (1) The American women's rights movement that rallied behind the need to improve patient care and to increase occupational horizons for women, (2) the experience of the Civil War whereby volunteer female nurses demonstrated the need for preparation in the care of the sick and wounded, (3) public acclaim for Florence Nightingale's accomplishments in reducing morbidity and mortality of hospitalized patients in the Crimea and London by

instituting a series of changes in the practice of nursing based on learned theories as well as acquired skills, (4) the growing recognition on the part of the public and some physicians that educated nurses were essential to positive therapeutic outcomes of medical practice, and (5) the increasing importance of the hospital as a matrix of health care services for all classes in society necessitating a ready core of disciplined nurses.

"The most effective leadership for reform in nursing practices . . . came from women interested in the struggle for women's rights" (Bullough & Bullough, 1969, p. 121). Although there were forerunners to the American women's rights movement, the 1848 Convention at Seneca Falls, New York is used to mark the beginning of the campaign. Its platform included a statement about eradicating the exclusion of women from various professions, most particularly medicine (p. 121).

Women in the nineteenth century had an unprecedented pattern of cooperation with each other in all-female voluntary organizations.

One reason for this proliferation of women's groups was the sense of a special female identity created, or at least intensified, by the gap between men's and women's experiences and responsibilities in an increasingly specialized urban and industrial economy. (Ameny, 1983, p. 14)

Dr. Elizabeth Blackwell's breaking of the medical barrier by graduating from Geneva Medical College in New York (1849) is well known. Following post-graduation study in Europe, Dr. Blackwell returned to New York only to find most hospitals would not grant her a staff appointment. Undaunted she opened the New York Infirmary (1857), a hospital for women staffed entirely by women. (Two other doctors assisted her: Emily Blackwell, her sister, and Marie Zakrzewska, a midwife from Berlin, both of whom, after considerable difficulty, were able to obtain medical degrees from Western Reserve.) The hospital charter granted Blackwell the right to care for the indigent sick, as well as to graduate women physicians and train nurses.

Blackwell's school, however, had limited training for nurses, the course being only four months in duration. Dr. Blackwell noted that nursing was such an unpopular type of work that it didn't attract high-quality students. She also bore some of the responsibility, feeling that because she had to devote so much of her time and energy to maintaining exemplary standards at the Infirmary, she neglected the nursing program. Nonetheless her work inspired upper-class women in Philadelphia and Boston to organize hospitals

where women had the opportunity to obtain medical and nursing training.

Marie Zakrzewska later founded the New England Hospital for Women and Children in 1862. (The hospital and school moved from Boston to Roxbury, Massachusetts in 1872). Linda Richards (1841-1931), and important early leader in nursing, graduated from the school, claiming the title of America's "first trained nurse." Although there were earlier graduates of the New York Infirmary, the nurses in Dr. Zakrzewska's school followed a course of one year (Bullough & Bullough, 1969, pp. 121-124). Later, Richards was to supplement her education with study in England in a Nightingale School (Roberts, 1964, p. 9).

The need for nursing schools was recognized by physicians and laypersons alike even before Florence Nightingale's Notes on Nursing had a major influence on American women (p. 8).

The Shattuck Report of 1850, given before the legislature of Massachusetts, advocated for nursing education proclaiming that ". . . bad nursing often defeats the intention of the best medical advice, and good nursing supplants the defects of bad advice" (quoted in Roberts, 1964, p. 8).

Shortly after the Civil War, Dr. S. D. Gross, founder and president of the American Medical Association (AMA) announced at a meeting in 1869: "It seems to me to be just as necessary to have well-trained, instructed nurses as it is to have intelligent and skillful physicians" (quoted in Bullough & Bullough, 1969, p. 128).

This led to the formation of the AMA's Committee on the Training of Nurses which Dr. Gross chaired. One year later its report concluded: "Thousands of human beings are daily lost by bad nursing. . . . Nursing, in its more exalted sense, is as much of an art and a science as medicine" (Gross quoted in Austin, 1957, p. 429). The committee envisioned district schools throughout the Union, placed under the guardianship of County Medical Societies which would be responsible for didactic instruction (p. 430). However, neither of these dynamic pronouncements actually produced any concerted action (Roberts, 1964, p. 9). Most likely it was the nascent AMA's lack of power and influence among the majority of physicians and society at large that prevented it from carrying out its agenda.

In 1871, two years before the first Nightingale Schools were opened in America, Godey's Lady's Book and

Magazine espoused professional education for nurses in its editorial. Some of the concepts expressed by its editor were very progressive even by contemporary standards:

There can be no doubt that the duties of sick nurse, to be properly performed, require an education and training little, if at all, inferior to those possessed by the medical profession. . . . Every medical college should have a course of study. . . .

When once the value of the "graduate nurses" became known . . . the demand for them would be very great. (Hale quoted in Austin, 1957, pp. 431-432)

Sarah J. Hale, writer of the editorial, was an advocate of education of women. The magazine itself had a strong influence on women's fashions and manners (Austin, 1957, p. 431).

Impact of the Civil War

The impact of volunteer female nurses on both sides of the Civil War guaranteed that nursing would become a respectable occupation for women. Not only did it give women from middle and upper classes entry into hospital work, many earned such names as "Lady," "Angel," "Mother" (Bullough & Bullough, 1969, p. 128). The Sanitary Commission provided a corps of nurses, salaried by the government, who served under an appointed superintendent, Dorothea Dix, renowned for her reform in mental hospitals but who was not a nurse.

Unfortunately, during the course of the war, Dix proved not to have the administrative ability needed, leading to the placement of volunteer nurses under the exclusive direction of medical officers (Bullough & Bullough, 1969, p. 127; Roberts, 1964, p. 10). The reluctant physicians were forced to use them since male nurses were sorely needed for fighting. Some of the women had difficulty negotiating their social status with the tasks demanded of nursing thereby causing discipline problems. For the most part, however, these nurses came to the service of their military patients even though they possessed little or no preparation for their work.

One woman from a prominent family in New York described her first assignment: "I shall never forget the hopeless state of my mind at that exact point. To be left standing in the middle of a long ward full of beds, full of sick men—it was appalling!" (Woolsey quoted in Austin, 1957, p. 389).

Nonetheless the experience contributed to the heightened public interest in nursing. Moreover, many recalcitrant physicians joined in acknowledging the value of female nurses in military hospitals. In 1861, the American Medical Times published this favorable

account: "The presence of these ladies has demonstrated that there are numberless little essential things essential to the care of the sick, which not one man in a thousand ever thinks of . . ." (quoted in Austin, 1957, p. 383).

This same editorial continued to argue that certain general civilian hospitals entirely managed by female were extraordinary. Referring to the nurses in one, it adjudged that they ". . . were educated, intelligent, and refined, and many of them were from the highest ranks of society" (p. 384). The editors extolled the nurses' skill, dedication, and thorough preparation by systematic training. Later, the article revealed that the nurses under discussion were the Sisters of Charity, thereby indicating the significant role religious communities played in furthering the cause of nursing reform (p. 385).

In actuality, over 600 Catholic Sisters from twelve religious orders served during the war assuming nursing duties in some of the largest government hospitals assigned to them. As a group they became recognized for their selfless devotion and skill. Outside of religious orders almost no nurses had any serious preparation for the demands of their work

(Dolan, Fitzpatrick, & Hermann, 1983, pp. 172-173).

The following account of a young volunteer from Fredericksburg, Virginia, reveals the enormity of their work as largely untrained nurses in a poignant letter written in 1864:

I was the first and only Union woman in the city. . . . today . . . some of Miss Dix' nurses came thru [sic] . . . We calculated that there are 14,000 wounded in the town . . . I . . . have worked harder than I ever did in my life; there was no food but hard tack to give the men so I turned in and dressed their wounds. (Hancock quoted in Austin, 1957, p. 408)

Influence of Florence Nightingale

It was these kinds of experiences that later reformers, such as Louisa Schyler, brought to the post Civil War period. Equally important, educated women were becoming familiar with the writings of the charismatic Florence Nightingale. Early reformers would use the success of the Nightingale education model in England as an argument for establishing schools of nursing here.

Elizabeth Hobson, in her Recollections, recalled:

One day, on my way home (from Bellevue Hospital) I stopped by a booksellers and ordered Miss Nightingale's works and some treatises on hospital management. These I studied, and with members of my committee visited the hospital constantly. We had learned a great deal that month. Miss Nightingale's papers had taught us what was required and what ought not to exist in a

hospital. But oh! how low our standards were;
how much we had to learn and act up to . . .
(1916, p. 84)

Louisa Schyler had a hidden agenda not shared initially with her powerful Visiting Committee. Even before the Committee assemble, she had already exposed her goal to Charity Commissioner Bowen for radical improvement in Bellevue Hospital's nursing service through the establishment of a training school for nurses (pp. 87-88). Several months later, as Schyler had plotted, it was Hobson's report to the entire Committee about the inhumane conditions of the Women's Surgical Wards that won unanimous support for the project (pp. 90-91).

But getting the approval of the medical community was not as unencumbered. Although the Ladies had the devoted support of some, clearly the majority was threatened by the prospect that educated nurses from the middle class would not do as they were told (p. 91). By the time the Medical Board had appointed a committee of four to confer with them on the subject, the women had already planned a strategy to get public support. Articles were prepared for newspapers—some had already gone into print—and a pamphlet for circulation in New York and neighboring states was

planned for the coming month. (Visiting Committee Minutes, November 24, 1872).

It is significant to note that many physicians, especially young house staff, gave full cooperation to the Committee in securing the data they needed at great personal risk of dismissal (Hobson, 1916, p. 92). Several physicians on the Hospital Board eventually became renowned for their labors on behalf of the school. One of the most prominent is Dr. W. Gill Wylie who, at the age of 23, used his own funds to go abroad and study other schools of nursing. On his return he produced a personal letter from Florence Nightingale that contained her advice on the organization of a training school and the distinction between nurses and medical women (physicians) (Hobson, 1916, p. 94; Wylie, 1897).

Even with these important victories the committee frequently found itself in adversarial role with physicians. The Annual Report of the Visiting Committee on February 1, 1874 exposed the inhuman conditions of Charity Hospital situated on Blackwell's Island with the added proviso concerning the lack of involvement of physicians in the total welfare of patients. It noted, ". . . if each physician would

conscientiously exercise a rigid supervision over his own department and boldly expose every instance of dishonesty and neglect he might discover . . . hospitals in very short time a credit to the city. . . ."

That same year the Medical Board vigorously opposed efforts of the committee to establish student nurses on the Maternity Ward. The school was already in existence for one year and had proven its value in revolutionizing the care of patients on the six wards it initially took over. In this case the women were concerned about the high post-partum mortality rate and believed the incorporation of trained nurses would greatly alter the problem (Hobson, 1916, pp. 103-105).

Not the least intimidated by the physicians' aggressive campaign to defeat them, the women followed the same course that Florence Nightingale did in reforming her country's military hospitals. By going over the heads of doctors to men of their own class of greater power and authority, they were able to achieve their end (Starr, 1982, p. 155).

Although professional nursing neither emerged from a physician-initiated program for hospital reform, eventually medical doctors came to not only accept but

to rely on trained nurses (p. 155). Indeed Hobson would note in her Recollections concerning the Medical Board that, "The early prejudices, the opposition we had to contend with, have long vanished. . . . Now a surgeon would not undertake an operation of any importance without the attendance of a trained nurse . . ." (1916, p. 112-113).

Physicians soon concluded that the services of trained nurses could enhance their own practice as well as attract the needed teaching cases to hospitals. During the nineteenth century, lay people, particularly the poor, were fearful of hospitals, yet physicians had a vested interest in inpatient care as a means of developing medical education and as a source of their own prestige (Starr, 1982, p. 152).

In 1884 Dr. Lusk noted as a result of reforms brought on by the training, the poor eagerly availed themselves of Bellevue Hospital: the morbidity and mortality from surgery plummeted and surgical procedures once regarded as impractical could be successfully accomplished. Not only did the hospitalized poor benefit from improved nursing care, but private patients treated at home did also. Formerly the death rate for abdominal surgery, both

inside and outside of all hospitals, was at least thirty percent. The advent of trained nurses changed this awesome prospect. Consequently physicians preferred hiring graduate nurses for their private sanitariums and home cases (Wylie, 1897). While both these physicians acknowledged the important influence of the introduction of antiseptics on mortality rates, they expressed the view that without trained nurses, the successes would not have been significant at all.

Economic Advantage of Students Versus Professional Standards

As one might predict in the face of such successes, hospitals whose clients were more apt to be from the working and middle classes began to agitate for their own training schools.* One case in point is Mount Sinai Hospital in New York City whose house staff complained about the difficulty in obtaining knowledgeable nurses. By 1880 the introduction of trained nurses in some wards led to greatly improved patient care. However, as occurred at Bellevue Hospital, when the Ladies' Auxiliary began to pursue a

*Three schools using variants of the Nightingale model of Education opened in 1873. Bellevue Hospital was first, commencing its program in May. It was followed in October by the Connecticut Training School in New Haven and in November by the Boston Training School in Massachusetts.

training school of their own to assure a constant source of scientifically educated nurses for the hospital, they were initially opposed by the Medical Board. When finally the School finally opened, it found itself in a grave financial crisis in only four years. The Board of Trustees undertook to explore the possibility of obtaining graduate nurses from other sources but was forced to conclude that the most cost-effective means was to maintain its own training school. As a result the School's Board of Managers found itself having to share administration with the Board of Directors and to accept a medical advisory committee in order to receive requisite funding (Hirsh & Beka, 1952, pp. 65-74).

It proved unfortunate for the professional aspirations of nursing that hospitals saw an economic advantage in establishing schools of nursing. Beginning with the last quarter of the nineteenth century, as the numbers of hospitals increased across the country, so did the training schools. It was quite evident to administrators that lowered morbidity and mortality rates made hospitals more attractive to heretofore reluctant inpatients, while at the same time the students provided a cheap source of labor. Soon

hospitals rather than independent schools controlled the training process. (Bullough & Bullough, 1969, p. 130; Dolan, Fitzpatrick, & Herman, 1983, p. 206).

Financial problems never failed to plague the first schools. Boards of Managers for the earlier independent schools of nursing had to raise funds to house, clothe, and educate students, as well as salary their supervisors. Although government funds were being made available to educate teachers, society had not assumed the obligation to finance nursing education. Consequently, students had to earn their small stipends from the hospital through service. This frequently meant that attendance at lectures was co-opted by ward responsibilities. Moreover, during the second half of their two-year program, students were hired out to wealthy patients as a means of securing additional income for schools, consequently they were deprived of important clinical experience. There were other equally vexing problem: when the school took over particular wards in the hospital, the students had to assume all the non-nursing functions of their predecessors including scrubbing, cooking, dishwashing, and laundering soiled dressings for reuse. Over time many of these tasks were delegated to other personnel;

however, as long as it remained hospital based, the conflict involving the dominance of hospital service over the educational needs of students continued to plague nursing education (Dolan, Fitzpatrick, & Hermann, 1983, pp. 202-207).

Evolution of American Hospitals

It would be impossible to dismiss the evolution of the American hospitals from the discussion of the development of training schools. "Both hospitals and the nursing profession have been caught in a dilemma traceable to the historical circumstances that made rapid advances in medicine and the consequent demand for nurses coincide with the beginnings of nursing education" (Bridgman, 1953, p. 43).

When the editors of the journal of Hospital Management were searching for an appropriate date for the first annual National Hospital Day in 1921, they decided to use Florence Nightingale's birthday (May 12) rather than any other endless options they might have had. This gesture indicated how closely the histories of nursing and hospitals are tied in America. It also portrayed management's wish to share the charitable and "saintly image" of the founder of modern nursing. However, by this time as their commercial potential was

becoming conspicuous, the vast majority of hospitals were no longer just charitable institutions (Reverby, 1979, p. 207).

It was the depression of the 1890s that hastened the decline in the charity function of hospitals when they could no longer count on large government funds and private endowments to support their avowed mission. In the immediate period that followed the more modern voluntary hospital system arose (Rosner, 1979, p. 118). These new institutions attempted to separate the sick from the poor and marginal populations, as well as to provide a haven for the occasional person from the upper classes in special circumstances. The managers and physicians in these hospitals excluded the contiguously ill (who continued to be sent to pesthouses), as well as the chronically ill and the incurable and those believed to be "wicked and undeserving" in order to make the hospital attractive and more acceptable to the middle and upper classes (Starr, 1982, p. 151). Municipal and later the state governments were called on to bear a large portion of the care for indigent patients.

In general the hospital turned to the paying patient as a source of revenue thereby changing the

provision of hospital care from an act of charity to a commodity to be bought by all those who could afford it. The decision to establish fees "was rationalized as part of the larger Progressive Era movement toward order, efficiency and bureaucracy" (Rosner, 1979, pp. 118-119).

Physicians became interested in creating hospitals as a means of promoting medical education and as a source of prestige. Initially they were not successful in gaining control, largely because they were not trusted. The poor, in particular, feared they might be used for public experimentation or turned over to medical students upon death to be used for dissection. Physicians had to turn to merchants, bankers, lawyers and political leaders for capital. As a result, early hospitals developed an organizational structure in which lay boards, rather than physicians, retained final decision-making authority in both the private and municipal hospital systems.

At the turn of the century the growth of successful surgery improved the image of medical care. On this basis hospitals expanded, having acquired the impetus to realize profit from patients who could afford to pay. Proprietary (for profit) hospitals

became prominent, many of them built by surgeons who seized this opportunity to assert their professional control (Starr, 1982, pp. 152-157).

As scientific medicine emerged, it became institutionalized in the hospital, and while the physician became essential to the function of the hospital, the hospital became more indispensable for the practice of good medicine (Rosen, 1963, p. 31).

Before 1800 there were only twelve hospitals in the nation; in 1873 there were 178, and by 1923 the number reached 6,830. The sudden proliferation in hospitals was due to the rapid population growth as well as the advances in medical care. Nursing schools were apace with the hospitals so that by 1910 there were over 1,000 schools. Until the 1930s, nursing students became the major employees of hospitals (Bullough & Bullough, 1969, pp. 131-132; Reverby, 1979, pp. 207-208).

In 1911 an editorial of the American Journal of Nursing advocating reform in training schools revealed:

. . . the multiplicity of small hospitals owned by medical men, where training schools are maintained for strictly commercial purposes, is the greatest problem. . . . It is a condition that prevails to a greater or lesser degree over the country.
(quoted in Wheeler, 1985, p. 31)

Hospitals were able to grow into profitable

institutions largely as the result of the free labor provided by students working 12-16 hours a day for room and board and a small amount of spending money (Wagner, 1980, p. 273). Ironically once the students graduated, they were not usually employed by hospitals because they were viewed as "too expensive, too hard to discipline, and too willing to quit" (Reverby, 1979, p. 211). Those who demonstrated executive ability might be retained as head nurses or superintendents but not as general staff nurses. The vast majority of graduate nurses worked as private duty nurses in the home and in the hospital as well (p. 211).

Medicine's Constraints on the Emerging Profession

From the successes acquired from the first Nightingale schools in 1873 to about 1900, nurses in this country more than proved their value and effectiveness. Since their skills were widely respected they could insist upon some degree of independence. Nurse activists, such as Mary Alice Snively, would proclaim that a physician's reputation was directly correlated with the quality of care given by nurses (Ashley, 1976, p. 19).

By the late nineteenth century it was clear that without antiseptic conditions, adequate

nutrition, pre- and post-operative monitoring and rehabilitative care, no amount of diagnostic and surgical skill could save lives. Nursing provided the actual care for patients once the doctor made his short visit. (Wagner, 1980, p. 273)

But their gains in power arising from their triumphant outcomes was short lived.

Realizing their dependence on nurses, both hospitals and physicians felt they had to begin controlling their nursing staff and its training program. Hospital schools of nursing became associated more with labor management than with professional activity and hospital administrators worked to suppress their nurse's recognition of the importance of their knowledge and skills. (Ashley, 1976, p. 19)

Actually, while physicians saw the student and graduate nurses as necessary assistants, they also were aware that they were "potential threats" to their own autonomy. At this time most states had not yet passed physician practice acts that would grant them a virtual monopoly to practice medicine, hence physicians began to fear competition from graduate nurses once they left the hospitals. Based on this fear physicians cooperated with hospital administrators to severely limit the parameters of nursing practice. "This early delineation of what nurses could do, and the hospital's and ultimately society's acceptance of it, did much to prevent nursing from developing professionally at the

same rate as did medicine" (Echols, 1989, p. 281).

As alluded to earlier, prior to the advent of scientific medicine hospital governance was mediable by a tripartite system of authority:

The nurse superintendent acted as mother in charge and the Board of Trustees acted as father responsible for finances and over-all decision making. Physicians, especially those with staff appointments, received respectful attention but were not in a position to control internal events in the hospital. (Lynaugh, 1988, p. 28)

Nurses, of course, followed the physicians' instructions regarding diet, medications and treatments for inpatients.

Teaching Hospitals such as Johns Hopkins became the exception. Physicians in these institutions were expected to play a major role in the daily operation of the hospital (p. 28). In the years after 1900 board members of community hospitals found it necessary to cede control over hospital affairs to physicians when the "closed staff system" was instituted. Under this arrangement, the financial solvency of the institutions was directly tied to staff physicians who had exclusive control over hospital admissions.

The newly gained power over the financial welfare of the hospital gave physicians increasing latitude over all aspects of the affairs. The erosion of the

trustees' authority put nursing administration at a distinct disadvantage since "hospital board members were less able to mediate differences between nurses and physicians effectively."

To the degree that physicians depended on hospital access was proportional to the increasing complex technology associated with medical practice; so was their need to control the nurses in the hospital (p. 31).

Answering a patient's questions about his condition or planning a program of teaching him about his health needs was not permitted. Nurses were instructed to answer very briskly, "I don't know—ask your doctor." . . . the physician demanding that the nurses not answer any questions but refer them to him lowered the status of nurses and prevented health teaching. (Dolan, Fitzpatrick, & Hermann, 1983, p. 207)

Physicians at medical society meetings would warn one another to ". . . never allow nurses to talk to 'their patient.' Warn them at once that physicians only have patients, and that nurses are merely to obey the orders which they receive from them" (Wilcox, 1898, p. 89).

Consonantly, many physicians objected when they suspected that students were receiving "too much theory" because they felt it would make nurses less compliant and more apt to challenge their clinical

judgment (Echols, 1989, p. 282; see also Melosh, 1985, p. 125). Nonetheless, nurses were managing to increase the content of their courses, especially in the sciences. This provoked many physicians to protest and to gain public support for their sentiments. As one editorial in a New York paper declared in 1906, "An overtrained and 'learned' nurse is apt to be a nuisance" (quoted in Kalisch & Kalisch, 1986, p. 185).

Gender Constraints on Nursing

Nursing has been described as a developing profession singular for its correspondence to society's collective image about the nature of women. Historian Barbara Weller described "The Cult of True Womanhood" as it was extended from Victorian England into the twentieth century in this country. Rooted in religious ideology, good women were to possess "the four cardinal virtues of domesticity, submissiveness [obedience], piety and purity" (Bryant & Colling, 1990, pp. 153-154).

Most Americans, like their Victorian counterparts, believed that God had ordained that the two sexes occupy different domains and have different roles. The doctrine of separate spheres, as it became known, was

intricately laid out in the literature, law, medicine and religion, decreeing that women's personal lives center on the home, husband and children (Freedman & Hellerstein, 1981, p. 118; Kerber & DeHart-Matthews, 1987, p. 12).

This customary separation between the spheres became markedly pronounced during the nineteenth century when occupations in the male sectors of industry and commerce moved further and further away from the household. Women at home became idealized as "angels" who specialized in "emotional and spiritual life, protecting tradition and providing a stable refuge from the harsh, impersonal public sphere" that was drawing men in increasing numbers (Freedman & Hellerstein, 1981, p. 118).

Accordingly, segregation of domains based on gender rather than individual talent or potential had the effect of separating women into certain occupations. Since it was commonly accepted that women's basic talents were domestic, female wage earners were persistently directed into jobs that conformed to their traditional domestic roles in the home. Thus, in the nineteenth century, women who sought economic independence through gainful employment

turned to nursing and teaching because these occupations emphasized that the "attributes required for such work were precisely those considered unique to the female sex. [Therefore] nursing, considered in pre-Civil War years an occupation no respectable woman would enter, was eventually touted as a profession eminently suited to women" (Kerber & DeHart-Matthews, 1987, pp. 10-11). So long as women adhere to the proper deportment of their sphere, practicing piety, purity, submission and domesticity they were assured a place of respect (Hymowitz & Weissman, 1978, p. 67).

Although nurses were not expected to equal or surpass the physicians cognitive skills, the feminization of nursing acted to establish a separate sphere of authority for nursing—one based on the peculiar capacity of women "to function in a sphere of emotion and empathy." When combined with the high social status of some nursing superintendents, they would provide a formidable challenge to the wide power enjoyed by physicians.

However, the plan was foiled in that few women from the upper ranks of society sought careers in nursing; this would leave the young occupation without a sufficient countervailing force to help neutralize

the increasing control of medicine over its aspirations. Instead nursing had only the ideology of feminism to sustain itself; but this second half of the equation only served to enhance the "women's necessary subordination in medical care. Sacrifice, devotion, and sensitivity, not intellect and decisiveness, were women's appropriate contribution to the physician and the nurse team" (Rosenberg, 1987, p. 232).

Nurses encountered difficulty when:

They sought to establish professional standards in a context—medicine and the hospital—within which women had little authority. Physicians provided professional role models, but nurses had to cope with tensions generated by their attempt to create a modern occupation while not abandoning their traditionally nurturing feminine identities. (Vogel, 1979a, p. viii)

Undoubtedly, nursing accrued certain essential benefits through its close relationship to medicine: "medicine's ever increasing authority did help legitimate the social claims of nursing" while individual physicians endorsed nurse training, enthusiastically proclaiming the subsequent improvement in patient care. However, the nature of the relationship acted to perpetuate the subordination of nursing both "in the hospital and in patient care generally" (Rosenberg, 1987, p. 231).

CHAPTER IX

Nursing's Entry Into Teachers College

The tenor of nursing education in the United States has strong historic ties to the first postgraduate course for nurses established at Teachers College in the fall of 1899. Teachers College became the first of higher educational institutions in the United States or in any other country to offer advanced training for nursing teachers, superintendents and supervisors. "To a large extent, those responsible for setting the educational directions for nursing during this period were graduates of the Teachers College program" (Murdoch, 1986, p. 19). Matriculation within a prestigious university was a most auspicious milestone in fulfilling the professional aims of the early American leaders.

To the degree that their oft stated intention was to promote nursing as a profession on par with medicine, how they perceived professionalism for nurses can be inferred from the philosophical foundation and the evolving structures of the early curriculum they designed. Key to this understanding are questions that ponder whether the architects of the Teachers College program had in mind a more autonomous nursing role as

one of the critical goals of advanced education for leadership.

In what manner the leaders meshed their ideas about the heritage from Nightingale with their professionalizing ambitions, while negotiating their status as women in a health care system dominated by men, has affected the way nurses would be exercised and thus socialized into their occupational roles for the generations that would follow. One should ask if individual nurses were slated for greater independence in the educational reforms they propagated or whether the first postgraduate course in a university intentionally, or as an unintended consequence, fostered a greater separation between worker nurses (frequently referred to as "rank and file") and an elite strata who had the benefit of higher education and who associated with or became the leaders.

Ultimately, in keeping with this study, the whole question is how their decisions line up with current interpretations of the importance of autonomy to professional status for any aspiring occupation. It has already been established that Nightingale wanted nurses to keep and develop that essential core of nursing practice she identified as independent of any

other field in health care, particularly medicine. This aspect of her model for nursing tended to get obscured by the urgency of those who assumed the leadership to have nursing established as a profession.

Insofar as teachers colleges suffered the imputation of not achieving the distinction of their liberal arts analogues, Teachers College at Columbia University had established itself as a national leader in education.

The administration's high valuation of helping educate educationally deprived groups was central to its decision to help nurses raise their standards through higher education (Bullough & Bullough, 1984, p. 30). Nursing got an early foothold in academia because, in contrast to other countries including England, "American universities had flexible curricula, could admit students without liberal arts backgrounds, and could offer degrees in practical fields." In this respect they became a catalyst for skilled occupations that were trying to upgrade their work and improve their status (Glaser, 1966, p. 12).

Nursing Begins to Break Down Long-Standing

Resistance to University Education

The problems associated with bringing nursing into the university setting had much to do with conventions about education that were held over from medieval Europe. In earlier times universities were citadels of scholarship quite apart from the knowledge that was used "in the pursuit of everyday affairs" of citizens. Gentleman scholars and clergyman indulged themselves in "Greek, Latin, ancient history, [abstruse] mathematics and moral philosophy" in order to qualify themselves as "guardians of intellectuality and liberty of spirit." (Davis, Olesen, and Whitaker, 1966, p. 143). Although medicine and law were granted admission to American universities in the eighteenth century it wasn't until they eschewed their apprentice education and narrow vocational interests and subscribed to the "value of learnedness for its own sake" that they begin to enjoy a bonafide scholarly status (p.140).

Traditionalists within the academic community defined nursing as "crassly vocational" with "militaristic and technical" attributes that conflicted with the spirit of the university (p.143).

But, fortuitously, the philosophical commitment of university education would undergo a radical change. This came about as a result of the combined influences of science, humanitarian principles, and reform efforts leading to the Progressive Movement, as well as "strong democratizing ideals" that had taken hold in America.

The academic establishment, within a matter of decades, largely abandoned its dedication to Greek, Latin and natural philosophy. Empiricism, first in the natural sciences and then in the social sciences, became the dominant order of the day, so much so that representatives of what had once been the core curriculum of the University (that is, the humanities) soon found themselves on the defensive. . . . (pp. 143-144)

Within this milieu occupation previously barred from the University gained access.

The ground up on which the universities and the new occupations, such as nursing, were welded was the ideal of professional service and its promise of joining learnedness to altruism and furthering the general welfare. (p.144)

Educational programs were one of the firsts to

[experience] revitalization as faculties and student population increased. . . . Curriculum revitalization opened the question of specialized training for teachers. Some of the better normal schools began to revamp their offerings and to design bachelor's programs. Gradually they metamorphosed into teachers' colleges. Universities and liberal arts colleges cautiously began to introduce education courses and by 1890 over one-fourth of the higher institutions in the country offered some kind of pedagogical instruction. (Christy, 1969a, p.7)

When the first Nightingale training schools were established here in 1873 there were only a few colleges that admitted women and none of these would have wanted the stigma of being associated with a training school. Most preparation for elementary education was confined to normal schools while the only subject matter for women that was making headway in a college was home economics.

Emma Willard, who has been called the pioneer of female education in this country, champion courses build on preparing women for improved housewifery. Her views mirrored those of women's education advocate, Dr. Benjamin Rush of the University of Pennsylvania. In 1878 he outlined an elaborate "female curriculum" to teach women about the "duties of social and domestic life." Later, advocates like Catherine Beecher were responsible for the establishment of normal schools, which gave women an opportunity to secure an education for employment outside the home.

The founding of women's colleges in the east (i.e. Vassar, Wellesley, & Smith) proved that women were capable of mastering as rigorous an academic program as was offered in the best men's colleges, however they preserved a particular focus on branches of learning

deemed appropriate for their students' gender.

Although teacher-training colleges, joined by newly established programs in social work, were preparing women for professional careers in the 1890s, traditional all-female colleges were geared to liberal arts education and deliberately shunned anything that resembled vocational or professional training.

Although conceding that students were to be intellectually challenged, their life's work was viewed within the traditional domain of marriage and parenthood. Undoubtedly class differences made nursing unwanted on campus: in contrast to the upper middle class women who were found in the early colleges, training schools tended to attract primarily lower middle class students.

What is significant to point out here is that women who were graduated from colleges offering a diverse liberal education were not able to compete with men of comparable education in the workforce. In essence, since approximately 45 percentage of female college graduates would never marry, compared to ten percent of the women who did not attend college, their education held low promise for economic advantage in the workforce (Bullough & Bullough, 1984, pp.51-52;

Schlesinger, 1951, pp.113-114; Simmons, 1976, pp. 116-123).

It should not be unexpected then, that when nurses began to find accommodations in academia, teachers colleges would be their natural habitat. The majority of women in this era who were bent on a career in nursing would remain unmarried (Reverby, 1987, p. 112). Concomitantly regardless of their social position, American nurses were in search of an education that would guarantee them a respectable living. During the late nineteenth century and early twentieth century, American women who sought careers in nursing were motivated by financial necessity, in some cases as the result of downward mobility, as well as for a desire for personal fulfillment and independence (Mottus, 1981, p. 110).

Another important factor to be considered was that most of the early nursing schools were started on the east coast while most sexually integrated state-supported colleges and universities were located in the West, Midwest, and South. The lack of proximity made it virtually impossible for most schools of nursing to be affiliated with or sponsored by colleges and universities (Bullough & Bullough, 1984 pp. 51-52).

Similarly, state-supported medical schools with university affiliation appeared most often in the same sections of the United States, and while medical schools moved from private hospitals to private universities in the east, these same private universities often had barriers to women and were too status conscious to accept nursing students. (p. 52)

Nursing's movement into academia was fraught with obstacles ever since modern nursing gained momentum in the United States. The gender of nurses was the most obvious and expected obstacle the occupation would have to face, but just as important was its social ranking below medicine. Most physicians harbored mixed feelings about well-educated nurses, wanting their expertise to serve their career interests yet fearing the loss of control that their rising status could exert.

In order to understand the evolution of ideas that forged the values of the early leaders it is important to examine the circumstances under which they were fostered and hewn. A singularly important observation at this stage was that they were all graduates of the earliest hospital sponsored training programs, thus their first inclination was to support and modify the only educational system for nurses in existence.

A denotative place to begin would be the university hospital school of nursing at Johns Hopkins.

Under the leadership of Isabel Hampton it opened in 1889 with a great deal of optimism by those who wished to demonstrate a superior nursing education model. Hampton was educated at the Collegiate Institute of St. Catherine in Ontario, after which she held a teaching position in an elementary school for three years. In 1881 Hampton entered Bellevue Hospital Training School for Nurses. As a new graduate she promptly acted as a substitute superintendent of nurses at Women's Hospital in New York, and later went on to earn an impeccable reputation as superintendent at the Illinois Training School in Chicago (Christy, 1969c, p. 26).

At Hopkins, Hampton concentrated her efforts on establishing high standards for nursing as she envisioned them, hence the ideals of "service, respectability and strict military discipline" became the philosophical matrix of the curriculum for the first half of the twentieth century. Although a militaristic hierarchy style of administration was the norm in the first Nightingale school in America, Hampton's influence in maintaining its preeminence in nursing schools and hospitals would later be viewed as a strong deterrent in the direction of nursing autonomy (Ramos, 1997, pp. 26-27 & 32).

In May of 1894 Mary Adelaide Nutting, a member of the first graduating class at Hopkins succeeded Hampton when she resigned to marry one of the prominent Hopkins gynecologists. Nutting was educated in private schools in Quebec and taught piano prior to entering nursing (Christy, 1969b, pp. 20-21).

She was chosen precisely because she could be counted on to continue the traditions begun by Hampton. Eventually Nutting became convinced that there could never be a suitable accommodation between nursing education and hospital service.

In February 1896 Nutting conducted a national survey of students' work schedules which produced unmistakable evidence to support her contention that schools of nursing require financial independence in order to keep their educational programs free of the exploitation of service institutions. This conviction would influence Nutting's work over the succeeding decades (Ramos, 1997, p. 28).

At the beginning of the 1890s the leaders had sensed an urgency to remedy the chaotic conditions nursing was in. An official nursing organization was needed to address the problems of nursing education and other professionalizing strategies. The upcoming

World's Fair in Chicago in 1893 was a fortuitous event from the standpoint of providing a forum for setting a collective ongoing agenda to set national standards for nursing schools.

Dr. Henry Herd, superintendent of the Johns Hopkins Hospital, was appointed secretary of the section of the International Congress of Charities, Correction and Philanthropy and was commissioned to set a program on hospitals, nursing, dispensaries and first aid. Arrangements were made for Hampton to become chairperson of the committee charged with planning a Congress of Nurses. Mrs. Bradford Fenwick, leader and professional advocate for nursing in Great Britain, was there to arrange a nursing exhibit (Roberts, 1964, p. 21; Christy 1969a, p. 13). Fenwick and Hampton collaborated in planning the nursing congress. Hampton also asked for and received advice from Nightingale (Benson, 1993, p. 9).

At Hampton's suggestion approximately twenty superintendents of nursing met before leaving Chicago. A preliminary organization was set up with plans to summon a convention of training school superintendents in New York in January 1894. At that meeting the American Society of Training Schools for Nurses in the

United States and Canada (hereafter the Society of Superintendents) was born.

The Society of Superintendents was committed to advancing the profession of nursing by establishing "a universal standard of training and by promoting fellowship among its members by meetings, papers and discussions on nursing subjects, and by an interchange of opinions" (Roberts, 1964, p. 23).

Observing a mercurial decline in the ideals that framed the initiatory reforms in nursing education, American leaders turned to a postgraduate university program for teachers and superintendents. Aligned with their ambitions to turn nursing into a profession, the university program became an essential tool to control the momentum in this direction. After all, it was widely accepted that those who rose to distinction during the first era had much to do with the attributes of their character and the relative sophistication their backgrounds provided them.

If anything, the Nightingale experiment proved to American leaders that nursing could only gain public respect in a competitive health care market if it continued to attract and nurture women of high caliber—

educated women who were willing to make the sacrifice that its leadership extracted.

But American leaders sought prestige through educational reform. Because many had backgrounds as former teachers and normal school graduates they pursued curricula with a strong theoretical basis (Glaser, 1966, p. 11). The number of graduates from schools with high standards who could be available to fill leadership positions around the nation was minuscule compared to the demand (Roberts, 1964, p. 20). The huge amount of requests made for Hopkins graduates to fill administration and teaching positions could not be met.

. . . those who quickly accepted administrative positions were quite bewildered by the variety of services and judgments they were expected to render, from the merits of the laundry and sterilizing equipment, bookkeeping, and personnel management to developing a training school. . . .

In desperation these young graduates turned to their former teachers for assistance in teaching and administrative procedures and institutional management. (Marshall, 1972, p. 87)

While at Hopkins Nutting was deluged with requests for help from graduates. When she met with nursing administrators who shared her views, the urgency of a postgraduate study for teachers of nursing and hospital administrators became an evolving topic; "To them it seemed as normal as the preparation for teachers of

history, home economics, and vocational subjects" (p. 88).

Changing the image of the candidates who entered schools of nursing from one of a "convenient means of getting a great mass of hospital work done" to that of a legitimate student of an emerging profession (Nutting, 1914, p. 607) had been a goal since the onset of the Society of Superintendents. Hampton (1949) would deliver a stirring paper on the "Educational Standards for Nurses" at the Chicago World's Fair in 1893 in which she described the chaotic condition of nursing education across the nation: "The teaching methods of no two schools will be found alike. . . . Each school is a law unto itself(p. 4). A trained nurse may mean anything, everything, or next to nothing . . ." (p.5).

Rallying around the cause they all believed in so passionately, members of the Society of Superintendents became absorbed in finding a way to establish standard curricula in training schools and believed this could best be accomplished through a unified system of training for teachers (Christy, 1969a, p. 20).

Sensing the critical importance of such a venture at their 1898 convention the members proposed a

Committee on Education with Hampton (now Mrs. Robb) as its head to explore the possibilities (Marshall, 1972, p. 90). There were hospital based graduate courses in management being offered by various hospitals but they failed to meet the scrutiny of the committee members who turned to higher education. In her search for suitable instruction for nurse teachers Robb investigated various normal schools and schools of pedagogy (Cunningham, 1959, p. 269).

The Education Committee had very specific requirements for the college and courses they would choose. At the Sixth Annual Convention held in New York on May 6 1899, Robb reported that they had written to a number of schools of pedagogy, and interviewed professors of pedagogy, but none met their specifications (Christy, 1969a, p. 16).

Within a short time Robb and Nutting arranged an interview with the dean of Teachers College. Working out of the college catalogue they presented him with a draft for a course to prepare nurses for administrative and teaching positions in nursing. They selected established courses in psychology, biology, domestic science, and physical science to which they would arrange lectures on subjects germane to nursing

education and administration (pp. 16-17). Eventually he accepted their plan.

Teachers College was proud of being at the cutting edge of educational change which came about under the leadership and foresight of James Earl Russell who served as dean from 1898-1927 (Cremen, Shannon & Townsend, 1954, pp. 41-42). Russell "insisted that democratic principles necessitated a unique type of education . . . [which] must be closely correlated with the common life of the people." It was his openness to the economic and social demands of the new century that gave university entry to what had been perceived as "nonacademic fields." One of the first nonacademic fields accepted in Teachers College was nursing (Christy 1969a, p. 9).

In 1899 Russell outlined four major characteristics that became the goal of Teachers College education: he stressed professional knowledge and technical skill in the particular subject matter the teacher represents combined with general culture and scholarship (p. 8).

What made Teachers College a likely place from which a postgraduate program in nursing could gain a significant foothold has much to do with the unique

origins of the college. The mission of Teachers College is traced firmly to Grace Hoadley Dodge, a daughter of a wealthy New York merchant who possessed a strong progressive ideology. In 1880 Dodge joined the Kitchen Garden Association which was "dedicated to the amelioration of slum living through education for household management." In 1884 it was reorganized into the Industrial Education Association and became involved in different facets of education for commercial enterprise. The public interest in this project was huge prompting members of the association to face the prospect that without sufficient teachers schooled in the industrial arts they wouldn't be able to accomplish their purpose.

In 1887 Nicholas Murray Butler, associate professor of philosophy at Columbia University, became president of the association after which he joined with Frederick A. P. Bernard, president of Columbia College in establishing the New York College for the training of teachers.

In 1893 the college received a permanent charter from the New York Regents under the name Teachers College. One year later Teachers College became allied with Columbia which gave it its status as "the pedagogy

department of the university." In 1898 under the leadership of Russell the university accepted Teachers College as its professional school for the training of teachers, thus it was given equal status with the law and medical schools (pp. 7-8).

During this time:

The prevailing approach to instruction relied upon the assumptions inherent within the classical tradition. Education was seen as a process of discipline or strengthening the faculties of the mind through exercise, just as muscles are developed through use. . . learning was thought to be largely a matter of memorizing words and reciting them back . . . the nursing curricula or the nature of the methods of instruction . . . was in step with the standard educational practices of the time. (Murdock, 1986, p.17)

In contrast, the educational approaches being implemented at Teachers College by a variety of pioneers in the field would challenge the prevailing attitudes about learning. Among the reformers were educational psychologist Edward Lee Thorndike, whose research incorporated the understanding of human behavior in the educational process, philosopher John Dewey who generated ideas of progressive pedagogy, and Frank McMurray, a renown expert on teaching methods (Cremen, Shannon, & Townsend, 1954, pp. 43-47).

When the leaders initially approached Dean Russell, they discovered that he had many of the same

views about nursing as did other academics. In his mind, there was no association between nursing and teaching. Undeterred, Robb and Nutting took him late one evening to St. Luke's Hospital. There they met a class of very young students who had recently been relieved of twelve hours of duty on the floors. In their overworked and exhausted state Russell saw them "reciting aloud verbatim from Gray's Anatomy, the page listing the bones of the human body." This experience served to convince him that nurses were subject to instructors who lacked the knowledge on how to teach; he was doubly sympathetic at seeing them as "the victims of ignorance and exploitation."

They told him there is no reason why the principles that applies to teachers of teachers in the fields of practical arts, domestic science, manual training, woodwork, shop work, and school administration should not apply also to teachers in nursing education. . . . They believed Teachers College had same obligation to the nursing profession. (Marshall, 1972, p. 98)

At first, Dean Russell wanted a two-year course but when he was told it would be impossible, he approved a certificate program for postgraduates that would run over one full academic year (Cunningham, 1959, p. 270).

On January 17, 1899, Helen Kinne, professor of Home Economics, under which the Hospital Economics

course was originally placed, wrote to Robb with a critique of the suggested schedules of study the Society of Superintendents had submitted. The correspondence reveals the extent of the flexibility of Teachers College in the process of subsuming what it once considered a "nonacademic field."

Except for the courses in Hospital Economics, students took all the subjects under faculty in various departments within the university. According to Kinne's letter, the courses included Elements of Psychology, Application of Psychology to Teaching, Physiology of Hygiene, Bacteriology, Foods, Food Production and Manufacture, Advanced Course on Foods, Home Sanitation and Management, Chemistry of Foods and Stimulants, and Principles of Education.

Much of the content of the courses that fell under the Department of Domestic Science (those dealing with food, home management and sanitation) would be unusual in today's nursing education programs related to stark changes in the function of professional nurses. At Teachers College, students were taught about the "Presentation of food," "Fancy dishes," "Cookery for invalids" as well as "Systematic arrangement of house-work [sic]," "Laundering," "Expense and Accounts," and

the "Structure of the House" including the "Character of the Soil" and the "Disposing of Waste." Since nurses needed preparation to function in dietary and household management as superintendents of hospitals and in private nursing in the home, these topics were not only pertinent but also put them on the cutting edge of the rising importance of domestic science at that time.

The two required courses that fell specifically under Hospital Economics were Methods in Teaching and Hospital and Training School Management.

Robb's handwritten notes returned by Kinne indicate the early resolve of the superintendents to use the course in Hospital Economics to begin the process of unifying standards in training schools. Topics included were "Training School Organization and Management," Organizing Ward Work," "Uniform Curriculum," the "Grading of Probationers," "Ethics," and "Examinations."

Kinne informed Robb that Dean Russell approved the superintendents' plan to bring nursing students from nearby St. Luke's Hospital to the college in the evening to facilitate the postgraduate students' teaching experience under supervision.

The brochure, Domestic Science Course in Hospital Economics 1899-1900, describes a required one-hour history course, which, according to Kinne's letter, the Superintendents originally requested. The students could select either Industrial Evolution of Society or Social Reform Movements. The content specific for the superintendents' role as described by the brochure included the duties of the superintendent, hospital construction and sanitation, equipment, and professional organizations among other related topics. The fact that the early program was devoid of any specific nursing content became a source of contention among the early graduates (Cunningham, 1959, p. 27).

A Board of Examiners of expert superintendents from the society was organized to screen applicants. Once admitted, the course spanned two semesters after which a certificate would be awarded, provided a required examination was passed indicating that the nurse was qualified as a superintendent of a nursing school or hospital. In conjunction with the program, students had to spend three to four months preceding or following the course work doing private duty nursing (Christy, 1969a, pp. 16-17). Since most hospitals were using students to fill staff positions, private duty in

the home or in the hospital was considered important to solidify the graduates' clinical nursing experience before moving on to positions of leadership.

The members of the Education Committee were the original faculty for the hospital Economics course which was one hour the first semester and two hours the second.

The Superintendents believed . . . that "our students" would acquire their advanced preparation in nursing in the nebulous part of "our course" that was not given [by] Teachers College. More specifically, they relied upon admissions requirements, demanding, as prerequisites, endorsement from the applicant's training school and a prescribed amount of private duty experience. Later on, a postgraduate course in a hospital was advocated. (Cunningham, 1959, p. 271)

The postgraduate courses were independent of the Society of Superintendents and the College.

In May 1900, Dean Russell addressed the Seventh Annual Convention clarifying the purpose of the program at Teacher's College. Of particular interest here is his support for the leaders' desire to maintain an exclusive student body.

. . . It is not for the rank and file of the profession that we are working. It is for the few [emphasis added] who can spend time and money in raising themselves to the next higher stage, that they may better themselves and help the profession. So we cannot take over the training of nurses. That must be done in the nurses' training school. . . . For those who are to teach,

who are to look to the raising of the profession, they must have a training superior to those who are with them in the profession. They must go beyond that which they have achieved in order to bring the pupils up to and beyond the industrial or apprentice grade. (quote modified from Christy, 1969a, p. 20)

At the 1901 Society of Superintendents Convention, Robb made it clear that prospective students entering the course would not be in a postgraduate course in clinical nursing, but rather it was an advanced course for nurses who already had expertise in general nursing practice (p. 25).

It would be a misnomer to call this 1899 "course of study" a program in nursing. In planning and launching [the program], the members of the Society of Superintendents were not seeking to establish nursing as a subject of collegiate study; they were trying to arrange for the preparation of their successors. (Cunningham, 1959, p. 268)

The Hospital Economics Program attracted very few students in its first half-dozen years and managed to survive by contributions of money and the teaching services of Robb, Nutting and a few others (James, 1979, p. 235).

Because it was directed toward top leadership training, the program was planned for the "exceptional woman." Applicants were to have a high school diploma and a diploma from a nurse training school that offered certain specified courses. Moreover, the \$400 the

students had to pay for tuition and lodging would have been difficult for the average nurse to raise. Although an occasional scholarship might be made available by a training school, there were no scholarships offered by Teachers College.

When the course was started, the committee had to pay the college \$900 a year and the college returned to the Society \$75 out of the \$400 tuition each student was assessed (Christy, 1969a, p. 26). The Society of Superintendents was literally living "from hand to mouth" as it tried to meet the payments. Superintendents donated their personal money but often it wasn't enough (p. 27).

Nutting's arrival at Teachers College signaled a campaign for financial solvency. After a national appeal (in January 1908), she received donations totaling \$3,526. These had come from individuals, alumni groups and graduate nurse associations across the country. Most donations "were two or three dollars—the daily wages of a nurse at the time" (p. 37).

In 1910, one of the trustees of Teachers College, Helen Hartley Jenkins, endowed the nursing division with \$150,000. The grant allowed nursing education to

separate itself from the Department of Household Administration and become its own Department of Nursing and Health.

After the "Department of Nursing," as it was sometimes called, became independently endowed with its own faculty and new freedom to pursue its special needs, it assumed a reputation as "a renowned institution of higher learning. . . . Nutting had, through her leadership, acumen, prestige, and ability, set a course destined within the next thirty years to affect nursing and nursing education throughout the world." (p. 41)

Nursing courses were planned to meet the increasing responsibility nurses were assuming in all areas of health care. Nutting brought in prominent leaders in medicine, nursing and public health, including Dr. C. E. A. Winslow and Lillian Wald to be guest lecturers (pp. 49 & 53).

Influence of Leaders: Via Teachers College

From her distinguished position at Teachers College Nutting was able to dominate nursing education for two decades. Her influence was felt through her students whom she was able to sponsor into "innumerable other schools and hospitals" as well as the leadership

she provided for reform within the profession and her representation of nursing "to interested influential outsiders" (Strauss, 1966, p. 76).

Nutting saw her mission at Teachers College primarily as spearheading educational reform of the "less progressive training schools" whose best interest would be served by hiring the trained teachers certified through the postgraduate course.

These teachers could be expected to have an impact upon the training of students. They could help to implement a reduction of students' working hours, as well as urge upon their supervisors additional measures useful for "raising standards." Hours spent on studies definitely should be lengthened; adequate classrooms, equipment, books should be provided; classes should be given during the day, rather than after a day's grueling work; certain subjects such as bacteriology should be taught; and the students' total years of attendance at the school should be extended. [In short] Miss Nutting's suggested solution to the basic professional problem was, in brief, to integrate genuine schools into hospitals, most of which possessed only sham schools. (p. 77)

The increased financial resources made it possible to enlarge the teaching staff and to extend the scope of the educational programs. Stewart would recall

Courses were introduced in municipal sanitation, social science and social legislation, statistics, social case work, and a number of other subjects. A little later, mental hygiene and child hygiene were added. Most of the courses were open to other students in the college as well, and in that way the nursing department enriched the general resources of Teachers College. (1932, p. 2)

At the inception of the Hospital Economics course the college agreed to make accommodations for nurses who didn't have a high school diploma: they could prove their competence by passing a stringent examination demonstrating adequate knowledge of classical literature, composition, history and mathematics (Domestic Science Course in Hospital Economics, 1899-1900).

On April 11, 1900 Robb wrote Dean Russell, "There can be no doubt that the entrance examination has been a stumbling block in the way of some women who might prove good candidates." Nonetheless, the prestige associated with the endowments made it possible for the Department to be more selective since applicants increased dramatically. In 1912, only those nurses with a properly "certified" high school diploma were eligible—provided they had graduated from approved schools of nursing (Christy, 1969, pp. 46-47). At this time most training programs were not requiring a full high school education for admission; some didn't even require a year (Nutting, 1912, pp. 25-26).

Nutting justified the decision:

. . . our students must be able to enter [the university] on the same basis as other students—that is, a good high school training which is

properly certified. . . . It is [also] a very grave question whether we can receive students whose training has been secured in a number of affiliated schools, with no definite control or direction anywhere; or where the theoretical work is meager or irregular . . . (quoted in Christy 1969a, p. 47).

While admission standards increased, many graduate nurses desiring college courses to prepare for educational and executive positions found that they did not have enough broad, preliminary education to meet the requirements. Once registration was established by law, all applicants had to be registered nurses who graduated from schools meeting pre-established standards; however, this alone was "not considered sufficient guarantee of a good professional background" (Stewart, 1932, p. 9).

The superintendents raised the admission requirements as soon as it became feasible, in terms of maintaining a satisfactory rate of enrollment in the school. No doubt they were galvanized by their disappointment in the performance of some earlier graduates. It was determined that the blame lay in the deficiencies of their basic nursing education and experience. Their lack of expertise in nursing was not aided by the loose structure of the first postgraduate nursing course. The postgraduate students, in fact,

complained that the college offered insufficient instruction in nursing.

The college's early drawback is that it didn't have a hospital or training school of its own in which to provide the graduate nurses with the kind of practical experience they needed for hospital administration and teaching. This facet of the program drew perhaps the most consternation, considering that Teachers College philosophy was predicated on providing standards of practical education commensurate with the field of study that is undertaken. Consequently, the program's graduates took positions as superintendents without experiential preparation.

Finding suitable teaching experiences for the students was not without its share of problems. The state of the early program can be surmised by the fact that nursing superintendents from nearby training schools would not allow their nursing students to be "experimented on" by the Teachers College students who wanted to teach them. Until they could secure the services of Laura Franklin Hospital and later St. Luke's Hospital, the graduate nurses had to hone their skills on grade school children, along with students of elementary education (Cunningham, 1959, p. 271).

Meanwhile, a major administrative change took place at Teachers College: in 1912, two distinct departments were formed, namely the School of Education and the new school of Practical Arts. Nurses who wanted to pursue teaching or public health would register under the School of Education; those who were interested in practical, scientific or administrative work would now come under the aegis of the School of Practical Arts.

With the new policies it became possible for a high school graduate interested in pursuing a career in nursing to register for a Preparatory course within the School of Practical Arts. The student was required to study preliminary science over a one- or two-year period, enter an approved training program, and then return to Teachers College to complete the necessary courses for a degree. The student received college credit for the nursing school experience. This plan made it possible for Teachers College to have a direct contact with a training school (Christy, 1969a, pp. 46-47).

By 1914, the small Hospital Economics course grew into five tracts according to the students' specialty: (1) Teaching in Schools of Nursing, (2) Administering

Schools of Nursing, (3) Hospital Administration, (4) Administration and Teaching in Public Health Nursing, and (5) Public Health Nursing (School of Practical Arts Department of Nursing and Health Announcements, 1914-1915).

As nursing education and hospital administration became more complex in keeping with the advances of medical science and technology, hospitals could no longer require superintendents, supervisors, or head nurses to assume the additional role in running the nursing schools. Training schools progressed from two to three years with various degrees of curricula uniformity, thus it became necessary to invest the education in those nurses who would qualify themselves as teachers. The report of the Department of Nursing and Health in 1918 reveals it became enormously difficult to meet requirements for suitable faculty.

The problem of instructors is apparently so acute in training schools now that the Department is trying to find some way of helping to meet the demand through the summer school. It is offering a special group of courses for teachers and asking Training School Superintendents to look about among their graduates or students for those who have had normal school training or teaching experience before taking up nursing, and who could with a few weeks of special study get themselves ready to be of some immediate service. (p. 3)

Nurses who completed the postgraduate course at Teachers College didn't necessarily receive any economic benefit in terms of their careers. Instead, they were told to expect that the reward for their work was not to be found in generous wages but rather by the results of their service (Beard, 1912, p. 789). As one graduate of the early program explained, "The course has given me . . . a greater confidence in myself. . . . While I do not feel I bettered myself, it was a good investment . . ." (American Society of Training Schools for Nurses Course in Hospital Economics, 1906).

Gradually, certified students could extend their studies to qualify for a bachelor's and master's degree under the new department. Graduates of the program began filling positions of leadership in almost every part of the world. They made their contributions known by "establishing new university centers of nursing education, in improving standards of teaching . . . and in extending the public health idea to all phases of nursing (Cremin, Shannon, & Townsend, 1954, pp. 55-56).

Teachers College remains a major symbol of nursing's triumph in traversing the discrimination it bore as lacking the intellectual ingredients and

qualified practitioners sufficient to be allowed in academia.

Isabel Stewart, who would succeed Nutting as Dean in 1925, credits Teachers College for its courage and foresight when it opened its doors to nurses who "have so often met with opposition or grudging cooperation in their efforts to secure wider educational opportunities" (1932, p. 3).

Nursing's entree to Teachers College was built on a series of milestones, some relatively small and humble, others like an eventual endowment to create a department all its own, continue to be unsurpassable in its history. What sustained the project in its early stages was an incredible degree of faith and persistence on the part of members of the Society of Superintendents who never publicly expressed disappointment that only two students enrolled in the first class. By the time Nutting retired in 1925, the department she administered "had grown from the smallest division of the College [sic] to the largest single unit" (Cremin, Shannon, & Townsend, 1954, p. 55).

The Society of Superintendents planned that Teachers College would be the exclusive training

grounds for their successors. Their professionalizing strategies placed the highest priority on the notion that qualified nurse teachers, supervisors and superintendents could raise the standards of education in hospital schools sufficiently enough to attract better candidates into nursing. It is significant to note that at the early inception of the postgraduate program at Teachers College the advocates for a professional model had acquiesced to the apprentice model of education for basic nursing education, although there were substantial changes they wanted to engineer. In essence, American nursing's victorious entry into academe had as its foundational scheme a two-tiered system of nursing education, with the plurality of nurses having to be satisfied with hospital training.

There would be movement from this direction to some degree as will be explored in the succeeding chapters.

CHAPTER X

Schism in an Aspiring Profession

Early American leaders, like their counterparts in England from upper middle and middle class families, were separated from the average working nurse by the social distance of their status and their educational backgrounds. They were more at ease in interacting with physicians, educators and other professionals to influence support for their point of view. But when different, attractive, less labor-intensive fields of employment opened up to women from these social classes, the question arose: who would be the leaders from what was perceived to be the mass of ill-prepared graduates from the lower rungs of society? This was the incessant concern of the women who were bent on professionalizing nursing.

In 1932, Isabel M. Stewart writing on the history of Nursing Education at Teachers College reflected on the circumstances of modern nursing noting that since its inception there had always been a need to promote and foster those who could be counted on to move the profession forward. In Nightingale's school it was shown how she prepared and coached women from the upper classes who had the advantage of better education and who had

learned management skills in running the staffs of large Victorian households to be the principal promulgators of her methods. It is hardly speculative to attribute the success of these ladies to the fact that their superior social status in an aristocratic society allowed them to assert themselves with impunity in situations that would be proscribed for ordinary nurses. Be that as it may, America was a different case.

Louise Darche, superintendent of New York City Training School, observed in 1893 that in contrast to English Training programs

The [American schools] had been started on very democratic principles. The women who entered to train—whatever their previous position in life—were placed on the same level or plane, and none were engaged to do the higher or more special or nicer parts of the hospital nursing. They all began at the bottom, to work on and up to the more responsible duties as they showed capacity for advancement. (1949, p. 96)

According to Stewart, "pioneering conditions" in America provided opportunities for women to "come to the top as needed" and they would, in turn, get the experience necessary for carrying out executive responsibility. This method did produce early leaders who were "courageous, resourceful, and forceful women" (1932, p. 1). Albeit when schools of nursing began to

proliferate they were necessarily compelled to accept less qualified women to run their programs.

In contrast, by the 1880s some students entering British training schools had the benefit of high school and college education which were beginning to take root for women. The newer generations were imbued with notions of equal opportunity with men. However, many of the early lady probationers were attracted to nursing as a result of their religious and spiritual beliefs, hence they were not interested in status (Baley, 1986, p. 195). Therefore the leadership was pulled in two directions, one espousing the advancement of nursing as a women's cause while other forces clung to sentiments of self sacrifice and duty.

After Nightingale popularized nursing as work for respectable women, some hospitals readily took on a higher proportion of paying probationers, enabling them to cut down on the expenditures associated with running a training school. Being ambitious and better educated than their peers, the lady pupils were equipped to assume the functions formerly carried out by the dressers, "Thus redefining what was the proper task of the nurse." Unquestionably the entry of upper class women into nursing had the initial effect of expanding

nursing practice in terms of its role in health care as well as multiplying the number of schools that were started under Nightingale's Fund Council (Baley, 1986, p. 219).

Membership in the Society of Superintendents (which became the National League for Nursing Education in 1912) was deliberately limited to carefully selected heads of schools of nursing of large hospitals only. The advocates of educational reform who were pursuing professional status for nurses intentionally created this schism to prevent being overruled in policies by the self interest of hospitals with strong proprietary underpinnings. The decision to confine membership to nurse educators further exacerbated the rift in the nursing community by deliberately excluding those supervisors in hospitals without nursing programs (Echols, 1989, p. 283).

In 1881 some schools began to form alumni associations. At the Society of Superintendents convention in 1896 provisions were made to establish the Nurses Associated Alumni (NAA) of the United States and Canada the following year. (In 1911 it became the American Nurses Association and Canadian membership was discontinued.) Like The Society of Superintendents,

membership in the NAA was highly selective; alumni of smaller or narrowly specialized hospitals were not permitted to join.

Both groups worked in concert to establish more stringent educational standards for all schools. The NAA also organized state campaigns for registration in an effort to obtain binding statutes to enforce minimum standards of preparation for nursing practice (Melosh, 1982, p. 33). In order to accomplish this it was necessary to establish state nursing associations to help shape and influence legislation (Fifteenth Annual Meeting of the New York State Nurses Association, 1916).

Impressive as these accomplishments are, in retrospect they made little difference to nurses in active practice. Only a relatively small number of superintendents had membership in the Society of Superintendents, and only an inconsiderable number of graduates joined their school alumni associations which might have made them members of the NAA (James, 1979, p. 235).

Dock and some leaders were in a minority when they proposed that nursing associations be more responsive to the heterogeneity of trained nurses. Arguing

against the stark exclusivity of their membership, they saw the danger in not accepting a more conciliatory attitude toward colleagues whose circumstances did not match the ideals set by the founders. It was reasoned that legislated registration regulations could protect the public from the harm of ill prepared graduates (Baer, 1990, pp. 318-319). Dock (1901) admitted, "I think . . . they have been largely influenced by the spirit of 'caste'" (p. 470).

But others like Goodrich (1906/1993) argued against broadening the admission criteria during a Society of Superintendents' Convention. "We have the opportunity to-day, in the revision of our Constitution, to open wide the door of our Society. I think we cannot open them too wide . . . " (p. 63).

Concomitantly, "class differences mediated the efforts of marriage on the nurse's work experience." For most nurses marriage meant they had to drop out of the labor force to manage a household and raise children. In contrast, women whose husbands could provide domestic help were free to offer volunteer labor in parallel class-related activities such as serving on boards of public health agencies or hospitals (Reverby, 1987, p. 112).

With the exception of Isabelle Hampton who continued to be an influential participant in shaping the policies and direction of the first national nursing organizations after her marriage to Dr. Hunter Robb on July 12, 1894 until her premature death on April 15, 1910, the profile of the activists in the movement to professionalize nursing was one of mature, unmarried women who were dedicated to promoting their interests. In most cases they rose to prominence in positions of leadership as administrators and teachers in leading hospitals with training schools and they became known in the nursing organizations as well (Bullough & Bullough, 1984, p. 45).

Although the leaders valued clinical expertise (Cunningham, 1959 p. 271; Robb, 1909/1993, p. 79), and indeed their backgrounds in hospital nursing attested to their clinical knowledge, they forged their goals predicated on their ideas about nursing without consultation with the rank and file nurses who were directly involved in the intricacies of direct patient care. It was commonly understood that the higher a nurse rose in leadership, the further removed she was from contact with actual nursing practice (Bullough & Bullough, 1984, pp. 43-45).

Since decisions were often arrived at more or less autocratically, if only because power was limited to a small group of dedicated professionals, the decisions often reflected the special needs and interests of this group rather than those regarded as more pressing by the hospital nurse or even the registry nurse. (p. 45)

The geographical location of the organizational leadership within the first half of the twentieth century all the more added to a narrow internalists view of nursing. They were concentrated in a few urban areas in the northeast: New York, Boston, Baltimore, and Chicago. The latter city served at the Midwest Center.

In terms of education, the leadership had strong ties to Teachers College in New York. When nurses began to go on to college for postgraduate work and higher degrees, most went to Teachers College. Hence the leadership formed a general agreement about goals that was increasingly independent of "what was happening in the rest of the country. The connection with [Teachers College] meant that most of the advanced nursing education dealt with how to teach nursing rather than encouraging scientific or scholarly investigation of the kind carried out in various disciplines" (pp. 45-46).

The emphasis on preparing nurses for teaching at

Teachers College can be understood in terms of how the leaders perceived nursing's most pressing problems at the time.

Until this time elite schools were positioned to command stringent admission policies that guaranteed their students would stand out among the pre-reform hospital nurses because of their social class and education. For instance Bellevue Hospital would not take pupils who were domestic servants (Reverby, 1987, p. 87). The Committee on the Training School for Nurses Attached to Bellevue Hospital indicated they sought women who were:

Daughters and widows of clergymen, professional men and farmers throughout New England and the Northern states . . . and who received a good education [at] common schools and academies and [were] dependent on their own exertions for support. (quoted in Giarelli, 1990, pp. 208-209)

In the early years following the opening of the school at Johns Hopkins, students tended to belong to the middle and upper-middle classes and to reside in urban rather than rural settings. Before 1920 New York Hospital's training school graduates were apt to be from "the middle class and touched on the upper class" (Baer, 1992, p. 17; Reverby, 1987, p. 87).

It was not uncommon for a nurse who graduated from

one of the elite schools such as Bellevue, Massachusetts General or Johns Hopkins to be hired as a superintendent in another institution (Reverby, 1987, p. 105).

In 1909, half the members of the American Hospital Association were nurses. Graduate nurses hired into administration had a reputation for being intelligent and conscientious hospital executives (p. 106).

However earlier in the 1890's, Hampton and other superintendents of the best schools were under pressure to accept students whom they would ordinarily reject in order to meet the nursing service needs of their respective hospitals. Starting in 1900, as hospitals with student programs expanded and other occupations were available to women, the schools found themselves admitting less prepared students. Moreover, "The supply of middle and upper-middle-class [women] with good educational backgrounds dwindled further, as many who might have entered nursing in the 1890s elected to go to college" (James, 1979, p. 235).

According to Reverby by the 1910s the larger, elite schools could still command students with better credentials in terms of respectability and educational background while smaller schools offering an inferior

training would be chosen by "poorer" women with "little educational advantage." At the completion of the respective programs, all graduates would be considered "trained nurses." It was precisely "this heterogeneity that characterized and therefore came to divide nursing" (1987, p. 94).

While the leaders frequently extolled some of the older training schools of exceptional "standing in which living conditions are excellent and nurses are carefully trained" they had to admit that most of them failed to meet their educational criteria (Medical Commission, 1916, p. 6).

At Bellevue, which was typical of other reputable schools at the time, students recruited from a "better class of women" replaced the untrained nurses. But their working conditions were little changed from the staff they replaced.

The greater respectability of the pupil nurses, and the glamour shed upon nursing by Florence Nightingale, concealed from the public . . . and from the pupils themselves the fact that they were as much an exploited female labor force as the old hired nurses had been. (James, 1979, p. 207)

The group of aristocratic women who founded the training school could only realize their goal for reforming nursing to a level that frustrated their

highest aspirations. Without sufficient funding they "could raise standards no further. Municipal officials and the medical staff were satisfied with things as they were" (p. 207).

Class Differences Affect Career

Decisions

Which training school a nurse graduated from became a fairly reliable determinant of the kinds of employment options she could expect. Alumni of a less prestigious schools were more likely to enter private duty whereas "institutional positions went predominantly to nurses from the more elite schools," (Reverby, 1987, p. 113). Correlatively, it has been suggested that students in other training programs were really on two tracks in that those demonstrating characteristics of leadership were groomed to take the few hospital positions open to graduate nurses, thus circumventing a career in private duty (p. 113).

One study demonstrated that nearly one half of the key leaders in nursing between 1873 and 1945 trained in six large schools located in teaching hospitals on the east coast; nearly one-third of the women graduated from Bellevue or Hopkins. In contrast to the vast majority of trained nurses, the leaders were

distinguished by middle-class background and high school and college education (p. 124). The Bellevue Training School produced most of the nursing leaders of the second generation of nurses following the introduction of Nightingale-modeled schools in the United States (James, 1979, p. 207). Hampton Robb and Lavinia Dock, who would succeed Nutting at Hopkins, were both graduates of Bellevue Hospital. Dock came from an upper-middle class background (Siegel, 1983, p. 43) and served as night supervisor at Bellevue Hospital after graduation (Christy, 1969d, pp. 72-73).

Ironically it was precisely these leaders who endorsed and propagated military discipline protocols to govern nursing behavior. They wanted nurses to rule nurses within a ranking order that specified their relationship in terms of subordinate to superordinate.

Absolute and unquestioning obedience must be the foundation of the nurse's work, and to this end the complete subordination of the individual to the work . . . as necessary for [the nurse] as for the soldier.

To say that there are any lines on which the medical profession may not control the nursing world may sound revolutionary. It is not so. . . . It may be claimed that if the military idea is the basis of the school, the members of the medical profession being undoubtedly the superior officers, should properly control the school [of nursing]. . . . This might hold good except for one simple yet radical point of difference. The private soldier in the ranks and the soldier in

command have the same profession. The officer is also a soldier and knows every detail of the common soldier's work. The nurse and the physician have different professions. The doctor is not a nurse . . . (Dock, 1893/1949, pp. 16-17)

Curricula of training schools were infused with the military discipline model, but Dock attempted to make one exception.

On one field only does the school properly come under the command of the medical profession and that is in the direct care of the sick. Here indeed the command is absolute. The whole purpose of the school centers around this point, and the pride of the well drilled nurse is to make this service perfect. (p. 17)

Since Robb and Dock were both graduates of Bellevue, it is not surprising that they found themselves in complete agreement about the rigid hierarchical arrangements for nursing students and staff. Both thought that Nightingale's ideas about military tradition was the ideal way to structure nursing practice (Marshall, 1972, p. 51).

Many nursing superintendents lived the Nightingale ideals as best they could and infused them into their schools. The authoritarian model could and did "retemper" many women. It imparted to nurses idealism and pride in their skills, began to differentiate the trained from the untrained nurse, and helped to protect and aid the sick and the dying. It could provide a way for virtuous women to contribute to the sick and dying. (Reverby, 1987, p. 57)

One explanation for this phenomenon could be found in Armeny's (1983) study which focused on the unique relationship nurses had with philanthropic women that began with nursing reform movements such as the one at Bellevue Hospital and ended around the First World War. Her burning question is: How was their political alliance characterized in terms of the traditions of cooperation among women and the social feminist perspective during this period?

Her analysis concluded that the alliance did not adopt feminist values and ideas in terms of expounding on women's nurturing role in society. The philanthropic women's and nurses' goals were important to women because "nurses were women fulfilling a traditionally womanly function." However, they never made a commitment to women's solidarity (pp. 15-16). Nor did nurses fit into a model of bureaucratic thought that triumphed during the early twentieth century with the advent of a "'new middle class' with self-conscious professionals in the 'vanguard'" (Wiebe quoted in Armeny, p. 16). Instead, Armeny argues convincingly that nurses shared the Sanitary ideal with their allies, extolling expertise, order, discipline, collective purpose as opposed to individualism. Both

groups believed that organizations could work efficiently only when they were in control of persons who were equipped by birth or training and when authority moved downward through clear hierarchical lines.

Student nurses were socialized into the Sanitary ideal as it was passed on by lay women and nurses who adopted its ideology from the work of Florence Nightingale. But it was the experience of the upper-class women in the Sanitary Commission of the Civil War who used its principles to systematize private aid to Union troops and to encourage order and discipline in army camps (pp. 16-17).

An important feature of the Nightingale system integrated into the early American schools of nursing was the recruitment of women of good character. Training was seen as much more than a formal educational experience. Teachers had to carefully inculcate students in all the ramifications that proper demeanor and good moral behavior imply. As alluded to earlier, a large portion of the early probationers came from "'good' if not well-to-do families." Many had previous careers as school teachers or were educated in seminaries.

When the outstanding students went on to become superintendents after graduation, they in turn would often be called upon to establish one or more training schools and the process would repeat itself as their graduates instituted more schools. Within this perpetual system teachers believed that "genuinely trained nurses" would be reproduced (Strauss, 1966, pp. 66-67). However, more than nursing expertise was passed on from one generation to the other.

Nurses were not immune to the psychological effects of the oppressive apprenticeship system in the hospital. They became convinced of their inferiority and the justification for subordinating themselves to the medical profession; to the extent that "many nurses identified with the system that oppressed them and worked to support its continuing existence" they came to believe wholeheartedly in the hospital training system.

Apprentice education by its nature has no substantial place for liberal or general education. Most often it is forged to constrain intellectual growth as it prepares workers to conform to the prevailing customs and traditions of an occupation.

For apprentice nurses these traditions, which were

at once in conformity and at odds with Nightingale's designs, prepared them to be obedient and docile and to equate the poor conditions of work with a form of professional discipline. Under these circumstances students were carefully socialized to acquire attitudes of complete loyalty to the hospital that trained them as well as to the physicians (Ashley, pp. 32-33).

The rapid growth of nursing schools allowed medicine to become more specialized, if only because medicine could delegate more and more tasks to nurses. Inevitably this led to a raising of educational standards for physicians and an increase in their income and status. It would . . . be fair to state that it was only because nursing education moved into hospitals that medical education could move into the university. (Bullough & Bullough, 1984, p. 52)

But apprenticeship in training schools had a different meaning from that of other fields. For hospital-based programs students became apprentices from the start as a means of rendering services in return for their instruction as well as for acquiring first-hand knowledge. In most other occupations apprenticeship exists to provide experience in beginning positions after a foundation of preliminary education has been given (Bridgman, 1953, p. 15). Again, in contrast, the nursing student was led to independently fill some of the most sophisticated roles

in a nursing service in order to prevent the necessity of hiring graduates. Some of their responsibilities were forced on them by physicians who wanted to shed themselves of particular tasks.

Medicine is steadily transferring to nursing, duties and procedures hitherto performed only by physicians. The giving of anesthetics, for instance, has been in some places turned over entirely from physicians to nurses despite the fact that the laws in other sections have been enacted forbidding it. (Nutting, 1923/1991, p. 361)

In 1910 Stewart lamented the lack of control nurses had in defining the parameters of their discipline.

In some of our hospitals . . . the pupils are trained to give . . . X-ray, Finsen light treatments, etc., under general medical supervision. This extension of the nurses' province has not usually come about through any demand on her part. Indeed, resistance to such added duties and responsibilities has usually come from the nursing staff, while the pressure has been exerted from the side of the staff of physicians. . . . (p. 16)

Specific examples of conflicts between nurses and physicians were generally not exposed in the nursing journals and literature of the time but given the dynamic of their prescribed relationship instances of problems arising from dilemmas incorporated in the clinical management of patients must have been numerous. These predicaments were bound to occur when

students had to adhere to ethical standards of behavior and at the same time comply with absolute obedience to physicians and nursing superintendents.

An interview of a former student at The Johns Hopkins Hospital Training School under Hampton offers a rare glimpse of how these problems arose and how they were dealt with.

C. said that the nurses were given a great deal of responsibility in the early days of Johns Hopkins. . . . as a pupil nurse [she] was in charge of a gynecological ward . . . the doctors were trying out new methods of treatment. Miss C. said she was frequently instructed to give treatments that doctors today would insist upon giving themselves. In one case Miss C. reported to a doctor that a certain patient was very miserable. But C., although she did not want to give the treatment, could not say so because nurses were instructed to obey. However, C. finally did not give the treatment but telephoned the doctor to come to see the patient. When the doctor arrived he said C. was right not to continue the treatments even though she had been ordered to do so. When the head doctor came, he ordered [surgery] because the woman [suffered] a rupture. The operating surgeon was very severe on C. for he barely saved the patient's life. C. did not report the details to Miss Hampton because she had not been asked for the details. Finally when [C. was blamed] C. could not blame the doctor. (Carr, 1940)

The nurse's response in this instance is congruent with precepts contained in the Hopkins Code of Ethics adopted on June 4, 1896. "The nurse's first duty was to carry out the physician's instructions, never to criticize him with patient or friend, and to accord him

respect for his higher professional position."

Directives espoused in The Hopkins code were characteristic of those which would mold nursing over the next half-century (Marshall, 1972, p. 81). As late as 1916 Sara E. Parsons, Superintendent of the Training School for Nurses at Massachusetts General Hospital, advised inexperienced nurses in her widely read book to avoid direct confrontation with physicians in matters of clinical judgement. She added a cautious qualification for the nurse who had been in practice for a time (pp. 57-58).

When she becomes sufficiently experienced to detect a mistake she will, of course, call his attention to it by asking if her understanding of the order is correct. All are liable to make errors, and where lives may be at stake each must act as a check on the other, regardless of an old supposition that doctors could not err and that a nurse had only to obey orders regardless of the consequences. The nurse is the doctor's assistant, but her work is no less responsible than his. His success and the patient's recovery often depend upon her intelligent interpretation of his orders. She must not allow her work to be underestimated. (p. 58)

Nurses formed the assumption

that physician authority and control over patients was vital . . . [and] that [their] own clinical authority depended to some extent on maintaining that of the physician. When nurses could no longer count on delegated power from the lay hospital board members, their dependence on physicians increased. (Lynaugh, 1988, p. 30)

Looking back on the evolution of nursing education Stewart diplomatically asserted in 1910 that the strong traditions of military discipline that had come to permeate nursing education and practice in the United States had to be de-emphasized. "There is no doubt that this system . . . tends to undermine individual responsibility and initiative which, after all, are qualities that are very greatly at a premium in this profession" (pp. 22-23). She cautioned that although "soldier-like discipline" had been passed down in the Nightingale system, largely as a result of her Crimean experience, the foundress of modern nursing had exhorted adherents: ". . . true loyalty to orders cannot be without the independent sense of responsibility which alone secures real trustworthiness." Stewart proposed that on "democratic soil" schools are bound to face a modification of these customs, although as she had predicted, it met with a lot of resistance from the "more conservative" members of the profession (p. 23).

Although Nutting never openly disagreed with her close colleagues during her active career regarding the strict control of students' behavior, there is a recorded casual conversation she had on August 1, 1939

in which she indicates her disdain for the "military discipline of nurses education." As a student, Nutting resented the unreasonable administrative methods used by hospitals, but credits Hampton's gracious and warm style for having remained in the program at Hopkins (June 31, 1939).

Leaders had long rallied for the elimination of the small stipends most training schools held out to students to help defray the cost of uniforms, books, and other expenses. If payments were stopped, they argued, the exploitation of their services would necessarily diminish. Underlying the whole issue, however, was the desire to discourage working class candidates who would rely on the payments from entering schools. Used as a professionalizing strategy to raise entry standards, the whole matter of payments proved to be a red herring. Rank and file nurses angrily protested what they perceived to be an artful ploy to create an exclusive occupation. Others argued for the reinstitution of payments where they had been stopped noting that women from families of "refinement" who were having financial difficulties were being prevented from entering nursing. Overall there was an overpowering sentiment that the payments were justly

deserved by the overworked students (Reverby, 1987, p. 124-125).

Accepting defeat over the issue of stipends, leaders put their full support behind securing state registration as a means of achieving their goals. Approximating the British experience, those espousing the professional model wanted laws passed that mandated stringent educational standards for graduates who would qualify.

Perhaps nothing else could epitomize the expanse between worker nurses and the leaders than the movement for registration. The focus on educational reform and registration laws by leaders within the professional associations were perceived as jeopardizing the ranks of working nurses who needed a measure of job security and freedom from economic hardship. They rightfully construed the leaders as hostile to their vital interests.

The professional leadership, in order to exclude "badly trained" or "unprofessional" nurses, saw such women, and the small institutions where most of them trained, as nursing's gravest threat. The concerns of such nurses—for improved working conditions, income and recognition for their skills—were perceived as antithetical to the professionalizing effort . . . for the majority of working nurses.

. . . A professionalizing strategy, emphasizing upgrading of standards of training schools and their curricula, threatened the already shaky

status and economic situation of many practicing nurses. (Reverby, 1987, p. 142)

The leaders were not only opposed by worker nurses but also traditionalists who argued that the values inherent in nursing are the "commitment to the importance of character and devotion to service." and that those were the criteria that should be used to judge a nurse's qualifications to practice.

Their adherence to nursing skill measured in womanly virtues was less a conservative and reactionary stance than a belief, transcending class and educational background, in the nurse's individual character and workplace skills. Such a belief grounded altruism in supposedly natural, rather than educational soil. (Reverby, 1987, p. 142)

But, as Reverby observed, the leaders attempted to redefine, in part, the appropriate character for nurses within the bounds of educational achievement through a "rigorous theoretical and scientific training" (p. 125). Many graduates opposed the standardization of education believing that such upgrading would only serve to erode confidence in their own skills and their hospital school diplomas.

Skeptical of the claims of educational reformers, they upheld apprentice training as a part of nursing's craft tradition. In this conception, education meant more than acquiring skills and knowledge: it was a process of initiation that transformed the student from a lay woman into a nurse. (Melosh, 1982, p. 39)

In line with their ambitions for the profession, the leaders chose to focus on the movement to secure state licensure at the Third Annual Convention of . Associated Alumni of Trained Nurses held in New York State (Robb, 1900). Of paramount concern "was both the lack of uniformity among trained nurses and the multiplicity of their trained competitors" (Tomes, 1983, p. 110).

At the convention Isabelle Hampton Robb put forth arguments that would crystallize the resolve of the members:

As the matter stands at present, the woman who has spent years of hard work and study in acquiring skill and knowledge as a nurse, on undertaking private nursing finds at once she is classed on a level with all sorts and grades of so called trained nurses; nor has she any redress. She is expected to work side by side with the uncertified hospital nurse, who has been dismissed for cause before the expiration of her term as student, with the half-trained nurse from the specialty hospital; with the nurse who has received the kind of instruction that makes her dangerous, with the adventuress and the amateur—women masquerading as nurses, a matter of uniforms with no knowledge behind them . . . (1900, p. 102)

Robb goes on to define the ultimate objective of reform and licensure:

The professional status of the trained nurse will be defined no less sharply than that of the physician or of the lawyer. By these means also

the public will be provided with a distinguishing mark whereby they could know whether any given nurse has been properly trained and is a suitable person to take charge of the sick (p. 103).

It is difficult to ascertain from the rhetoric of the convention that the leaders ever envisioned a protracted battle such as occurred in New York that would end twenty years later with the passage of a significantly weakened bill. Tomes (1983) aptly conveys the final outcome for nurses as "one step forward, two steps backward" (p. 123).

Ironically, the nursing registration law first passed in 1903 with the blessings and support of the State Regents' Office, the medical establishment and several large hospitals. Criteria for registration rested on graduation from an approved school and a passing grade in a statewide examination. The new law provided the impetus necessary to continue the significant strides in educational reform already underway in New York. Progressive physicians looked upon the reform as a method of securing more reliable assistants. Furthermore, the prospect of putting smaller hospitals out of business through the exclusion of their training schools from state recognition had appeal to progressive physicians, as well as the

managers and superintendents of influential hospitals. Both of these groups saw regulation of nursing as advancing scientific medicine and hospital efficiency (pp. 112-113).

Unlike physicians, however, nurses had to acknowledge the limits of their political influence. The original registration bill did not make registration a criterion for practice (as the leaders would have chosen), but rather a means of distinguishing those who met educational criteria. As long as the registration process was voluntary, training schools as well as nurses in practice and their employers were free to ignore it. In fact many graduates of approved schools chose not to sit for the required examination; those who did and failed, found that it did not restrict their occupational opportunities (pp. 112-113; 121). This arrangement was not to last for long.

In this view the leaders decided that the results of the first law fell short of the original intent to raise the status of nurses. Consequently, in 1910 Annie Goodrich, the new school inspector, decided to enforce the Board of Regents admission requirements for schools of higher education, thereby excluding anyone

with less than one year of high school education from the state approved schools. To this, the State Association added the proviso that the registration law had to be amended to restrict the practice of nursing to the registered nurse alone (pp. 117-121). Such a position had the effect of making enemies out of the bill's earlier supporters. Consequently, powerful hospital and physician lobbies were joined by disgruntled nurses and commercial school proprietors (pp. 121-122). Hospitals and their physicians worried that training school enrollment would drop, thereby impinging on the cheap student labor force. Of equal issue was the concern that the nurses' association would become powerful enough to affect hospital management.

The association was further weakened by the polarization of large numbers of graduate nurses in the state who found it impossible to meet registration criteria. One major stipulation required that their home schools achieve acceptable educational standards before they could be grandfathered in under the 1903 law (p. 120).

In 1920 a much compromised bill was passed that mandated registration for practice; but in the process,

nursing leadership suffered a tremendous loss in autonomy. Among their losses was the change in Regents' policy, making its advisory council for nursing multi-disciplinary by altering the former all-nurse composition to include equal representation by hospitals and physicians. Moreover, nurses were forbidden to increase preliminary educational requirements beyond one year of high school until 1930. This occurred in spite of the fact that the Regents agreed to raise entrance requirements for other schools of higher education to four years of high school beginning in 1924. The new law also provided for the registration of experienced nurses without taking a preliminary examination (p. 122).

As might be predicted, progressive physicians and hospitals supported the aims of nursing as long as they saw them as rationalizing and systematizing the hospital. But once nurses interpreted the law to further their own interest at the hospitals' expense, they found powerful opponents (Tomes, 1983, p. 123).

Tomes succinctly notes that:

Registration's critics viewed the nurse not as an independent worker, but as a doctor's assistant and the hospital's worker. It seemed only fitting that nurses, as handmaidens of scientific medicine and hospital efficiency,

should set their professional standards subject to the approval of doctors and hospital representatives. The issue of gender became subsumed within a narrower justification for the nurses' subordinate position in the medical hierarchy. (p. 124)

Because nurses were novices in legislative measures, many of the early nurse practice acts in various states were ineffective. Some made no provision to evaluate whether schools met stipulated criteria. Others failed to specify the qualifications and methods of selection and appointment of members of boards of nurse examiners (Roberts, 1964, pp. 74-75). Still the leaders remained optimistic that laws could be amended to tighten controls over the educational system. They had only to look at the success medicine had in obtaining tighter regulation over its educational system by establishing state boards in every state by 1900 (Shannon, 1975, p. 1328).

As early as 1910 Isabel Stewart optimistically proclaimed, "The registration movement has been, perhaps, the most effective agent in forcing out poor schools and keeping others up to the standards prescribed by state laws" (p. 9).

Although nursing registration strategies moved nursing closer to the professional model, they also

succeeded in further polarizing the nursing community. Moreover the leaders carefully inculcated values of obeisance to superordinates in the bureaucratic forms of administration they endorsed. By maintaining hierarchical chains of command based on degrees of expertness, they unwittingly helped the physician's superiority in matters of health care to become more firmly established.

The gulf between the leadership and rank and file nurses continued to widen as each pursued different agendas. Within this dynamic the physician's role in determining the work and content of education of nurses could only be strengthened.

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CHAPTER XI
Basic Nursing Education in
Collegiate Schools

Eventually Nutting had to reconsider her original ideas about the relationship of hospitals and training schools for nurses. Societal changes were perhaps the largest single force that brought her to conclude that the goals and missions of the two institutions were widely divergent and irreconcilable (Strauss, 1966, p. 77).

Women who formerly would have chosen nursing school because of its promise of an education without tuition and a chance to secure a respectable career were being besieged with other attractive alternatives.

"American nursing as a self-conscious claimant to professional title began roughly in the 1880s" (p. 64). Although the leaders began to use the word liberally in conjunction with nursing they were aware that its use was open to dispute. Over two decades later Nutting contended:

I suppose if Abraham Flexner were here, he would take issue with me on the use of the word "professional" as applied to nursing in the usually accepted sense, and I hope to take up that point at some time later. . . . (1916, p. 3)

The early leaders of nursing reform believed that nursing was a profession and they were successful convincing the public of this notion. But, as Strauss enlightens us, it is important to comprehend their perception of the meaning of profession as it applied to their ambitious aims.

It is clear enough that profession meant to them an occupation with impeccable standards—or at least they strove for such standards—along with [Nightingale's] idea of a "calling." But that is not all a profession meant to them. Again, let us turn to Miss Hampton since she was perhaps the most influential nurse of the day. . . . During her inaugural speech in 1889 [as superintendent of the training school of Johns Hopkins], she made no mention of nursing as a profession: only good training through careful recruitment, relatively rigorous discipline, high standards, and the best kind of teaching available. (Strauss, 1966, p. 69)

The inception of the Hopkins Training School within the university hospital dashed any semblance of a bonafide college education for nurses, as we understand it today. With Hampton in complete agreement, the Hopkins Board of Trustees never considered the school of nursing to be anything more than a "superior training school not a place where [nursing] students got a university education." Ironically, while the University President, Daniel Coit Gilman, was the prime mover in establishing a scientifically-based medical school which became part

of the university instead of being affiliated with the hospital, he found no such vision for nurses. From his perspective, the education and function of the nurses was veritably technical: if their training was superior, then they could better serve the hospital and the physicians (pp. 69-71).

The early nursing leaders could not justly bear the blame for not emphasizing a university education at this point in time considering that nurses were functioning "in a man's world" under the watchful eye of physicians who tried to keep them in their place.

. . . we ought to remember also that the idea of professional training qua university training had yet to emerge clearly on the American scene. The idea had been born; it was in operation. But before the 1890s, legal training . . . consisted mainly of apprenticeship, and medical training either involved apprenticeship or was given in diploma mills. Many academic professions . . . were just being initiated. . . . The age of burgeoning professionalism had yet to arrive. (p. 71)

At the close of the nineteenth century the nursing leaders "could only see the medical profession as the model." This was

. . . completely comprehensible . . . since physician and nurse worked as companions in arms against disease. That the nurses looked up at the physicians, as well as across the bedside at them, is also understandable. The physicians were men, in command. And more advanced in their cumulative knowledge. (p. 72)

Even though nurses saw medical men as the exemplar of what being professional means, in the last decade of the nineteenth century medicine itself had not yet become a profession in terms of current sociological criteria (James, 1977, pp. 203-204). As late as 1900 members of the Medical Society of the State of New York were discussing whether the recent law to require a high school diploma to enter medical school was sufficient preparation (Raymond, p. 59). Moreover, prior to 1910, nurses who graduated from academically superior hospital schools were better educated than most medical students. This caused one physician from New York to write that nurses were "overtrained" since they took almost equivalent courses in anatomy, physiology and bacteriology (Ashley, 1976, p. 83).

In 1897, Agnes Brennen, Superintendent of Bellevue Hospital's School of Nursing, expressed the ambivalence leaders felt at the time about sacrificing any clinical time in the hospital in order to expand the theoretical content of nursing education. With not a little mettle she emphasized that in contrast to other learned occupations like medicine, nurses are given full access to practice for the duration of their training.

In the universities and colleges of the world, the intention now is to make teaching far more

practical than heretofore; this is particularly so in medical colleges. We all know that the young physician . . . when he enters the hospital as interne [sic], is utterly unfit, in spite of his splendid theoretical knowledge, to put into practice what he can fluently discuss. . . .

Now with the nurse it is different . . . from the first day she enters the school, she begins with the practical, and takes up the theoretical to enable her to give intelligent care, to expand her mind by contact with greater minds, in lectures and books. . . .

Theory in conjunction with practice is what we want . . . still we must remember that "too much reading tends to lead to mental confusion." . . .

Practice helps to impress and retain in the memory the knowledge obtained by theory, otherwise forgotten by practical application. (1991, pp. 24-25)

We must bear in mind that Brennen was not unlike the other leaders who had become only too aware that if nursing wanted to attract and retain women from the middle classes, they had to offer them more than an apprentice training.

Now, no woman of education and refinement would spend two years in a large city hospital . . . unless she had some compensation in the form of theoretical teaching and training. . . . An uneducated woman may become a good nurse, but never an intelligent one; she can obey orders conscientiously and understand thoroughly a sick person's need, but should an emergency arise, where is she? She works through her feelings, and therefore lacks judgment. (p. 23)

While capable women were beginning to turn to college for advancement in other fields, the leaders continued to assign a high value on preserving hospital-based education in terms of testing the

character of its future practitioners. The prime importance Nightingale placed on the reputation and integrity of the nurses who would be certified at St. Thomas was a constant they wished to preserve. At the Society of Superintendents' convention in 1898 Nutting made this point succinct:

We can train women as nurses but we can not change the character. We may not be able to discover the faults in character early; they may come out afterwards to our great regret and grief, and we should be very careful about signing our names to diplomas even after pupils have reached the degree required by the school and have come to the last months of their career there. We do not stand in the position of colleges and universities. They do not vouch for character but only for a certain degree of training or schooling. We stand in a different and peculiar position. We assume a moral responsibility for the character of the nurses we send out. (quoted in Marshall, 1972, pp. 88-89)

In all hospitals with training schools the superintendents and supervisors of nursing assumed dual responsibility for the education of students and the service needs of the patients, but there was a continual role conflict. Meeting the educational needs of the students inevitably meant the supervisor would be viewed as impairing the economic security of the hospital. If the service needs of the hospital were given priority, it would have to be at the expense of the students. "The resultant role dilemma was the

basis for the first schism that began to appear in the late 1880s and 1890s between nursing service and education leaders" (Echols, 1989, p. 283).

Some superintendents chose to resolve this quandary by deciding to support the hospital's goals (that is, acting in concert with the administrators and the physicians in control). They reasoned that the quality of patient care was correlated with a sound hospital economy (283).

The extent of the conflict was expressed by Hampton Robb while she had been superintendent of nurses at The Johns Hopkins Hospital in Baltimore. As late as 1897 she had proposed that "A superintendent of a training school owes a duty, first, to the hospital, and secondly to the nurses under her." She attempted to qualify her stance that both obligations "are of equal importance" making it incumbent on the leaders to find a way to satisfy both obligations without sacrificing one or the other (1897/1991, p. 15).

Her position had not changed significantly since 1893 when she wrote her textbook, Nursing: It's Principles and Practice. The opening pages conveyed her belief that the superintendent's first obligation is to her employing hospital and second to the patients

under her care; student nurses were allotted the third place (Strauss, 1966, pp. 69-70).

The establishment of the apprenticeship pattern was probably totally unavoidable at the stage of social evolution in America at the end of the last century. Society in general "felt comparatively little responsibility for women's education or for vocational education of any type." However, the trenchant speech given by Dean Russell of Teachers College before the Society of Superintendents in 1900 informed members that professional status could never be achieved under such an educational system (Bridgman, 1953, p. 42).

Like Nightingale, many early American leaders strongly defended the apprentice system of training with the hospital being the pivotal source of nursing experience. But the tension between their educational aims never failed to clash with the changing nature of the hospital's mission. In this respect they were consistent with Nightingale's belief that "gaining a theoretical understanding of health care was more important in the students' learning experiences than was their service function" (Schyler, 1978, p. 48). Most American training schools, on the other hand, set their curricula according to pedagogical principles

that placed greater emphasis on practical experience. A survey done by the Tenth Annual Convention of Superintendents in 1903 demonstrated that it was rare for students in training schools to be taught the scientific rationale underlying nursing care (p. 49).

But advocates of the professional model did not control the organization of nursing (Glaser, 1966, p. 9). Trainees in America were socialized into the role of worker whereas Nightingale instilled ideas of leadership in her students (Giarelli, 1990, p. 210). British graduates were commissioned to spread her ideas wherever they were assigned, regardless of their class (Schyler, 1978, p. 46).

Significantly, the British system abided by Nightingale's admonition for a strong matron (equivalent to a superintendent in the United States). Consequently, matrons were granted greater authority than superintendents had in American hospitals and they held substantial political influence to shape the educational practices in their respective hospitals. As demonstrated earlier, the plurality found it to their advantage to maintain a robust apprentice system of education (Glaser, 1966, p. 11).

Nutting had left Hopkins in 1906 to chair the new Department of Institutional Management for all the household arts at Teachers College under which the Hospital Economics course ran (Cunningham, 1959, p. 270). In keeping with her desire for independent financing for nursing education she agreed to head the Hopkins School of Nursing's Alumnae Associations Endowment Fund Committee (Ramos, 1997, pp. 30-31). All nursing graduates received a letter from Nutting, who was now at Teachers College, appealing for donations. In retrospect it can be deduced that Nutting had not yet seen the value of placing basic nursing education within a university. "Her letter mentioned the educational opportunities of the university, but not the placement of the school within the university" (notes, p. 44).

Many who failed to support the notion of a collegiate program for nursing were those who complained that there were too many ill-prepared candidates filling supervisory and administrative positions in nursing. Conversely, qualified women with college background would have been more amenable to choosing nursing once it was established on a

collegiate and professional level (Bridgman, 1953, p. 86).

Hence the leaders were faced with the prospect that many desirable and qualified women were choosing other occupations. Correspondingly, colleges for young women were multiplying while the increased prosperity of the country made securing a college education possible for many. By putting more importance on the intellectual aspects of nursing, the leaders sought to recoup their losses and strengthen their professional aims (Strauss, 1966, pp. 78).

But it wasn't until 1916 that Nutting would fully endorse the university setting as the ideal location for schools of nursing, noting their superior educational resources such as scientific laboratories, libraries, and specialized facility. By then, some better schools of nursing had already secured university affiliation (p. 77).

Nursing education under the control of a university would, the leaders believed, free nurses from the contradictions inherent in their student roles as apprentices to hospitals. By 1900, occupations seeking professional status singled out the American university as the preferred pathway for its educational

programs. Concomitantly, medicine, law, engineering and social work developed solid ties to the university. Nurses, however, would have to wait until after World War II to substantially realize this aspiration (Lynaugh, 1988, pp. 31-32).

The transformation of some schools of nursing into university-sponsored programs can be traced to the Society of Superintendents meeting in St. Paul-Minneapolis in 1909. There, Dr. Richard Olding Beard announced that the University of Minnesota had approved the establishment of a school of nursing—the first of its kind in the United States. Beard acknowledged that it was Robb's prompting and enthusiasm that made him an advocate for the university approach to nursing education (Marshall, 1972, p. 165). This was not, however, a degree program. Students had the arduous task of meeting all the university's standards for admission and classwork but, unlike its other undergraduates, they had to work 56 hours a week in the hospital. At the program's completion in three years, they received a diploma as did nurses in other hospital-based schools. "This modest alliance with academia was copied by a few other tax-supported

universities, including Cincinnati, Indiana, Virginia, and Washington" (Bullough & Bullough, 1984, p. 53).

When the Board of Regents of the University of Minnesota approved the establishment of a school for nurses, the first goal was to "furnish a nursing service for the University Hospital" and then "to give a thorough training to nurses." Quite simply, the students were needed to staff the hospital (Powell, 1911/1991, p. 161). The "thorough training" contained a core of subjects which could be found in curricula of responsible schools throughout the country, albeit university sponsorship was supposed to guarantee that the quality of the education would be high. To all intents and purposes, however, the leaders were interested in the students of better standing that a training school connected with a university could marshal; they were needed to fulfill their professionalizing ambitions for the occupation and to assure nursing's social prestige. Although a high school diploma was required for admission, preference was given "to women of broader education" (p. 61). As one leader commented about the students of the University of Minnesota:

The quality of the probationers . . . is to me strikingly different. They are certainly better

prepared to do the work easily and attack their problems more intelligently. And I feel certain the doctors get better service and the patients better care. The reports of the head nurses confirm that. (p. 162)

It is worth noting here that the leader's reference to pleasing the hospital physicians certainly reflects the commitment of all hospital training schools at the time. As much as they rejoiced over the loosening of nursing education from the ties of hospital-controlled programs, there remained the task of negotiating the unequal relationship at the bedside of the patient.

Ironically, some collegiate schools of nursing came to be regarded primarily as a facility to serve their respective hospitals rather than being an integral part of the university (Bridgman, 1953, p. 100). Be that as it may, moving nursing education into a collegiate structure was not the immediate cure-all that the leaders sought. Even with the handicaps under which hospital school facilities gave instruction, some were superior to their collegiate counterparts (p. 68).

Nutting outlined the advantages offered to schools of nursing when they became aligned with universities or colleges in the Educational Status of Nursing (1912, pp. 46-48). By this time several of them already had regular departments within universities with favorable

results. The leaders observed, "All university relationships presuppose a rationale system of hours of duty, and there can be no escape from the ruling that every increase in the amount of theory means a corresponding decrease in the amount of practical work" (NLNE, 1917, p. 32). Apparently, this admonition was not always heeded.

Where, however, the university opens up its classrooms and laboratories to classes of students from schools of nursing and fails to look into the nature of the practical training in the hospital and the conditions under which it is carried on, the result may be far from satisfactory. (p. 32)

Isabel Stewart warned at the Nineteenth Annual Convention of the National League for Nursing in 1913:

The fact it is becoming more and more common to link up nursing schools with universities or colleges raises the question of the nature of such affiliations. We have several protests against a certain type of so-called affiliation, where there is not the slightest pretense of adopting university standards or of improving the real status of the school. It would seem to the committee that some effort should be made to prevent the discrediting of nursing education among college students which must inevitably result from this practice. (Stewart, 1991, p. 166)

At this time Nutting envisioned college education for certain categories of nurses but not for all who were practicing. Dr. John A. Hornsby, editor of Modern Hospital, wrote Nutting in an attempt to elicit whether she preferred women to have a college preparation prior

to entering a training school. Her reply, dated November 1913, indicated she believed high school education was sufficient.

I am so far from favoring such a thing [a college education prerequisite for nursing] that I would be strongly opposed to it, as neither necessary, advisable nor practicable. Of course, we need a good many well-educated women in certain branches of our work, as superintendents of training schools and as assistants and teachers in such schools, educated women are necessary. Equally are they required as supervisors, and we must have training schools of such character and of standards of work as will attract these educated women and hold them through demands upon their intelligence, as well as upon their physical powers. (quoted in Marshall, 1972, p. 204)

No doubt Nutting was influenced by the fact that hospital-based programs requiring a high school diploma were still a minority. Having risen to the ranks herself without a college education, she was also a practical woman who understood it would be unrealistic to restrict entry into nursing education beyond the point of high school graduation.

In the letter Nutting subtly conveys that the major purpose in raising the standards of schools of nursing was to make them sufficiently attractive to the type of women who were more in keeping with the leaders' ideas of what they needed to move the occupation to a professional model. Four years later,

Nutting and her colleagues continued to emphasize this notion in the introduction to the Standard Curriculum.

In positions of leadership especially we are suffering for the lack of well-trained women. . . . Unless the hospital itself selects good women and gives them a broad substantial foundation to begin with, there is little hope that we will develop many of the kind of leaders who are needed for our very responsible educational and administrative work. (NLNE, 1917, p. 6)

What is also becoming clear is the notion that it was nurses in specialized areas of practice whom Nutting and her colleagues wanted to have collegiate preparation, but that it was less important or perhaps not essential for nurses who engaged in general practice.

Higher education for women began to open up largely as a result of the women's movement which gained momentum at the turn of the century. By 1916, there were 16 colleges and universities in America that had nursing courses, departments or schools. The strongest incentives for moving nursing education into colleges and universities was spurred by the serious need for nurses in civilian and leadership roles during World War I (Echols, 1989, p.85).

The experience of the war helped the public to recognize "that nursing is in a very special sense a

national service, and that the training of the nurse is a matter of vital concern . . . to the country at large" (NLNE, 1917, p. 5).

When collegiate degree bearing programs were established on a generic level, they were usually designed with two years of college courses on to which was added a nonintegrated hospital school training taught by a separate nursing faculty. Each school undertaking such an affiliation, whether it be with a college, university, or in some cases with a medical school, made curricular arrangements that might vary from this pattern to some degree. An example would be collegiate courses that ran simultaneously with hospital training. But the striking observation is the persistent dichotomy between the two segments of the educational plan: they were in essence "two programs" running side by side.

Nursing schools were never considered to be "equal partners" in the sponsoring institutions "partly because of financial considerations and partly because nurse educators were not aware of what constituted conventional educational status." The leaders' attention was on more pressing goals "pertaining to

influence over hospital schools and over the nursing profession itself" (Strauss, 1966, pp. 80-81).

But the leadership couldn't help but notice that women's private colleges as well as professional schools in medicine, law, journalism, theology and the newer applied sciences were being endowed with unprecedented funds to expand and improve their enterprise. Meanwhile, schools of nursing remained totally ignored (Nutting, 1916, pp. 1-2).

There had been attitudes generated in the public that nurses were "overtrained" and that more education was apt to make them question a doctor's orders and to want to go beyond the scope of the nurse's role. Physicians tended to shape the perception and thus limit nursing practice "to a service and literal carrying out of orders and to technically perfect attendance on themselves" (Doheny, Cook, & Stopper, 1987, p. 17).

Nutting had hopes that Columbia University would eventually undertake the generic education of nurses through an appropriate hospital connection (Medical Commission, 1916, p. 6). The leaders, like Nightingale, were not yet at a stage where they could envision the basic core of nursing education as taking

place anywhere else but in a hospital. University sponsorship or affiliation was needed to ensure that the educational mission of training was salient, as well as to provide opportunities for a broader curriculum with high standards. As Nutting observed, "Efforts to improve the character of the teaching are going on steadily in our training schools, notably in those which have recently been established under the direction of universities" (p. 6).

The leaders were astutely aware that university or college affiliation meant students would have to pay tuition and fees, thus guaranteeing they would generally be from a higher socioeconomic strata. Peers who had no other alternative chose schools that either paid them a small stipend or offered free education in exchange for their labors.

The University of Minnesota school did not confer a baccalaureate degree on graduate nurses until 1919, after several other colleges had already taken this step.

In 1916, the University of Cincinnati . . . [established] . . . both a diploma and a baccalaureate degree . . . [which] took five years. In 1917, Columbia University put together a five-year program in conjunction with Presbyterian Hospital in New York, and a similar program started in San Francisco, at the University of California. These five-year degree

programs included two years of basic sciences at the university, two years of nursing experience in a hospital, and one year of special training in public health or education. (Davis, Olesen, & Whittiker, 1966, p. 142)

Nutting had arranged the affiliation with Presbyterian Hospital that would allow women with two years of college to matriculate at Teachers College while they went through a three-year training school. At graduation, having completed five years of study, the student was eligible for both a diploma from the Presbyterian School of Nursing and a Bachelor of Science degree from Columbia University. Although this scheme would insure a higher grade of students than would be found in the average training program, it didn't satisfy Nutting's vision for a total university school of nursing (Christy, 1969a, p. 58). Her dream would materialize in 1922 when the Presbyterian School was connected with a new medical center at Columbia University. This arrangement allowed the university to develop all the undergraduate courses. Nutting had Teachers College discontinue its ties with the program by 1924 in order to permit the Nursing Education Department to place its full concentration on the needs of graduate nurses (p. 68). Significantly, Columbia-Presbyterian was the only school with a degree option

residing in the East. The other 16 schools offering degrees originated in the southern or western sections of the United States (Bullough & Bullough, 1984, p. 31).

Impact of Nursing's Domestic Image

Along this progressively uphill trajectory nursing's ability is to establish itself as a scholarly discipline had suffered from the negative impact of its domestic image. The thread of domesticity, as it coincided with modern nursing practice and education, can be understood from the perspective that nursing was viewed as an extension of women's responsibility in the realm of "home life and household affairs." As discussed earlier, middle class women, during the Nightingale era, could choose to nurse outside their homes with approbation only by extending the concept of family to the sick in the community and all of society. In this context "Nursing was considered the natural extension of the new discipline of 'domestic science'" (Bryant & Colling, 1990, p. 155).

When nursing moved into academe with its first postgraduate program at Teachers College, this early curriculum was strongly influenced by its domestic orientation. In 1906, Nutting's unpublished notes

revealed that she thought "All good nursing included the constant use of . . . housekeeping arts [and that] hospital management consisted of expert housekeeping on an enlarged scale" (Feigenbaum, 1990, p. 200).

Students in hospital-based training programs were inculcated into the role of nurse as guardian of the well-being of the "hospital family." This meant the nurse had to look after the needs of everyone from patients to physician. Moreover, all "departments of the hospital from wards and operating rooms to store-rooms and kitchens were staffed and kept open 24 hours a day by nurses" (Bryant & Colling, 1990, p. 156).

In 1893, Hampton delivered a paper at the International Congress of Charities, Correction and Philanthropy, titled "Educational Standards for Nurses."

Every woman before entering upon hospital work should be a thoroughly trained housekeeper. Practical household economy should be a part of her home education, for in the hospital wards the nurses are its stewards, the caretakers of the hospital property, and upon their thrift and careful ordering must depend the economical outlay of hospital funds. I cannot dwell upon this practical household economy with too great emphasis, for experience has shown me to a painful extent how this branch of women's work is neglected or superficially understood by so many women in all ranks of life. A total lack of or appreciation for the principles that govern such work will inevitably be followed by a deficiency in thoroughness and system. . . . But too often

. . . training schools are obligated to not only teach in two short years all that pertains to nursing, but try as well to teach the first principles . . . of domestic science, and much valuable time is spent in doing this that should really be given to nursing. (1949, p. 11)

In retrospect it seems as if Hampton was looking ahead to a time when nurses would be established at a teacher training institute with a course on domestic science (Christy, 1969, p. 13).

Nutting believed that "hospital management consisted of expert housekeeping on an enlarged scale." Unpublished notes found among Nutting's papers reveal her propensity for bringing advanced preparation for nurses under the umbrella of Hospital Economics. Clearly the hospital was viewed as the prime locus of nursing education. "[Since] the term Hospital Economics, . . . embraces all the interests of the hospital, courses of study are gathered together and appropriately grouped, for the purpose of preparing nurses of special ability for highly responsible posts of administration, supervision and instruction" (Nutting quoted in Christy, 1969a, p. 36).

Nutting became involved in the home economics movement through colleagues with whom she attended summer conferences dedicated to promoting household efficiency. At these conferences Nutting gained

recognition for her expertise through papers she delivered on institutional management (Reverby, 1987, p. 151). The household reformers believed they could replace "the void the loss of productive work had left in women's domestic lives" by applying scientific principles that would transform drudgery to mentally stimulating activity. The idea was that by improving standards women might also improve themselves. "Ellen Swallow Richards, the movement's leading figure and theoretician, recognized the parallels between nursing and her own work. She cited the introduction of trained nursing and trained woman superintendents as examples of 'the first success in modern housekeeping'" (p. 152).

Patently, nursing leaders came to believe that the focus on scientific management might grant the leverage they needed to place nursing on a more equal playing field with physicians and administrators. Like Nightingale who wanted to reform hospitals through sanitary science, each realized that improvement could not be considered apart from upgrading the training school's educational programs. "Nursing standardization, the leaders realized, was necessarily

connected to hospital standardization" (Reverby, 1987, pp. 152-153).

When Nutting began her tenure at Teachers College, she

was grateful for every association that she had had with institutional housekeeping at Johns Hopkins, every minute spent with Rachel Bonner in the kitchen, the linen rooms, and the laundry, the long hours with Dr. Hurd going over the hospital accounts, and perhaps most of all for her mother's abiding lessons in thrift and economy. She subscribed to a clipping bureau for articles on domestic economy, laundry, cleaning, and the management of servants. She herself was an inveterate clipper of household hints and shortcuts adaptable for hospital use. Soon she was drafting courses in management which would appeal to home economics majors as well as to those in hospital administration. (Marshall, 1972, p. 152)

However, by 1914 Nutting would regret this earlier emphasis concluding that the underlying theme only served to repel desired candidates from entering nursing. She cited the reasons as

. . . the still existing prevalence of a sentiment which looks upon nursing as an easily-acquired homely art, in preparation for which nature leads the way. . . . In other words, the public is still really willing to accept ignorance and incompetence in the care of the sick . . . (p. 603)

Study Points to the Advantages of

University Affiliation

As early as 1911 Nutting had been trying to engage one of the philanthropic organizations to undertake an

analysis of nursing education that would parallel the Flexner study of medical education (Christy, 1969a, p. 64).

The Flexner report, sponsored and funded by the Carnegie Foundation, stimulated major innovations in medical education which resulted in fundamental improvement in medical practice.

As nurses . . . lost ground in their efforts to establish standards, their counterparts, the doctors, were well on their way to bringing their sprawling profession under control. The American Medical Association was reorganized in 1901, and in 1904 it began the process of inspection and grading of medical schools which, culminating in the Flexner Report of 1910, forced dozens of inadequate schools to close. (James, 1979, p. 236)

Nursing leaders wanted similar changes in nursing education. When the Society of Superintendents approached the Carnegie Foundation for comparable support, they were told that the foundation's funds were already earmarked for studies of dental, teacher and legal education (Echols, 1989, pp. 284-285).

Nutting drew up an outline of a plan to investigate nursing education (circa 1911) hoping it would be sponsored by the Carnegie Foundation. She wanted help in identifying how schools of nursing could become more attractive to "intelligent women" (p. 2). Nutting estimated that the general amount of

theoretical work during the three years averaged only two to three hours per week (p. 4). She had hoped that one result of such a study would be the recommendation to diminish the number of schools by amalgamating many existing ones (p. 8); that being so, there could be better control over who entered nursing and the caliber of the educational program.

Henry Pritchett, President of the Carnegie Foundation for the Advancement of Teaching, wrote Nutting on June 17, 1911, ". . . it would seem to me that the education of the nurse must not be placed on the same plane as the training for a profession for medicine, in which a high degree of original thinking is required. . . ."

Not to be deterred, the leaders arranged their own study. As chairperson of the Committee on Education of the National League for Nursing Education (NLNE), Nutting conducted a study of nursing schools sponsored by the United States Bureau of Education in Washington. The results were published in a bulletin, Educational Status of Nursing, in 1912 (Christy, 1969a, p. 47).

The Educational Status of Nursing was the first comprehensive study made on nursing education in the United States and possibly in the world. It was widely

received and commented on in newspapers across the nation. The government's entire printing was sold out in less than two years (Marshall, 1972, p. 190).

The reports made good use of data showing the lack of uniform standards in schools concerning admission requirements, theoretical instruction and essential equipment such as library and suitable books.

Women whose actual formal education has not gone beyond the common school, and has ended at the age of 13 or 14, or who have had but one year of high school, or one or two years in private school or convent, enter training schools on identically the same terms as a woman bringing a college degree. (Nutting, 1912, p. 25)

Nutting drew attention to the educational advantage of the small number of training schools which had affiliations with universities or which, as in the case of the University of Minnesota, was in the direct charge of the faculty of the College of Medicine and Surgery. Students in these institutions had access to facilities just like any other college students.

Nascent nurses were exposed to accomplished faculty members with professional rank who emphasized the theoretical aspects of the subject matter. Congruent with ideas of transforming nursing into a profession, an academic environment stood to command and attract

students who fit the profile the leaders desired (pp. 47-48).

Nutting's message stressed the need to separate schools of nursing from the control of hospital service. Hospitals were essential for supplying the experiences needed for developing clinical skills, organizational ability and judgment, yet, as Nightingale planned, schools should have their own separate boards to govern in matters of teaching, training and discipline. The report stated that "The faculty should determine the requirements for admission, length of course, subjects to be taught, in theory and in practice, diplomas and degrees, vacations, salaries for staff, and other similar matters, and should make all arrangements with the hospital" (p. 52).

Bellevue Training School was established under these conditions with its founders proposing that one day they hoped to provide a college for the education of nurses with a charter from the state (p. 50). However, once the private endowments dwindled, the independence of the school was short-lived.

Nutting acknowledged that although the "large best equipped, and well-known schools" tended to attract the

most desirable candidates, they were not immune from the specter of having to accept those whose intelligence and educational preparation were seriously lacking where sheer manpower was needed (p. 26).

Appealing for uniform admission standards, she wrote

. . . as a country we believe in education; indeed we stand for it. . . . Is it, then, respectable for men of any standing to maintain that the "equivalent" of the first high-school [sic] year is too much to exact of women who are to be entrusted with responsibilities of life and death? Should we not be ashamed to assert that a primary education is enough for a hospital probationer, or that three years is too long a time for the training of a nurse, though it is not long enough for a complete knowledge of horticulture. . . . The thing of real importance is not that nurses should be taught less, but that all women should be taught more; not that courses of training for any serious work should be shortened, but better filled (p. 27)

The report's intended purpose was disappointing for although it stimulated much controversy, there followed little change. "Perhaps the poor condition of many thousands of abused workers in factory sweatshops captured the public's attention and spirit of reform more dramatically than did the plight of a few thousand nursing students." Gradually the students' workday was reduced to nine hours with an average of 56 hours per week. The rigid discipline of the past continued to be the norm and all physicians' orders had to be strictly adhered to (Echols, 1989, p. 285).

As late as 1922, entrance requirements to schools of nursing varied substantially according to statutory requirements of individual states.

Graduation from Grammar School (8 th Grade)	- 5 states
One year of High School	- 20 states
Two years of High School	- 7 states
Four years of High School	- 6 states
Determined by the Board	- 4 states
Good common school education	- 2 states
No legislation on the subject	- 4 states
(Preliminary Report on Training Nurses to the Council on Medical Education and Hospitals of the A.M.A., 1922, p. 6)	

It is apparent that although the leaders began to acknowledge the advantages of university-affiliated schools, they had to contend with the apprentice system and a domestic orientation that dominated nursing education from its inception. They hoped that well-placed schools in college and university settings with high standards for admission and retention of qualified nursing candidates could supply the prestige and future leadership for an emerging profession. It is not clear from the evidence that they ever believed that all nursing education should eventually come under university sponsorship. Ostensibly, they wanted an upscaling of nursing programs in terms of theoretical content and a student body capable of fulfilling the higher requirements. Eventually, they were forced to

recognize that it could only happen if the schools could obtain enough financial independence to divorce themselves from the service mission of the hospital. But even here they were sadly disappointed by some university hospitals who were as exploitative of student labor as any commercial hospital could be.

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CHAPTER XII

Standardized Curriculum Emerges

In 1910 Isabel Stewart, who became Nutting's assistant, laid out her ideas for a standardized curriculum for schools of nursing in the Teachers College Bulletin along with a discourse on her educational philosophy. No doubt she was influenced substantially by her own educational background and professional experience. Stewart, like many of the leaders on the eastern coast, first pursued a career as a schoolteacher before entering nursing. After graduating from Winnipeg General Hospital she worked for five years as a graduate nurse before enrolling in the postgraduate course at Teachers College where she stayed to earn Bachelor of Science and Master of Arts degrees (Christy, 1969a, p. 48).

It is noteworthy that Stewart gently touched on the notion that education should prepare nurses for autonomous functions and decision making. She thought that ". . . the aim of professional education should be to make those special adjustments, and to train those special powers which would give the student control over that particular environment which is determined by the profession of her choice" (1910, p. 11).

She also proposed that the ideal program would provide a proper balance between clinical experience and theoretical foundations, which ultimately would enrich and mold the characters of the future professionals (p. 11).

Nursing, she believed, was suited for the "welding of theory and experience." For Stewart, sound clinical instruction was of critical importance to the refinement of skills and clinical judgment.

In no college or normal school can the test of instruction be made as speedily and so completely. . . . Indeed, the actual teaching at the bedside, where instruction and application go hand in hand, is really ideal from the teaching standpoint . . . no situation could provide a stronger stimulation of vital interest, or more impelling motives for good work, than are found in this wonderful laboratory of the hospital ward. (1910, pp. 20-21)

Stewart was no doubt involved in thinking about an ideal curriculum from the standpoint that the postgraduate program at Teachers College was constructed on the premise that entering students would have to show evidence of an acceptable basic education in nursing. This criterion notwithstanding, assessing each applicant became a problem because there were no established criteria for what constituted a satisfactory curriculum.

Consequently, in 1914 Nutting and Stewart persuaded the Committee on Education of the National League for Nursing Education to undertake the monumental task of designing a model curriculum. At first they sought assistance from schools with superior reputations, but the strategy was disappointing when it was shown that their curricula were, in fact, remarkably different (Christy, 1969a, p. 51). Nonetheless, it has been suggested that the resultant proposed standards for nursing education, which found their way into early collegiate programs, had roots in a few outstanding hospital schools with trustees and administrators who recognized a social responsibility for producing qualified nurses (Bridgman, 1953, p. 44).

In 1917 the Standard Curriculum for Schools of Nursing was published by the National League for Nursing Education. Nutting wrote the preliminary portion, addressing the administrative problem, and Stewart compiled and wrote the remainder. Although the Education Committee wanted the publication to serve solely as a guide, some schools attempted to follow it exactly as it was. Predictably, while the Standard Curriculum had a strong influence on the schools, it drew harsh criticism from many hospitals and physicians

who thought the standards were set too high (Christy, 1969a, pp. 51-52).

Indeed, Stewart had anticipated strong opposition early on, noting ambitious superintendents who attempted to implement it "would probably have to fight every step of the way . . ."

And yet, if anyone of them were asked to name the qualification of a good nurse, it would be culture, refinement, serviceableness, common sense, adaptability, the power to put herself in another's place, which we might call social sympathy, self-control, strength—mental and moral as well as physical—these are the things they would think of first of all. These are supposed to come ready-made—the tricks of the trade, and the little bit of professional lingo which will enable her to understand orders—is all the curriculum is supposed to teach. No intelligent, interested, thinking woman is going to be satisfied with that thin diet. (1910, p. 19)

Nutting wrote a series of letters asking leading physicians to comment on their ideas about the scope of nursing education. Dr. Henry Baird Favill of Chicago would reply:

If we take the view that the nurses should be given an education sufficiently broad to enable them to have and exercise a valuable judgment, we at once enlarge the scope and almost inevitably obscure the lines of definition of a nurse's work. (April 3, 1912)

It is not clear to what extent, if at all, Nutting and her colleagues were influenced by such opinions.

The elaborate plan (which would be modified in subsequent years) was laid out in 166 pages. More than one hundred members of the National League for Nursing Education assisted in the work over a three-year period.

. . . the various subjects were assigned to members especially qualified in those branches, who proceeded with such help and advice as they were able to secure, to work out the outline according to a general form. Each outline was then multigraphed and copies were submitted to a number of representative training school superintendents, teachers, supervisors and public health nurses throughout the country for detailed criticisms and suggestions. . . . The outlines were then collected, the suggestions compiled and new outlines were made out which were again, in several cases, referred back to various members before being finally approved. Opinions differed frequently and in such cases the majority opinion was accepted. (NLNE, 1917, p. 8)

The Hospital-Based Model Predominates

The authors presented a comprehensive curriculum that was reflective of nursing practice as it had evolved, thus giving the plan immediate practical value; but, as the committee lamented, they had to consider what was workable, given the current structure of the educational institutions. Therefore it did "not recommend that the average hospital should undertake anything further than the fundamental subjects which would be required in any of the commoner branches of nursing practice" (p. 7).

The curriculum proposal included objectives, content, methods of instruction and the resources required for each course or subject. Its content was spread over three years and demonstrated a grading system which provided for a student's progression from elementary courses such as anatomy and physiology, applied chemistry, nutrition, hospital housekeeping, bandaging, drugs and solutions, and the historical and ethical basis for nursing, before moving on to subjects of a more complex nature. In the second term of the first year, students were to be engaged in learning pathology, diseases, pharmacology and elements of psychology.

The last term in the third, or senior year, was to be spent on modern social conditions, professional problems, and emergency nursing. If time was allotted, students were to explore the various branches of nursing such as public health and social service, private duty, visiting nursing ("Home Problems of the Industrial Family"), institutional work (in schools, orphanages, clinics), as well as specialized work in diseases such as tuberculosis. The latter suggestions were optional (p. 39) and were "not to be introduced at the sacrifice of the more fundamental subjects" (p. 7).

It is commonly asserted that early nursing education was dominated by medical treatments because a body of knowledge belonging to nursing had not been strictly defined (Doheny, Cook, & Stopper, 1987, p. 18). Lacking research methodology to investigate clinical issues and questions, nurses were not in a position, as were their medical partners, to establish scientifically that they made important contributions from their own discipline to the outcome of patient care or in areas of illness prevention. This would come much later in the evolution of nursing.

But when the early leaders and educators painstakingly began to demarcate a core curriculum for the entry-level practice, there began to emerge some degree of agreement across the country about what should be the knowledge base common to all graduates of reputable schools.

Designating a curriculum supported by a consensus among prominent members from within the nursing community was a crucial step in nursing education for two reasons.

1. Most salient, perhaps, was the need to set a standard of education that was worthy of assuring society that graduate nurses were qualified as

competent practitioners. In terms of their own goals, the leaders never lost sight of educational excellence as a means to secure professional recognition for nurses.

2. Another motive, inexplicit but nevertheless unmistakable, was the acknowledgment that when nursing moved into the college or university setting, there had to be a collateral core curriculum in place to demonstrate nursing as a distinctive field of study.

Nutting and Stewart began by concentrating on a curriculum that would be suitable in any geographic area of the country. They already had data published in the Educational Status of Nursing based on a questionnaire sent to 1,100 schools which supported their contention that the "great majority ranked from poor to mediocre educationally" (Christy, 1968a, pp. 203-204).

The leaders knew that they couldn't continue to interest "intelligent and competent women in hospital and nursing work" unless they could make their courses comparable to those "given in other technical and professional schools" (NLNE, 1917, p. 7). The Standard Curriculum offered an exhaustive list of suggested reference books, textbooks and resources through the

different sections. Schools were strongly advised to plan scientific laboratory components where it was germane to students' learning: specific guidelines were given for laboratory exercises. "No up-to-date school or college attempts to teach any science or art without providing laboratory facilities for each pupil" (p. 29).

The authors took great pains to ensure that the courses they proposed could meet approval for college matriculation. While some hospital schools were gaining educational benefit and prestige through their association with universities and colleges, what was slower in coming was the actual recognition of nursing courses as credit bearing.

The committee estimated that the subjects covered in the suggested curriculum should yield 36 credits ("points") or the equivalent of one year of college work. But to the extent that so much of the students' clinical education was taken up with repetitious experiences and "more routine household procedures," it was difficult to assign a specific number of credits to the practical work.

A formula was eventually agreed upon which amounted to one full day of hospital work per week

being equivalent to one laboratory credit. (A day could be from eight to twelve hours or more.) Since most students worked at least six days a week, they could receive six credits per term (p. 161). At that time one or two universities were granting the equivalent of two years of college credit "for work in a first-class, three-year nursing school for students working towards a Bachelor of Science degree" (p. 162).

The amount of hours devoted to each section was specified by the committee, but they were acutely aware that each instructor following the plan would have to negotiate what was considered appropriate and workable at her training school.

For example, Orthopedic Nursing was allocated ten hours to be divided accordingly, "Lectures or clinics by orthopedic specialist—4 hours . . . classes and demonstrations by a nurse with special training in orthopedic work—5 hours . . . lecture on social aspects of orthopedic work by head of social service department—1 hour" (p. 102).

The lectures on the social problems associated with orthopedic practice included education and training of the physically handicapped, employment

opportunities, special schools and institutions, and the role of the visiting nurse and school nurse in case finding and therapeutic management. It also directed the nurse in methods of collaborating with social and educational agencies. The entire orthopedic section of the curriculum was to be "correlated closely with courses in surgical nursing, in disease of children and massage" (p. 103). Clearly the intent was that nurses should be sufficiently educated to direct the care of patients beyond the hospital setting. But hospitals with training schools were not inclined to consider the career interests of nurses once they graduated (Roberts, 1964, p. 56).

The selection above for orthopedic nursing would be considered legitimate by modern standards. A major difference would be that probably all aspects of orthopedic principles and pathology would be taught by nurse educators. Physicians are not, as a rule, found on nursing faculties in generic education programs.

Looking ahead to the time when nurse educators would assume full teaching responsibility, the subsection on teaching "reflected the increased educational sophistication of the nursing leadership." Stewart and others who helped construct the curriculum

were graduates of Teachers College and thus were exposed to newer, more progressive ideas on educational thought (Murdock, 1986, p. 19). The Standard Curriculum proposed that

Every detail of teaching should be planned out ahead, and not left to the spur of the moment. Slavish dependence on a text-book usually means slipshod, ineffective, training, and rambling remarks, no matter how interest, can never take the place of clear-cut, well directed questioning and thoughtful discussion. (NLNE, 1917, p. 28)

One major early improvement that was supported by the leaders and gradually accepted by all schools was the launching of a pre-clinical period for incoming students mandating they pass courses in basic scientific and nursing principles and preparation in elementary nursing techniques before being permitted to assume the actual care of patients (Bridgman, 1953, p. 44).

At the onset the leaders acknowledged that indeed there were a few schools that went beyond these standards and encouraged them to continue taking the "lead in working out something better than we have reached yet" (p. 5). The most challenging task ahead of them, however, was to try to elevate schools of potentially good standing to the recommended level they prescribed.

Like Nightingale, they drew attention to the fact that nursing meant far more than caring for patients with acute illnesses. Although nursing care in disease became the focus in hospital-based schools, the whole question of preparation for the expanding roles nurses were beginning to fill had to be decided. The new emphasis on disease prevention and health education for the public that was taking root in American society had always been a dominant theme in Nightingale's concept of nursing (Winslow, 1911, p. 916). But medical practice in the acute care hospitals where nurses trained kept the focus on pathology. That being the case, it seemed as if the leaders were compelled to view health prevention primarily within the domain of nurses working in specialty areas or advanced practice.

Another limitation of the ordinary training is that it deals only or mainly with disease, neglecting almost entirely the preventive and [patient] educational factors which are such an essential element in the many new branches of public health work, such as school and visiting nursing, infant welfare, industrial welfare and hospital social service. Similarly, the physical causes and evidence of disease have been recognized as important, but the social and economic conditions which lie at the root of so many of our disease problems have usually been overlooked in the course of training. This knowledge is fundamental, particularly in the newer branches of nursing, and the lack of it is a distinct handicap to the nurse in her work. (NLNE, 1917, p. 6)

What is particularly instructive in the suggested outline for Principles of Ethics as Applied to One's Work or Profession (p. 133) is the pervasive work ethic theme and strains of self-abnegation. Phrases such as "Putting one's soul into one's work. . . . The value of work as a means of happiness. . . . Dangers of . . . materialism" permeate the values that were supposed to be taught. Except for a small reference on developing "good judgment" as a quality necessary "in leading and guiding others," there is no other hint at preparation for independent decision-making.

Despite Nutting's expressed desire for autonomous nursing programs, the new curriculum guide was designed for adaptation within hospital-controlled schools (Marshall, 1972, p. 232). It was welcomed by most state boards of nurse examiners and the better schools and it "proved [a worthy] blueprint for the thirty-one units of the Army School of Nursing organized the following year" (p. 233).

CHAPTER XIII

Public Health Imperatives Fail to Change

Basic Nursing Education Programs

Nursing's movement into community health sparked new interest in the importance of nursing education. Opportunities would arise that could allow the leaders to endorse a baccalaureate degree as the ideal preparation for all nursing candidates, yet they opted instead to maintain the system as it had evolved. Although leaders pressed for university affiliation, they continued to uphold the notion that hospital-based schools should be the prevailing institution for basic education for the majority of nurses. Meanwhile Nutting had positioned the program at Teachers College to offer preparation for leadership in community health administration and education.

When training schools were first opened, the majority of graduates could only seek employment in private duty while only a small number were hired in public health and by the hospitals. But by the turn of the century other positions were opening up which gave them more options: the expansion of public health schools and industrial nursing as well as leadership positions in hospitals which found it in their interest

to salary head nurses and supervisors (Reverby, 1987, p. 110).

Graduates of large hospital training schools had wide experience in caring for seriously ill patients whose survival often depended on their expertise. Until the advent of antibacterials, nursing care was perhaps the most important factor in determining outcomes in the face of infectious diseases. Students entering these programs generally believed they would be disposed, without need for further formal education, to be full-fledged practitioners of nursing. Be that as it may, nurses began to accept the idea that teaching and executive positions in hospital work and public health warranted additional preparation (Brown, E.L., 1966, pp. 177-178; Fitzpatrick, M. L., 1975, p. 49).

In particular, after 1900 the urban problems associated with increased immigration and the concern of government for health led to a large growth in voluntary and government-supported public health agencies (Buhler-Wilkerson, 1985, pp. 1155-1156). With educational backgrounds that emphasized hospital practice, nurses were accepting the challenge of community nursing in record numbers.

The first nurse engaged in visiting nursing in the United States, had learned on the job in apprenticeship fashion. Gradually, courses to train nurses in public health work developed within service agencies, the first being that of the Boston Instructive District Nurses Association in 1906. Eventually, some nurses began taking courses at schools of philanthropy. (Fitzpatrick, M. L., 1975, p. 13)

Two nurses who became prominent were Mary Brewster and Lillian Wald who, in 1893, founded the Henry Street Settlement in lower Manhattan. Wald, who is considered the founder of public health nursing, went on to become president of the newly formed National Organization of Public Health Nursing in 1912.

By 1912 there were 3,000 nurses engaged in some form of public health nursing. This showed a remarkable increase from the less than 200 who were similarly employed in 1900. Within this time the visiting nurse "had become the most important figure" in the public health movement. Nurses were proving they could effectively manage households where sickness prevailed by using their skills in assessment, teaching and helping families to cope in the face of economic and social hardship. Nurses were also beginning to specialize in other public health outreach programs such as tuberculosis nursing, school nursing, and child welfare (Roberts, 1964, p. 83).

Asserting their independence, these nurses declared an end to "the old teaching" of the nurse as the handmaiden of the physician. She was instead a co-worker of the physician who helped him produce results he could never accomplish alone. (Buhler-Wilkerson, 1985, p. 1157)

Nonetheless, as nurses broadened the scope of their work in the community they came to realize that the educational foundation they received was inadequate for many of the challenges they were facing (Roberts, 1964, p. 15).

Through their program at Teachers College the leaders had positioned themselves to accept the challenges. Disease prevention and control became major sociopolitical interests during the first two decades of the twentieth century (Winslow, 1911, p. 910). On April 9, 1919, Nutting wrote Dean Russell:

No more effective educator on simple hygiene and sanitary matters has as yet been found than the visiting or public health nurse, who works and teaches simultaneously in the homes, schools, factories, infant welfare stations, health centers, and wherever she is called So what we now have to consider is the training of teachers for this great body of workers. Colleges and universities in many places are creating courses of instruction for public health nurses on similar lines to those which we laid down here ten years ago, when the Department was reorganized to include this branch of work. They turn to us confidently for women capable of organizing and developing such departments or divisions of instruction, for women who will be leaders in this field.

A National Study on Nursing Education
is Funded

In 1919, the Rockefeller Foundation agreed to fund a national study of nursing education. A committee comprised of leaders in nursing, public health, education and hospital administration conducted the investigation and published their findings in 1923 in what is now referred to as the Goldmark Report, named in honor of the committee secretary Josephine Goldmark (Murdock, 1986, p. 20).

The Rockefeller Foundation had become interested in the problems associated with the proper preparation for nurses involved in public health (Heinrich, 1983, p. 319). As a demonstrated pioneer in public health education, Nutting was invited, along with other experts in the field, to a preliminary meeting on December 16, 1918. From this conference seven members were elected to form a committee for the Study of Public Health Nursing Education.

Not only was Nutting elected to the committee, but so were her colleagues: Professor C-E. A. Winslow [public health professor at Yale], Chairman; Dr. William H. Welch of The Johns Hopkins; Dr. H.M. Biggs of New York City; [Lillian] Wald; [Annie] Goodrich [Teachers College and Director of the Henry Street Visiting Nurse Service], and Miss Mary Beard [President of the National Organization for Public Health Nursing]. Everyone, save Miss

Beard, had taught or lectured at Teachers College at one time. (Christy, 1969a, p. 65)

By 1920 the committee had enlarged to nine persons and the scope of the study was widened to include not only public health but all nursing and nursing education in the United States. The extent of Nutting's influence on the work of this committee can perhaps be measured by the fact that she had a personal hand in selecting Josephine Goldmark, an accomplished sociologist, to assume the position of Executive Secretary in June 1919 (p. 65). Nutting read all the reports and made extensive suggestions (Marshall, 1972, p. 261).

Basically the report did not recommend a college education (baccalaureate degree) for all nurses. Instead it stipulated that hospital-based programs be separated from the cost of nursing services and that each school establish an independent board as well as a separate budget. The committee's research found the content of education in hospitals was laden with menial non-nursing tasks and unnecessary repetitive experiences, therefore it proposed a shortening of the course to 28 months (Roberts, 1964, p. 179; Stewart, 1943, p. 200).

If nursing was to be upgraded, it was considered vitally important to develop and strengthen university-sponsored schools of nursing.

While the Committee did not advocate a university standard for all nursing schools, it did emphasize the need for more university schools of nursing offering education on a broader basis and on a higher level than the ordinary hospital school. (Stewart, 1943, pp. 201-202; see also Goldmark, 1923, p. 26)

The committee did put its force behind the endorsement of collegiate preparation for nurses beyond their basic education for entry into fields such as teaching, administration and public health (Roberts, 1964, p. 179). At this time Teachers College had already firmly established nationally and internationally recognized programs in all three areas.

In terms of any major reforms resulting from the committee's exhortations, the results were disappointing to the leaders. Lacking broad-scale preliminary publicity and organized follow-up in conjunction with the reports, the hospitals remained "disaffected by the emphasis on university affiliation" and turned a deaf ear to recommendations for shortening the basic course (Roberts, 1964, p. 180). Nutting had predicted in 1916 "that progress in this direction is not likely to be rapid . . . nor do I for one moment

believe that there is no other ideal than that which can be reached through the university (1926, p. 226).

Dr. Winford Smith, who had firm control over the Hopkins Training School, had become a member of the Goldmark Committee. In a fateful turn of events he wrote Goldmark in January 1922, noting it would not be necessary or practical for Hopkins to adopt the changes indicated in the report.

Committed to the Hopkins Endowment Fund Drive, Nutting, whose relationship with Smith was strained and at times hostile due to their differences, appealed to the Rockefeller Foundation in November 1922 for funding to gain university recognition of the nursing school. Nutting was summarily refused on the basis that the foundation was unwilling to enter into direct financial aid to specific schools of nursing.

Their non-involvement in nursing education notwithstanding, five months later the foundation funded America's first true university school at Yale. It has been speculated that Smith's opposition to university education for nurses may have been the deciding factor in directing the Rockefeller money to Yale instead of Hopkins. From this point, nursing made important inroads into academe beginning with Francis

Payne Bolton's endowment of Western Reserve University School which opened later that year (Ramos, 1997, p. 34). But at Yale, nursing's supposedly showcase collegiate program, it became obvious that the foundation's funding was almost penurious compared to the millions of dollars that poured into the medical school and other Yale institutes (Reverby, 1987, p. 166).

Nurses entry into community health in record numbers held the promise of breaking the shackles of physician domination over nursing education and practice. Society's stake in the nurse's role in disease prevention and health promotion projects helped to spawn one of the most important studies in nursing education in the United States. In spite of this renewed interest in nursing, most basic education programs would remain largely unchanged. Insofar as the benefits of university affiliation were acknowledged and encouraged by the leaders, it was understood that only a minority of nurses would qualify.

CHAPTER XIV

Conclusion

This study sought to test two hypotheses:

(1) Nightingale introduced an approach to education that would qualify nursing as a full-fledged profession, and (2) adaptation to the hierarchical roles of the modern hospital resulted in the achievement of only a subordinate level of authority which prevented nursing from the control over its own social position that is the hallmark of professional identity. The historical and sociological data encompassed in this document are used to argue in favor of the two basic propositions formulated at the start of the study.

Proposition 1: Nightingale provided an intellectual basis for a growing autonomous function for modern nursing.

Elliott Freidson proposed that an occupation becomes a profession when it can achieve "A dominant position in a division of labor so that it gains control over the determination and substance of its work" (p. xvii). Nightingale's pioneer work in upgrading and modernizing in an occupation that has

existed through the ages did at the outset seek to carve out a special and unique role for nurses in the health care arena. "Unlike many fields that had been generated in response to new areas of knowledge and scientific discovery, nursing emerged in direct response to a social need for caregivers before an active research base was established" (Dreher, 1989, p. 83).

Today nursing has become deeply involved with identifying and analyzing exactly what it does as well as establishing a basis for differentiating its practice from that of other health providers (p. 83). Scholars have only recently begun to discover and uncover the tremendous legacy Nightingale left in establishing a premise for nursing as both an art and a science. Although she was not the first reformer of her era to focus on the need to upgrade the nursing care of the sick, she was the only one who initiated the work by establishing a theoretical foundation upon which her followers could build the practice of nursing.

Retrospective analyses of nursing theory development during the past two decades have illustrated how Nightingale, as early as 1869, established the essential parameters of nursing

knowledge. . . . The key concepts set forth by Nightingale—nurse, person, environment, health—have emerged as essential ingredients of nursing theory. (Newman, 1992, p. 44)

Professions have become respected in large part because of their abstract theoretical knowledge base from which applied service for the welfare of the community is derived. Its members would have to undergo a prolonged and specialized training to acquire the knowledge peculiar to its discipline (Mumford, 1983, pp. 250-251). Major attributes of a profession include the responsibility for the continuous development of a new knowledge upon which its practice becomes dependent (Johnson, 1992, p. 24).

At the onset of her work, Nightingale consistently emphasized that nursing practice had an autonomous basis. "She was quite clear in noting that nurses worked with, but were not secondary to, others" (Rogers, 1992, p. 59). Nightingale recognized that nursing was unique in terms of the knowledge it used in practice (p. 59). "One of the most striking aspects of Nightingale's view of people is her attitude of caring for the person who is ill rather than being concerned with the illness per se." This perspective underscores

the distinguishing aspect of professional nursing practice (Fitzpatrick, J. J., 1992, p. 20).

In her Notes on Nursing Nightingale seldom refers to a specific disease, but rather attends to every patient experience with being sick (Dreher, 1989, p. 80), thus corresponding to modern nursing's focus on the person's "human response to health problems" (ANA, 1980, p. 10). Using this model, pathology is just one aspect of the total experience of being sick. Nightingale knew that nurses educated according to this perspective could comfortably distinguish their work from that of medicine; the approaches of medicine and nursing were to be complementary to one another in the care of patients.

Under Nightingale's direction nurses were beckoned to apply and use God's laws of health which were inimical to the laws of nursing. While stressing the importance of attention to fresh air, light, warmth, cleanliness, quiet and dietary therapy, she was quite adamant in noting that "The very elements of nursing are all but unknown" (1959/1992, p. 6). Nightingale was aware that empirical research was needed to expand nursing knowledge: ". . . the laws which make these bodies, into which he has put our minds . . . are all

but unlearned" (p. 7). Consistent with Nightingale's injunction, Robert Merton has observed that "expertness comes only from research, education, and disciplined experience," adding that "Research is quintessential to the professions" (1960, p. 663).

In contrast to modern medicine as it was evolving, Nightingale wanted nursing to develop approaches to patient care that encompassed holism, caring and adaptations to the individual "idiosyncracies" of patients. Her holism demands that nurses respond to the person's total experience of health and illness and to the role of the nurse in preventing disease. She places great emphasis on environmental measures.

Nightingale's laws of health are grounded in the observable, and often tied to environmental factors such as dampness and dirt. Nightingale's science and clinical practice are thus rooted in empiricism, which continues to be the predominant scientific methodology used today. (Fitzpatrick, J. J., 1992, p. 19)

What is significant is that Nightingale's laws in no manner can be inferred to emanate from or require the directions of physicians to execute.

Nightingale believed the knowledge nurses were to develop and use had to benefit all members of society. She referred to nursing as a "calling" because its practice required a deep sense of commitment to service

arising from a sound moral character and the capacity for self-sacrifice. To Nightingale's thinking a "calling" was a higher status than a profession because it was equated with the complete dedication of a religious vocation. Vestiges of Nightingale's concept of a calling exist today in almost all descriptions of professions under the criterion that members possess a strong service orientation (Bloom, 1963, p. 88; Goode, 1960, p. 903; Merton, 1960, p. 662).

Nightingale recognized that it was essential for nurses to be sufficiently versed in the sciences, which define medical practice in order to deliver highly competent technical care as well as to use sound clinical judgment. She forthrightly wrote that the nurse follows the physician's "conditional directions, upon which hangs the patient's life" (1882/1954d, p. 347).

But Nightingale passionately expressed her belief that the well being of patients demanded that all nurses be educated to understand the true nature of their work which exceeded this narrowly defined conception. She was aware that "Nurses do not practice in the presence of physicians and are not constantly supervised by them. Nursing care goes on without

either the consultation or the presence of the physician" (Ashley, 1976, p. 127).

This study demonstrates Nightingale played a leading role in organizing the occupation so that it appeared to be dependent on the expertise of medical doctors. Deep socio-cultural traditions within English society constrained Nightingale from moving in any other direction. However, in spite of these limitations, Nightingale was able to illustrate that nursing is different from medicine in many essential respects. Concomitantly, she held to the belief that nursing had to develop its own methods and its own knowledge. Under the rubric of "obedience to the physician" Nightingale was able to reveal in both direct and subtle messages that there were vast areas within the discipline of nursing that were independent of medicine; moreover, a careful reading of her publications uncovers recurrent themes that nurses must be educated ("trained" is the word of Nightingale's day) to exercise independent clinical judgment in the absence of the physician.

There can be little doubt that Nightingale espoused theory development within nursing but because her emphasis was on the empirical or practical level in

the application of scientific principles she has been considered by some to be anti-intellectual in her approach to nursing education. However, as we now understand, both abstract knowledge and empirical knowledge are important to the synthesis of nursing theory. Nightingale's views are actually consistent with current perceptions of theory development within nursing.

Theory consists of the abstract world as well as the real world. It is not one or the other. . . . The real and the abstract represent levels of theory. The abstract level is the general or the conceptual level of knowledge, while the real world level is the level of particulars, of empirical knowledge—the practice world. (Rinehart, 1978, p. 68)

Nightingale reminds us continually that nursing is an applied science and as such requires creativity in transforming conceptual knowledge into practical knowledge. "Look for the ideal, but put it into the actual. 'Not by vague exhortations but by striving to turn beliefs into energies that would work in all the details' of health" (1893/1948, p. 36).

Nightingale feared that the trend towards literacy education in colleges for women in England would foster the belief "that everything can be taught by book and lecture, tested by examination—that memory is the

great step to excellence" (p. 33). She argued inexorably that such a mentality should not pervade nursing education. Clearly, Nightingale's writings reflect her concerns that the accumulative fund of nursing knowledge was too complex to be reduced to measuring the qualifications of its practitioners by narrow tests. She worried about the standards of national written examinations for registration and whether these would serve to level all graduates at less than desirable standards of achievement (p. 365).

Being a product of her culture, Nightingale sought to work out her ideas within the constraints imposed on the education and status of women during the last century. Nonetheless within the apprentice system of nursing education she laid down, a new science and art were being created. Nightingale was keenly aware that the whole system she set into motion was rife with opportunities for creativity in forming a broad knowledge base on which to build the foundation of nursing practice. However the knowledge that was nursing's often remained hidden.

Physician Lewis Thomas, writing of his physician father who practiced in New York in the early 1900s alludes to this thesis:

Whenever my father spoke to me about nurses and their work, he spoke with high regard for them as professionals. Although it was clear in his view that the task of the nurses was to do what the doctor told them to do, it was also clear that he admired them for being able to do a lot of things he couldn't possibly do, had never been trained to do. (1983, p. 63)

When Dr. Thomas described nurses as being able to do "A lot of things he couldn't possibly do, had never been trained to do," he may not have been fully aware that he was in essence describing the independent function of nurses. It would follow that in order for these functions to gain recognition for their therapeutic effect the underlying principles, theories, and hypotheses, which were guiding nursing interventions, would have to be made explicit.

The special expertise in nursing that continued to grow in tandem with medical practice has not been fully recognized or identified. This happened because traditionally nursing knowledge has not been valued the way that medical knowledge is (Melosh, 1985, p. 123). Moreover, nurses have been chastised for asserting their judgment, especially if it was in conflict with the perspective of physician caregivers.

Fitzpatrick and Whall offer another viewpoint. They believe that although the practice of nursing is based on specific knowledge, "Nursing interventions may

or may not be formally explicated within the scientific domain" (1983, p. 1). Recent studies are documenting that aspects of clinical expertise may in fact "elude scientific formulations" (Benner, 1984, p. 2). Benner makes the case that formal knowledge must be tested in practice situations. This allows the practitioner to be able to develop first-hand understanding based on whether preconceived notions and expectations are challenged, refined, or disconfirmed by the dynamic of the clinical setting (P. 3).

While it has been affirmed that Nightingale was astutely aware that nursing needed a strong conceptual foundation on which to build the nascent profession, yet there is no evidence that she ever institutionalized a system for testing the laws she attributes to nursing. Moreover, Nightingale never expressed the need to chronicle the objective knowledge nurses were creating and accumulating in the course of their clinical practice. Although nursing content was being developed, as attested by the increasingly enlarged curricula of schools and colleges that followed the early Nightingale innovations, it was generally assumed that medical science was leading the way.

Using contemporary perspectives, it is still possible to see Nightingale as a woman of tremendous vision who was able to capture a sense of the unique knowledge that had to be developed and applied in the practice of nursing. In 1893, Nightingale sums up the results of the new era she heralded:

A new art and a new science had been created since and within the last forty years. And with it a new profession—so they say, we say, calling.
 . . . The art is that of nursing the sick. Please mark—nursing The sick; not nursing sickness.
 . . . This [fact that nurses care for persons who are ill] is one of the distinctions between nursing proper and medicine. . . . (1949, p. 24)

Amazingly, Nightingale set the foundation for the description of modern professional nursing as proposed by the American Nursing Association (ANA).

Nursing addresses itself to a wide array of health-related responses observed in sick and well persons. Those reactions can be reactions to an actual disease, or they can anticipate a potential health problem. Nurses diagnose and treat those responses, not the health problems themselves. The difference between a response to a health problem and the problem itself is worth noting, as it is here that an intermeshing and complementarity of the distinct foci of the practices of nursing and medicine occur. Human responses to health problems, the phenomenon, to which the action of nurses are directed, are often multiple, episodic, or continuous, fluid and varying, and are less discrete or circumscribed than medical diagnostic categories tend to be. (1984, p. 10)

Contemporary professional nursing incorporates a host of sciences, including the social sciences, in the

shaping of its practice; furthermore the unique way in which nurses synthesize and use scientific knowledge has resulted in a growing science peculiar to nursing.

Nurses use theory in the form of concepts, principles, processes and the like, to sharpen their observations and to understand the phenomena within the domain of nursing practice.

Such understanding proceeds and serves as a basis for determining action to be taken. . . . The theoretical base for nursing is partially self-generated and partially drawn from other fields; the resulting insights are integrated into a foundation for nursing practice. (ANA, 1980, p. 11)

Of course, Nightingale did not have the full range of scientific input that now exists, nor did she have the experience of a large core of educated nurses sharing their empirical observations and research through conferences and publications in professional journals and books. Rather, she was a major progenitor of such activity, yet it is tempting for contemporary scholars to impose a modern day yardstick to measure her intentions and actions.

A close examination of Nightingale's work has revealed her belief that nurses had to continue to develop and use their own knowledge in order to maintain an identity that allows them to make and

control their own special contribution to the health of society.

Actually Nightingale's philosophy of nursing education was augmented over a period of approximately 25 years. In the years since she initiated the school at St. Thomas

she had moved a long way from asserting the need for some lectures and keeping casebooks. It was her intent that the nurse should receive the fullest, richest preparation possible for the serious, weighty responsibilities she was to assume. The honing of the intellectual ability of the nurse, of her capacities for knowledgeable observation and intelligent reflection, would today be called critical thinking and analysis. (Palmer, 1983a, p. 17)

In her article, "Training of Nurses" (1882/1954c), Nightingale begins by specifying that the "physician or surgeon orders what is to be done. Training has to teach the nurse how to do it to his order." Then, in the paragraph following, she emphatically qualifies her injunction:

Telling the nurse what to do is not enough and cannot be enough to perfect her—whatever her surroundings. The trained power attending to one's own impressions made by one's own senses, so that these should tell the nurse how the patient is, is the sine qua non of being a nurse at all. (pp. 320-321)

Clearly Nightingale was alluding to the nurses role in independent clinical decision making based on a

thorough assessment of the patient's condition as well as the nurse's responsibility for intelligent discretion in carrying out the physician's instructions. Nightingale goes on to warn us that a conscientious nurse does not necessarily acquaint with competence; on the contrary, nurses need to be educated to be therapeutic in clinical situations.

Today's students of nursing are taught Nightingale's concept of holism to conduct a thorough assessment of patients taking into account the physical, social, mental and spiritual perspectives. During and after the compilation of these data, students analyze their findings in the light of current scientific knowledge in order to determine their significance, as well as the appropriate action to take. These actions are considered independent of and interdependent with other health disciplines, including medicine. The ability to elicit and recognize appropriate information and the ability to attach valid meaning to these facts in order to plan appropriate interventions are developed through education and guided experience. All of these avenues leading to competence were wholeheartedly endorsed by Nightingale. "Observation tells how the patient is;

reflection tells what is to be done; training tells how it is to be done" (p. 321).

But the emphasis on the advancement of science in nursing according to Nightingale's ideas was a later development in the evolution of its educational system, attributed largely to nurses who held advanced university degrees. Admittedly, the greatest obstacle to nursing's ability to progress intellectually as an autonomous profession was the tenacious hold early Nightingale's traditions had on its identity. "The Nightingale nurses were reared in an atmosphere of obedience and conformity and the second and third generations [held fast] to the principles that raised them. first to respectability, then to admiration. Obedience is inimical to innovation" (Baly, 1986, p. 222; Christman, 1991, p. 211). The working apprenticeship system promulgated by Nightingale eventually evolved in establishing a "set of values" that persisted over time. "The role induction process fostered a theme of anti-intellectualism, a conservatives ideology toward innovation and challenge, and a widespread lack of acceptance for educational plans that would disrupt the status quo" (Christman, 1991, p. 211).

Students learned from a "stereotyped behavioral model" who assured their induction into the nursing role assumed an "almost cloning effect." The scientific input from nurses themselves was very limited. Because so much of nursing education took place in small hospital schools, removed from the cosmopolitan influences of a university, nurses were further hampered in their ability to assess their situation. "Nurses become captives of local ideology and local hospitals and, in turn, hospitals become captives of the local nurse supply. Neither had many options or much freedom to innovate" (p. 211).

Modern nursing, at its inception beginning with Nightingale, did possess an intellectual core on which to build an autonomous function separate from any other health profession. Even though, its inability to surmount the hospital apprentice system education model would serve for a time to eclipse the fundamental aspect of Nightingale's heritage.

For most of the intervening [years] between Nightingale's work and the major accomplishment of the early American leaders in nursing, nursing's knowledge base has not been viewed as distinct from medicine, nor were serious efforts made to develop nursing knowledge. (Chinn & Jacobs, 1987, p. 36)

Theory development in nursing would not begin until the 1950s when Nightingale would again emerge as having supplied the vital elements from where to begin.

Proposition 2: The questionable status of nursing as a profession as it currently exists results from the socio-cultural accommodations to Nightingale's ideals.

There are what might be construed as contradictions in Nightingale's philosophy of nursing. For instance, she defined nursing as

. . . putting us in the best possible conditions [sic] for Nature to restore or preserve health—to prevent or to cure disease or injury. The physicians or surgeon prescribes these conditions—the nurse carries them out. (1882/1954d, p. 334)

Yet in her earliest writings in Notes on Nursing, she prescribes specific laws of nursing that have become the foundation of her nursing model. These laws "were revolutionary" at her time (Reed & Zurakowski, 1983, p. 19) and notably never have become outdated. Such an observation lends credence to the hypothesis that Nightingale indeed was carving out a much needed independent role for nursing, while simultaneously she was constrained not only by the prevailing culture of her time but also by physicians who were clearly

threatened by the prospect of educated nurses. Therefore, Nightingale's later works were tempered by these consideration. Concomitantly, Nightingale continually stressed that nursing intervention is probably the most important factor in determining favorable outcomes for sick patients.

The first and second generation leaders who had consummate influence over the direction American nursing took prior to the 1920s had overlooked Nightingale's injunction to develop a growing autonomous function for modern nursing practice through the educational systems that were designed. Nightingale was keenly aware that beyond the traditional acceptance of physician's delegated functions, which became more complex with the advances of medical science, nurses would have to be educated in principles of disease prevention, health maintenance and health promotion. She used sanitary science and holistic principles to frame a model that would establish nursing as a separate and distinct discipline within the health care system.

In their pursuit of professional status for nursing, the leaders worked with dedication for all of the traditional parameters usually associated with a

developing profession: they founded national and local professional associations, wrote codes of ethics and established a reputable journal. But the one essential ingredient they pursued—the formation of future leaders who could move nursing into a highly respected position comparable to medicine's rising status—became a persistently elusive goal. They were appalled by the dwindling standards of nursing education and the women who were entering nursing on a large scale in response to the rapidly proliferating hospitals which required the student labor to stay afloat.

The focus of the leaders turned toward upgrading basic nursing education and the need to set it free from the dominance of hospital administration. They began by establishing a postgraduate program at Teachers College for those nurses who would teach and assume positions as hospital superintendents and administrators. This strategy was designed as a means of getting advocates into the educational system who would be of like mind as the leaders in pursuing necessary changes. Nightingale sought basic change in the content of nursing work—wanting it to be distinctive in its mission to upgrade health through an emphasis on sanitary science. She

called for nurses to use the sciences under medicine to develop the art of nursing.

The members of the early Society of Superintendents yearned to change the image of nursing by insuring the graduates of basic educational programs in hospital-based schools entered with the attributes of a middle-class upbringing and education from which to build technical competence and militaristic values of leadership. Like Nightingale, they saw hospitals as the ideal training site for schools, as long as they adhered to their ideas about the standards for admission and retention of suitable candidates and an educational program that put less emphasis on physical labor and unreasonable hours of work, while taking serious the didactic preparation for nursing. Eventually the leaders would recognize that nursing education needed to disentangle itself from the control of hospital administration in order to pursue these goals, but without public support and funding it would be impossible to engineer on a grand scale.

Nursing entry into Teachers College at the postgraduate level was seen by the leaders as a prodigious decision in remedying the paltry supply of future leaders who could alter the dismal environment

in which nursing was growing. No doubt Nightingale would have applauded their giant step in seeking special training for teachers and administrators since she had lamented her inability to accomplish precisely this need in her system.

But university education had a deeper mission to educate scholars and professionals who would be grounded in methods of pursuing and developing knowledge in particular disciplines. Because nurses overlooked this side of university education in their initial entry into academia, they had been held back in their quest to elevate the occupation on a plane similar to medicine. Many historically valid explanations for the direction the leaders took have been demonstrated. Ironically, it must be pointed out that they failed to grasp an opportunity to develop the discipline-specific content of nursing on a theoretical level, which is what Nightingale continually said must be done for nurses to enjoy the independence of pursuing their own contributions to health. Indeed, Cunningham observed that Dean Russell was disappointed with the paucity of nursing content in the early courses at Teachers College. He believed that the

school should be a place where an occupation could develop the components of its discipline.

University programs in education have not been accorded the respect in the collegiate community as true academic disciplines. Although Teacher's College became an excellent school of education, it has been argued that nursing, in its successful venture to upgrade itself through affiliation with Teachers College, also became stigmatized by the process (Bullough & Bullough, 1984, p. 46).

The movement toward scientific education drove relentlessly toward research, toward graduate education atop college education, and toward the Ph.D. degree as the capstone of the graduate system. . . . From this scientific movement, as established in graduate education rather than in medical schools, nursing was effectively barred by its alliance with schools and departments of education. (Strauss, 1966, p. 8)

Educational degrees have been criticized for their narrow concentration on setting curricular standards, creating syllabi, establishing course content, and formalizing methods of instruction and evaluation—all of which appear to some as too regimented and bereft of true scholarly inquiry. Nurses, of course, did not see matters from this perspective

Florence Nightingale and the educators who followed her carefully circumscribed the content of the

formal teaching to that which had practical applicability. Therefore it is not surprising that the leaders would favor the "pragmatically oriented" focus of educational curricula. Meanwhile the Society of Superintendents looked upon the assistance given them in carrying out their roles as teachers and administrators as enormously beneficial. If the schools of education, beginning with Teachers College, had not accommodated nurses in those early years, where else could they have gone? (Strauss, 1966, pp. 82-83).

While Nutting and her colleagues placed the major thrust of their careers on improving the educational system for nurses, they had ignored the problems associated with nursing services outside of the educational framework. The leaders' philosophical views always stressed that high quality nursing practice would necessarily follow sound basic education programs. They later found their ideas subject to harsh criticism, especially from those who believed the leaders to be more interested in the education and advancement of nurses than in influencing the working conditions of ordinary nurses (Christy, 1969a, p. 55; Roberts, 1964, p. 57). Earlier it was established that nurses in the apprentice system of education passed

down a narrow internalist view of nursing from one generation to another. Even when nursing moves into a university setting, the structure of its leadership and the nature of its early postgraduate education did little to change this ambiance.

. . . nurses as women were denied power at the cosmopolitan level of being able to influence the world at large; instead, large numbers concentrated on influencing nursing. . . . This was an attempt to gain internal influence in areas where external influence was difficult, if not impossible, to achieve. (Bullough & Bullough, 1984, p. 43)

When nursing leaders were recognized for their achievements and abilities, it was more apt to happen within their nursing organizations rather than the larger community outside. Consequently they gravitated toward adopting those qualities and attitudes that were esteemed by colleagues. Thereupon nurses tended to mediate their vision of nursing in an environment that necessarily limited broader societal alternatives (pp. 43-44).

Upward mobility was possible within nursing for women of humble social origins: for many the entrance into an occupation that was calling itself a profession, and indeed had been recognized as such by lay persons, the very title of graduate and later

registered nurse (R.N.) was sufficiently satisfying to meet their aspirations.

Nurses instinctively knew that the work they were engaged in had a high social value and they looked forward to meaningful careers and a life of respect. Among the ranks of the graduate nurses who were without high school diplomas, undoubtedly many outstanding ones were chosen to teach and to assume supervisory positions in hospitals. Others would go on to be the early, anonymous pioneers in the public health setting as it was being shaped.

When the postgraduate course in Hospital Economics was gaining a foothold at Teachers College, the women described above were welcome to enroll according to modified admission requirements. Later when enrollment numbers dramatically increased, Nutting was heralded for raising admission requirements to a high level, the high school diploma being a principal condition. (Graduation from an acceptable training school had always been a prerequisite). Understandably, Nutting and her colleagues wanted nursing to have the respect and prestige enjoyed by other disciplines.

But these decisions effectively barred nurses who were functioning in elevated responsible positions from

the advantages that a collegiate postgraduate program was supposed to offer: improved competency in their field, the chance to network among colleagues, an opportunity to break the cycle of outdated teaching styles, and the prospect of broadening their world view.

Graduate nurses began to fall into categories determined largely by their socioeconomic backgrounds before entering nursing. In the minds of the leaders, candidates with inferior backgrounds entered inferior schools and inferior schools produced inferior graduates. But that was not always the case when better schools had to reach out to less favorable candidates to meet their quotas. As has been illustrated, the leadership in nursing was initially dissatisfied with the standards for registration set into law by the states, therefore from the start registered nurses were not perceived as having collegial parity with one another.

The professional organizations that were formed served the purpose of furthering the leaders' aims, therefore the vast majority of the working nurses had no incentive to support them, nor were they particularly sought after to join by their sisters who

enjoyed greater advantages. Roberts, a noted nursing historian with first-hand knowledge of this era, lamented the lack of interest shown professional organizations by the private duty nurses who were the largest group within the profession. If the leaders wanted support from this group, they could have featured programs that would attract the nurses in practice such as demonstrations of the latest nursing procedures at national and state meetings (1964, p. 46).

Prompted by their belief that only a particular kind of woman was eminently qualified to represent nursing and to fill executive positions, the leaders chose to severely limit opportunities for nurses whom they determined to be less than adequate. Instead, their professionalizing strategies concentrated on upgrading hospital-based education and enlarging collegiate programs, but along the way, "They lost sight of the fact that nursing services in hospitals without established schools would continue to grow and prosper." The overriding agenda they pursued left little concern for setting standards for nursing services outside of an educational framework (Christy, 1969a, p. 55).

By the policies they established at Teachers College, the leaders discriminated against the majority of nurses who had achieved RN status—in essence relegating them to a state of limbo in terms of educational advancement—because they had entered the occupational ranks from circumstances that defied the desired profile the leaders were trying to promulgate. As Baer has argued in the current circumstances of nursing, discrimination based on preset standards established by the profession should occur at the entrance into any of the professional schools (1990, pp. 318-319), but if this fails to occur, is it justifiable to discriminate against colleagues who have legally and ethically earned the right to practice?

Putting this matter in the perspective of Nightingale's ideas, the foundress of modern nursing, speaking from her era, believed that women who dedicated their lives to a career in nursing deserved and needed continued support to maintain their special calling. Nightingale never thought about meeting this need through professional associations, which is more in keeping with modern conceptions of professional occupations. Rather, she thought more in terms of supplying "common nursing homes" following graduation

to ensure that nurses would not stray from the ideals established in their home schools.

In 1873, Nightingale continued to view the content of continuing education for nursing practice as falling into two categories: technical skills that must keep apace with medical progress coupled with impeccable standards of personal character. Both required attention and surveillance to measure up to the expectations of excellence and to prevent backsliding.

May our hopes be that, as every year the technical qualifications constituting a skillful and observing nurse meet with more demands on her from the physicians and surgeons, progress may be made year by year, and that not only in technical things, but in the qualifications which constitute a good and trustworthy woman, without which she cannot be a good nurse. (1893/1948, p. 36)

In this respect Nightingale was certainly tuned into the concerns of any professional organization or regulating body of the government constituted to safeguard the public from unethical and ignorant practice by individuals who have been granted professional standing. Unlike the leaders in America, she was especially sensitive to the needs of nurses who entered private practice in the homes that they would become like "an irresponsible nomad" without a place where they could have "loving, trained, moral and religious, as well as technical superintendence

. . ." (pp. 32-33). What is salient here is that Nightingale believed that graduate nurses, regardless of their backgrounds, deserved opportunities for professional growth and for the renewal of their commitment for altruistic service to the public.

Contrary to Nightingale's intent, the average nurse on this side of the Atlantic faced a different scenario.

Isolated and overworked in the hospital and on private duty, [nurses] were separated from the vital branch of their profession which engaged in active combat with the social problems of the outer world, and sought to raise the status of women. The leaders at the top of what came to be the nursing establishment . . . continued to call for higher standards, with little response from the general public or a major part of their own constituency. The status quo would be accepted as women's place for a generation or more to come. (James, 1979, p. 238)

Isabelle Hampton Robb acknowledges that private duty nursing and community nursing absorbed most of the graduates of the training schools, but neither she nor any of her contemporaries at the time recognized that hospital-based education could not adequately prepare nurses for these fields. "Had she done so, such was her extraordinary capacity for leadership, the evolution of American nursing might have paralleled that of other professions" (Roberts, 1964, p. 22). If generic nursing education programs took this track,

there would have had to be less attention, if at all, on militaristic discipline while greater emphasis would have had to be placed on developing clinical judgments and self-reliance. Professional relationships built on collegiate rather than subordinate and superordinate rankings have evolved naturally out of a curricular focus that searched for ways to help junior practitioners explore and define the problems that were distinctive to these health care settings.

Manifestly, we have to return to the fact that the chief agents of nursing education were hospitals whose medical staffs and administrators kept the focus of nursing in narrower sights. As we have demonstrated, it is doubtful that the leaders could have stemmed this tide more than a little, but it is also true that Hampton Robb, Nutting, Dock and their contemporaries were basically supportive of the hospital-based schools, if only they could be independent of external controls and thus free to endorse high educational and admission standards. The leaders never publicly disagreed with the strong technical nature of hospital-based education, even though, as former teachers, many like Nightingale were likely exposed to liberal arts subjects. Nightingale did stress outside reading for

her students at St. Thomas and stocked a library with books that would stimulate their ethical and moral development (Schyler, 1978, pp. 42-43). The educational process adopted in America during this time period largely ignored this aspect of Nightingale's system (Giarelli, 1990, p. 210).

The emphasis on the technical aspects of nursing education was reflected in the Standardized Curriculum developed by the leaders and heartily adopted by many of the better schools. This model is directly parallel to the development of the early courses in teaching and administration at Teachers College which underscored a curriculum fully concentrated on the mechanistic and practical aspects of these two roles. The educational modes were directed at making nurses competent in all the tasks they assumed, but there was no concerted effort to define or conceptualize nursing, as did Nightingale, or to expand her vision in the practice of nursing as it was developing in the United States.

Without clear boundaries to determine what constituted a professional nurse, leaders concentrated on upgrading the status of incoming students. Educational standards were raised in terms of increasing the theoretical components of basic nursing

programs with the goal of becoming more attractive than other competing educational and career alternatives that were opening up to the better students. Hence the urge to obtain university connections for generic education in nursing became a major thrust for leaders who were seeking a professional model for nursing.

They initially sought college and university affiliation for hospital-based education insofar as it could guarantee them the desired candidates they wanted. University affiliation was supposed to ensure that there would be "uniform requirements for admission, standard curriculums, and a program weighted toward academic education rather than [repetitious hospital] experience." (Melosh, 1982, p. 38).

However, the Goldmark study illustrates that under the strong influence of Nutting and her colleagues who sat on the original committee, the final report refrained from recommending university education for all nurses. Instead it asserted the advantages of university affiliation which took hospital-based diploma education away from the exploitative control of hospital administration. What was strongly endorsed was university degrees for nurses who would embark on leadership positions in education, administration and

public health. The postgraduate program at Teachers College had already established an international reputation in all these areas.

Because the model of basic education used in university-sponsored schools was derived from the better hospital-based programs, medical science shaped the larger part of the nursing curriculum. Nursing perspectives of holistic care, clinical adaptations based on variables for each patient, patient teaching, preventive measures, which were the heritage of Nightingale, remained secondary to pathology and the dominance of medical care. Only in the new field of public health was nursing seen as being singularly expressive of independent judgment and actions.

Teachers College postgraduates were educated to improve, but fundamentally support, an educational system that held most nurses at a disadvantage on a continuum towards professional status defined by autonomy over one's work.

Those who would administer hospitals and direct the nursing programs had the advantage of advanced education to reinforce their authority in the rigid hierarchical system within hospitals. Their ideas of professionalism were mirrored in the "ethics" they

espoused: working nurses were to be well mannered, better prepared technically and scientifically from a medical perspective, but they could not question superordinates or physicians directly in the face of dilemmas or presumed errors.

Moreover, the institutional operations for administrators that were established in the postgraduate education program did not prepare future leaders to exert preponderant influence in making explicit the knowledge nurses needed to acquire and use that could differentiate nursing practice from medicine. Similarly, it is difficult to find evidence that the curriculum in education and administration was ever directed to assist nurses in identifying their independent role in the clinical setting of the hospital. The area of public health was a different matter. In that field nurses naturally evolved autonomous roles in fulfilling urgent health needs in settings that were for a time free of medical domination.

Graduates of nursing courses at Teachers College were not imbued with any notions of major change in the structure of nursing education for the average nurse. What the postgraduate program did is what it had

purported to do. It prepared qualified nurses to be better teachers, supervisors and hospital administrators, the consequence of which acted to insure the institutionalization of social constructs that had evolved from older Anglo-American traditions in hospitals and nursing care. Many of these traditions undermined, rather than enhanced, Nightingale's ideas.

The leaders perhaps could be accused of the very quality that would be anathema to relationships within a profession between peers: they practiced paternalism in relationship to the average working nurse by purporting to be the principal arbiters of what the fledgling profession needed to advance its causes.

For many women, sisterhood and "homosocial networks" served to overcome the limits of the separate spheres of Victorian life. . . . But nursing, from its very beginnings, created a female hierarchy in which sisterhood was difficult to achieve when class-based assumptions about behavior and work collided. Commonalties of the genders experience could not become the basis for unity as long as hierarchical filial relations, not equal sisterhood, underlay nurses' lives. (Reverby, 1987, pp. 200-201)

The leaders' public causes were always a matter of justice: curbing the exploitation of students caught in the harsh apprentice system and insuring the safety and well being of patients through uniform standards of

education. "But the solutions leaders offered reflected an underlying concern with preserving the prerogatives of an elite group of better educated nurses" (Melosh, 1985, p. 34). The vast majority of graduates with diplomas from various schools who were actively practicing nursing had no recourse under their plans. Through their strategies the leaders were in essence hoping "to recover the elite position of early training schools" (p. 34).

Actually, the "creation of a few underfunded collegiate programs" had little effect on what was happening in the greater number of training schools whose graduates had to contend with the effects of subsidiary education (Reverby, 1987, p. 166).

Despite Nightingale's intention that nurses have wide latitude to "act independently with wise judgment" (Schyler, 1978, p. 39), the American models of training schools failed to preserve their part of her philosophy. "Independent action was neither taught in class nor in practice. The critical skill of making value judgments was not taught or evaluated" (Giarelli, 1990, pp. 210-211).

The constant press for higher education for nurses who would teach or become the superintendents of

training schools did little to change their basic pedagogical methods. Even though nurses gravitated toward teachers colleges or schools of education they "continued to use rote learning, procedure manuals, and practice protocols," all of which mitigated against the development of independent judgment in the students they taught. Insofar as the greater bulk of students were from the working and lower middle classes, they were not in a position to afford the nursing education programs that were beginning to take hold in colleges and universities. On that account they were not exposed to the newer styles of teaching that incorporate the Socratic method and the use of case studies to develop critical thinking (Baer, 1992, p. 18).

The shift in greater power to physicians in the hospital was a quandary for nurses who saw their responsibilities increase, yet they were put into the position of "Walking a tightrope between deference and assertiveness" (Lynaugh, 1988, p. 29). In contrast to the nurses before the reforms of Nightingale and her contemporaries, the trained nurse had been thoroughly indoctrinated with the need to recognize the physician's authority "over his patients and over

nurses in relationship to the medical care of patients." But when nurses tried to make the distinction between authority over medical care and authority over themselves, their plight was hindered by the pervasive acceptance of the military metaphor for maintaining order and discipline within their ranks (p. 30). The physicians' superior ranking in terms of their gender and the growing prestige of medical science allowed them to assume increasing authority over nurses.

Aspiring professionals attempt to upgrade their work by encouraging socially superior workers to enter their field. In nursing, leaders explicitly called for the recruitment of "a higher class of young women." At various points in nursing history, others have suggested recruiting men as a means of increasing wages and winning more respect (Melosh, 1982, p. 20). But nurses' assumptions about gender which were consistent with the views of society were fully integrated into the professional ideology of nursing.

Traditionalists in nursing, however, claimed that female character was the essential qualification for nursing. Rhetoric carried over from the Nightingale era of the Nineteenth Century served to reinforce ideas

about the sexual division of labor and the ultimate subordination of women in the work setting. When the leaders exerted their plans for excluding those who failed to attain standards of expertise measured in terms of education and class, they met the vigorous opposition of a large working force of nurses who clung to the ideology of gender.

Deeply underlying the fears of those who stood protest was the inference that their authenticity as competent nurses and their ability to earn a living were in peril. On the other hand

[The] leaders strongest contribution, perhaps, lay in their claim to extend the privileges of a profession to women workers. In the process they had to modify and reinterpret professional ideology to suit the conditions of women's work and to accommodate the position of women workers. (Melosh, 1982, p. 22)

Nightingale inadvertently set into motion a class distinction among English nurses when, acting within an aristocratic framework, she chose women from the upper and upper-middle classes to be her first teachers and administrators. There is, however, no mention of her ever trying to modify this principle in later years when general educational opportunities opened up to all members of society. Historians Stewart and Austin highlighted the fact that England had many more wealthy

families than did the United States (1962, p. 194), therefore the pool of women from the upper ranks of British society willing to fill leadership positions in nursing was comparatively plentiful.

In contrast to the British, Americans prided themselves on privileges gained by achievement rather than ascription according to class origins. Nonetheless, the foregoing study points repeatedly to the influence of class in determining not only which career path graduate nurses took following the completion of their educational programs, but also their opportunities for advancement through post-graduate education. By means of their policies and politics, the early leaders, tied to Teachers College through the Education Committee of the Society of Superintendents and later the National League for Nursing Education, sought unabashedly to insure that those who shaped nursing's future would bring the perspective and advantage of middle-class backgrounds and education. This perspective is congruent with the professional ideology that was developing from out of the middle-class in America (Bledstein, 1976, p. 80).

Members of the Education Committee of the Society of Superintendents valued nursing's emphasis on

clinical education precisely because it was the best teaching method to form and internalize empathy and good judgment, to test character, as well as to develop psychomotor skills. No matter how they structured basic educational programs for nurses, the leaders wanted hospital experience to remain pivotal.

The emphasis on learning nursing at the bedside of the sick was drawn directly from Nightingale, who couldn't conceive of educating nurses any other way. However, once the hospital became essential to the work and education of physicians, they had to find ways to limit the scope of nursing practice before it could seriously infringe on their ambitions. Moreover, as competition for funds grew more intense, "nurses and their training schools inevitably emerged as a poor second to staff physicians" (James, 1979, p. 238).

Social conditions played a major role in determining the direction nursing education took at this time. World War I created an unprecedented demand for nurses, spurring the opening of 100 non-university-based schools each year. As a result, the apprentice model for training continued to dominate nursing education (Doheny, Cook, & Stopper, 1987, p. 18).

Nightingale would have mourned the growth of educational programs that were not under the control of nurses. The longer nursing stayed in physician-dominated institutions, the less opportunity it had to pursue its own agenda.

Summary

The early American leaders' lack of attention to making explicit a special identity for professional nurses in terms of developing a knowledge base for practice that could set it apart from the delegated functions it assumes from medicine was a marked departure from Nightingale's ideas. Instead, the leaders chose educational reform that reinforced technical-based educational programs fashioned on the diploma school model. They heartily supported and endorsed university-sponsored education for nurses, but the basic nursing content was little changed whether the campus was one of the better hospital schools or a university—albeit there were often distinct advantages offered by the latter, such as well equipped laboratories, extensive libraries and skilled teachers.

The leaders' decision to establish a postgraduate program at Teachers College arose from a stark need to prepare qualified teachers and administrators. The

curricular design basically used what was already structurally in place in the administrative modes and institutional models of hospitals and schools or nursing. The leaders sought changes in the form of grooming future leaders who would embrace their ideas of professionalism with the skills and acumen needed to expertly fill these positions.

Their ideas of professionalism had as much to do with middle-class breeding and education, technical expertise and ideas that authority was vested in rigid hierarchical constructs as it did with public service. The movement for registration at the turn of the century was in line with their professional aspirations. In New York State only graduates of approved schools could be registered (Aitu, 1994, p. 5). Thus the educational models proposed and/or supported by the leaders were perpetuated.

Whether in the generic or postgraduate level, the early leaders failed to envision any idea of nurses striving to use research as the basic tool of science in developing and appreciating the knowledge base of an aspiring profession. The parameters of nursing practice remained vaguely defined so that nurses became subject to taking on many of the unwanted and often

complex tasks of medicine for which they were ill prepared. Nightingale saw this peril from the onset of her work when she warned that medicine and nursing should have identifiable boundaries, otherwise the distinct quality of nursing would be intangible. Friedson states emphatically that a profession always controls its own work which subsumes that its work has been clearly defined.

The early leaders were women of high purpose who had enormous influence in gaining a foothold for nursing in academia. Unquestionably, the strong bias of liberal arts institutions and women's colleges would preclude options for anything else but a school of education for nurses to begin the process.

Nevertheless, it can be argued that the development of nursing's early curricula in academe received short shrift when nurses were not directed to critically examine and expand their own discipline using research. Nightingale had warned that the elements of nursing were still largely unknown. Losing sight of this important injunction, the leaders focused on goals that were highly diverse in the nursing community. This division is particularly evident in the education programs they pursued.

The leaders sought laws and educational policies that polarized nurses into two camps. Accordingly, they deliberately created a professional model that only a minority of nurses could achieve or identify with. This model consigned nurses to different levels of hierarchical authority or subordination in health delivery institutions based on class differences that determined their educational backgrounds in nursing (see Glazer, 1997, p. 308). It also influenced where nurses could work: the location of work for nurses who graduated from inferior schools was mainly in private duty away from the centers where nursing leaders were making decisions affecting their opportunities.

To the extent that the leaders focused their energies on raising the status of a relatively small minority of nurses to direct the emerging profession, they inadvertently subverted the original aim of Nightingale. The founder of modern nursing began her public pronouncements by laying out a foundation for what we now refer to as professional autonomy: she believed that all nurses needed a common fund of knowledge that would uniquely belong to nursing. Freidson's concept of autonomy for professions subsumes a unified body of workers who are clear about the aims

and mission of the occupation. This is accomplished through an academic model that insures each graduate a similar educational experience.

The excitement of scientific medicine and the promise it held to overcome most dreaded diseases that were common at the time overshadowed Nightingale's plan that nurses would be the standard bearers for sanitary science. Although some of the underlying tenets about the origins of infection were disproved, there are elements that remain essential to health. Nurses continued to carry out Nightingale's basic ideas about patient care, but they became less explicit, more obfuscated in the general therapeutic setting. Taken for granted, ignored, or hidden, the very essence of nursing work that separates it from any other health occupation remained obscure. Because nursing curricula became planned around the technical aspects of medical science, nurses were viewed as a subsidiary of medicine.

When Nutting and her colleagues tried to interest philanthropists in funding research to promote nursing, her goal was to gain support for upgrading the existing educational programs according to what the leaders wanted. They focused their concerns on the low

standards of nursing education and the exploitation of students. No substantial effort was made to highlight the unique contribution of nursing to the overall health of individuals. This was a strong point in Nightingale's writings. It is significant to note that nursing began to attract philanthropic interest when nurses were demonstrating their independence from medicine during the public health movement.

The leaders' tactics were aimed at securing professional recognition and privileges for the relatively small number of nurses who could meet the conditions; thus that had in effect ". . . cut themselves off from the broader support that a more inclusive [strategy] could have provided" (Melosh, 1982, p. 29). Unlike Nightingale, the members of the Society of Superintendents and later the National League for Nursing Education were never particularly interested in any serious effort to upgrade nurses already in practice (p. 35).

Ironically, by setting the standards using a "hierarchy of expertise," they unwittingly placed themselves along with all nurses in the irretrievable position of subordination within the medical division of labor (p. 29).

Perhaps more destructive to any prospect of a true independent role for the growing number of nurses was the support educational policies lent to the increasing stratification of nurses within their occupational institutions. The situation was aided in no small measure by the philosophical gulf between the two groups of nurses. Nurses outside the hub where professionalizing strategies were being discussed and implemented clung to strong notions that the essence of nursing was about caring and service. They feared that the emphasis on "mere skill" might overshadow nursing's humanitarian impulses (p. 24).

Neither group seriously considered what Nightingale had foreseen when she began to tackle the status of nursing in society: In order to achieve universal salience all nurses would have to be imbued with the need to discover God's laws which were really the laws of nursing. The discovery of this knowledge was to be used by all nurses because it was essential to the health of society. Without an explicit common identity in a growing body of knowledge unique to nursing practice, the occupational community would be vastly hampered in achieving the professional autonomy

increasingly sought as the twenty-first century draws near.

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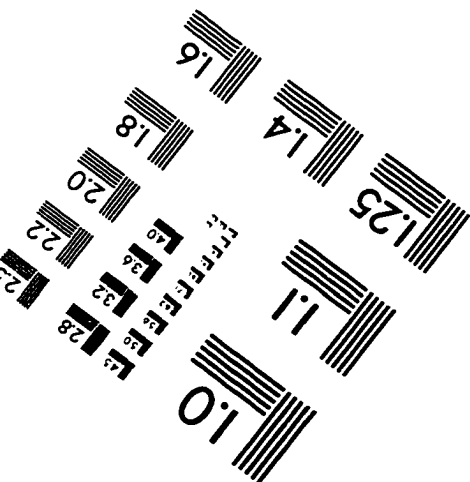
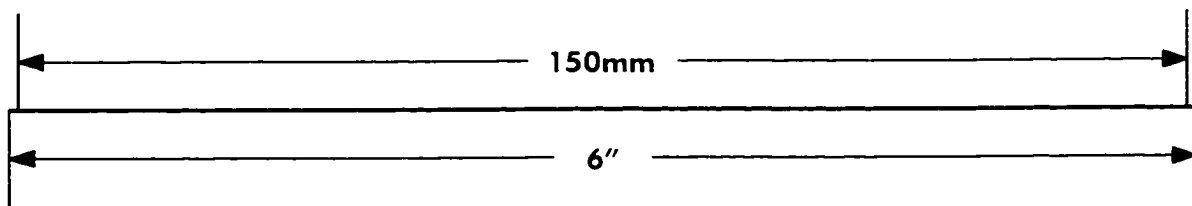
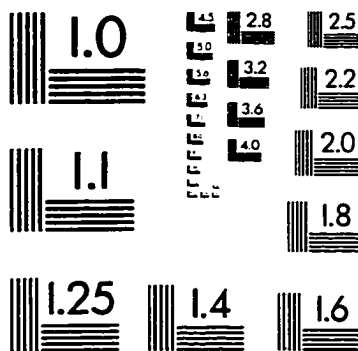
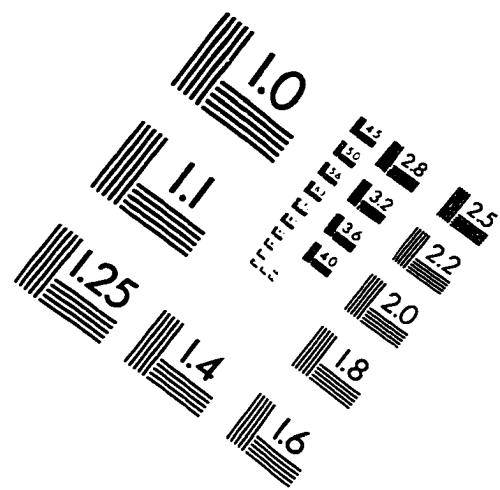
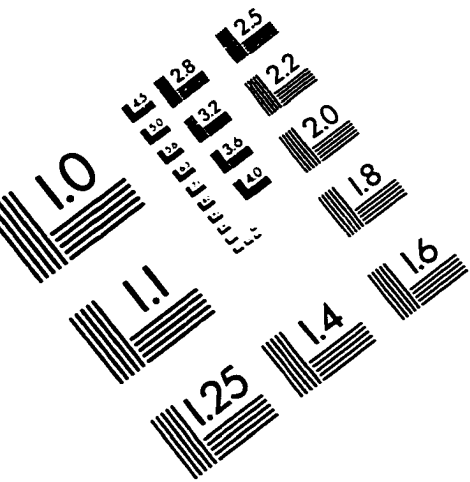
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