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Histories of Nursing: The Power and the Possibilities

Dantonio Patricia

Abstract

This article challenges the dominant paradigm of understanding the history of nursing as only that of relative powerlessness. By moving away from the stance of educators deeply concerned about the inability of the profession to gain control over entrance requirements and into the realm of practice, we use examples from our own work to discuss alternate histories of power. We acknowledge historical circumstances of invisibility and gender biases. But we argue that when we look at the history of practice, we see as much evidence of strength, purpose, and successful political action. Finally, we call for an acknowledgement of the rich and complex nature of the many different histories we can tell in nursing. And we suggest that an admitted inability to advance in one area of the discipline has not meant an inability to move others.

History matters. And it seems to matter more now more than ever in our collective memory. Each day public commentators report on how history and historical perspectives have informed the national debate about who we, as a society, are as citizens; what we want as a nation; and how we might move forward in addressing the most serious economic crisis of our generation. When studying the words of these commentators, however, it seems clear that there is not “one” history – that there is not one prescriptive formula that provides a simple solution or explanation for complicated problems. Rather, they present many histories – each starting from a particular stance, using different sources, and offering distinct perspectives. Still, when considered as a whole, these histories provide a much richer understanding of factors and forces that inform broad social policy and particular local practices. They bring real complexity to the forums in which the debate occurs. And they illuminate the complicated dynamics of power that are called into play when deeply held interests and issues need resolution.

History matters to nursing in the same way. And it matters more today now that issues of health care policy and practice, so central to the mission of the profession, have re-engaged the public agenda. We write, however, out of concern that there seems to be only one familiar history to which nurses turn as they consider their place in this process. This history has often been written from the stance of educators deeply concerned about the inability of the profession to control the many different educational routes to nursing practice. Its sources have been a long list of twentieth century reports on the status and future of nursing education. Its perspective has given voice to the language of education and educational reform as a proxy for nursing’s power. In the end, its story is most often one of failure of the profession to control its own destiny.¹

We do not deny some historical circumstances of marginalization, invisibility, and gender biases. They existed and still do. We also celebrate the achievements of extraordinary nurses such as Lillian Wald, the founder of the Henry Street Settlement house and public health

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nursing, and Mary Breckenridge, who brought nurse-midwives to the mountains of rural Kentucky.² But we also argue that the polarization of discrimination and exceptionalism do not do justice to the richness, complexity and the power in nursing's history. As Patricia D'Antonio has written, it is a history of how a small group of individuals transformed the most traditional of gendered expectations – that of caring for the sick – into respected and respectable work.³

We further explicate this position with selected and contextualized case study examples (a rich form of historical methodology) from our own work. We write from the stance of practitioners concerned with the possibilities as well the problems in nursing. Our sources vary, and our histories themselves range from nursing in formal institutions to those in more entrepreneurial initiatives, from practice at the bedside to policy formation in national forums. They share a commitment to an historical standpoint as a critical place to explore the contingent relationships among the social, political and economic forces that shaped nursing practice and modern health policy. And they provide examples that explicate the many different ways we can rethink and build upon sources of power and purpose in nursing. We begin with the organization of nurses' work, the central dimension to all of our practice.

Power and Practice

In the early 20th century United States, the private duty registry system, rather than hospitals and health care agencies shaped the work lives of graduate nurses. These registries, agencies which helped patients find nurses and nurses find jobs, provided the vital connection between nurses and patients. Private duty registries supplied a reliable way for nurses to seek patient cases and for patients and physicians to obtain nurses and verify their capabilities. Typically, nurses enrolled with a registry indicating their availability for work. The registry checked the nurse's qualifications, serving as a rudimentary credentialing system. Patients who needed a nurse made their requests directly to the registry which in turn sent out a suitable nurse for their situation.⁴

In the late 19th century, as the proliferation of schools of nursing proceeded, many alumnae associations of schools of nursing began establishing and operating private duty registries. By the turn of the 20th century, the success of these ventures motivated many in the nursing community to establish larger enterprises operated by nurses to deliver a wider spectrum of nursing services to community. Registries, owned and operated by professional nursing groups, and often local professional nurse associations affiliated with the national American Nurses Association, cropped up throughout the country. The combination of small alumnae association registries with the larger professional association affiliated agencies formed the backbone of the professional nurse registry system in the United States, operating until the mid to late 20th century.

These registries also served a second and equally significant function in setting up the conventions of nurses' work such as establishing standards for nurses' hours of work, fee schedules with both patients and hospitals, and minimum criteria for professional practice. In the case of alumnae association registries, for example, the alumnae themselves took responsibility for the decision making processes required in day-to-day registry operations. For the larger professional association affiliated registries, control over registry operation depended on the extent of participation by nurse members. A large amount of historical evidence exists documenting that the nursing workforce frequently demanded and very often received positive consideration of changes in conditions of work beneficial to their employment.⁵

The operation of these registries required business, entrepreneurial and negotiation skills seldom attributed to nurses. Registries usually operated in highly competitive environments in which a variety of similar type of agencies, many of them for-profit agencies, vied with nurses for a share of the patient care market. Yet, these registries not only succeeded in capturing a good portion of the market, they also maintained their businesses over decades. The Chicago-based Nurses Professional Registry for example, owned and operated by the Chicago area district nurses association of the Illinois Nurses Association, remained in business for over 60 years.⁶

Nurse administered registries also offered opportunities to develop critical negotiating skills useful in establishing appropriate working conditions. Early nurse fee and working hour arrangements were generally determined through deliberations carried out between nurses' groups, their representative registries, and hospital governing boards. Most of these discussions resembled in many respects collective bargaining arrangements carried out in the later 20th century, serving as a learning field for future generations of nurses.

Most early nurses did not question either the entrepreneurial nature of running a private duty registry or the negotiating mechanisms required to obtain fair working arrangements. They accepted this as a logical component of what historian Karen Buhler-Wilkerson labeled "the business of private nursing."⁷ Despite an uneven record of success in fully controlling nurses' professional practice and obtaining improvements in working conditions, nurses were not dissuaded from aligning with registries which remained popular as a preferred means of obtaining work throughout the lean years of the Great Depression and into the post World War II era.⁸

The legacy of private duty registries should not be over romanticized. Private duty nursing was hard work, with problematic financial security, and often too few nursing positions.⁹ Despite these constraints, nurses created a system which offered the potential for independent practice for nurses by nurses. The professional registry system faded as American hospitals assumed full responsibility for nursing the hospitalized sick. Yet, the story of nurse owned and operated registries provides a critical historical illustration of the power nurses have held over their professional lives.

Power within Institutions

As a registered nurse at the Farmingdale Tuberculosis Preventorium for Children in rural New Jersey for more than thirty years, from 1909 until the late 1930s, Jessie Palmer Quimby faced an isolated existence. She resided at the institution in order to be available twenty-four hours a day in case an emergency arose. Indeed, Quimby's work kept her so busy that she even had her family members vacation at the preventorium, so that she never had to take a day off.¹⁰ Unlike the physicians who staffed the preventorium, we know nothing about where she went to nursing school or even whether or not she married. In contrast to them, when Quimby died, she received no obituary in the *New York Times*.

Based on this description, one might assume that Quimby possessed little social, cultural, or professional authority. But it is a mistake to view Quimby through a dichotomous lens that categorizes people as "powerful" or "powerless." Quimby joined the nation's first preventorium within a few months of its founding in 1909. Just a few years earlier, new science had revealed that most children were infected with the tubercle bacillus.¹¹ In the preantibiotic era in which the "White Plague" resulted in high rates of morbidity and mortality, the importance of protecting children from tuberculosis became a public health emergency.¹²

Farmingdale strove to prevent tuberculosis in indigent New York City children considered “at-risk” for TB by removing them from their homes. Youngsters sent to the institution typically hailed from families in which one or both parents suffered from TB. Once there, they spent as much time as possible out of doors in camp-like settings where they received their education, meals, and rest according to a regimented daily schedule. Education about personal hygiene and healthy living completed most preventorium programs. Children stayed at the preventorium for months, even years, during which time visits from parents were occasionally allowed but not encouraged.¹³

Farmingdale represented the prototype for charitable institution that spawned hundreds of imitators across the United States. Physicians visited the facilities to provide medical care, but it was the nurses living at the preventoria who scrupulously oversaw the daily health needs and instruction of children. To this end, nurses made sure that food and supplies were ordered, laundry was washed, and the institution in general remained functional. They also monitored the children's emotions, comforting them when they were homesick, and responding to worried parents' inquiries.

Yet years before women won the right to vote, preventorium nurses managed all aspects of a complex health care institution.¹⁴ Preventoria were often founded and almost always managed by nurses. In addition to their roles as chief operating officer, educator, disciplinarian, counselor, and substitute mother, Quimby and her colleagues at other preventoria also needed sophisticated assessment skills. They tracked children's health and monitored their nutritional intake, weight, temperature, and other barometers of physical well-being. It was usually they who decided when a child was ill enough for a physician to be notified and it was they who decided which physician to contact.

Speaking to her colleagues at the nineteenth annual National Tuberculosis Association meeting in 1923, Colorado public health nurse Ida Spaeth stressed the nurse's importance to the preventorium movement when she observed that the nurse was “the connecting link” between all aspects of the pediatric TB preventorium movement.¹⁵ Preventorium nurses' role grew especially powerful during the 1930s during the Great Depression. Preventorium staff received not only a salary, but free room and board, making it a highly attractive place to work. The nurses in charge of preventoria made hiring decisions and she decided whether or not they remained employed. By the late 1930s, the economic, social, and medical trends that made the need for preventoria seem so compelling a few years earlier began to erode as the incidence of tuberculosis declined in the United States. By the end of the 1940s, the almost all of these institutions closed or became converted for other uses.¹⁶

Nurses who practiced in preventoria believed their work possessed meaning and importance in ways that few other people in the early 20th century could claim. Preventorium nursing represented the leading edge of not just one popular reform movement, but two, child-saving and tuberculosis prevention.¹⁷ Examining preventorium nurses' work only from the vantage point of 21st century health care delivery and contemporary notions of professionalism and authority not only discredits them, it loses the historical nuance that we need in order to understand, for example, what worked, and what did not with regard to infectious disease prevention in the past, and why.

The Power of the Personal

Another way to conceptualize power is through the experiences of those Catholic nursing sisters, often invisible in the history of nursing, who refused to consider themselves as powerless.¹⁸ In the 1930s, Sister John Gabriel Ryan, a member of the Sisters of Providence congregation in Seattle, Washington, worked extensively with social and legislative issues as they related to hospitals and nursing. Sister John Gabriel was a master's prepared nurse

who served as Hospital Consultant and Educational Director of the Sisters of Providence. She also was Vice-President of the Washington State Hospital Association, Councilor and member of the Legislative Committee for the Western Hospital Association, a member of the Board of Directors of the Washington State Nurses Association and the American Journal of Nursing, Vice-President of the Seattle Hospital Council, and a member of the Advisory Committee of the Catholic Hospital Association. In 1935, she served in Washington, DC, on the Advisory Committee of the Hospital Board of the Committee on Economic Security.¹⁹ The author of five books on nursing, she was a leading nurse educator in teaching and hospital administration in the Pacific Northwest and was a member of the editorial staff of three national hospital journals.²⁰

In 1935, Sister John Gabriel was awarded an Honorary Fellowship in the American College of Hospital Administrators, formed independently of the American Hospital Association in 1933 to provide non-physician and physician administrators with a professional association. This organization validated what Sister John Gabriel had been advocating for years: the need for further education of hospital administrators, including her own sisters. Malcolm MacEachern, Director of the American College of Surgeon's Standardization Program, became an honorary charter fellow in the new College; and he worked extensively with Sister John Gabriel in matters of hospital policy.²¹ Sister John Gabriel drew increased attention of the Pacific Northwest hospitals to the new program of hospital accreditation. In addition, she led the CHA in furthering its goal to better prepare the sisters for nursing and administrative work.²² Her courses in hospital administration throughout the United States and Canada laid a basic foundation for this field in nursing programs. And she tied her courses to colleges for credit wherever she taught.²³

Sister John Gabriel was active in these policy initiatives and in local, state, and national hospital and nursing associations.²⁴ She went to Washington, DC, and to Olympia, Washington, to speak on matters of policy, both to further desirable legislation or to oppose what she considered dangerous proposals.²⁵ For example, she was instrumental in helping to defeat a Washington state senate bill that would allow the admission of chiropractors and osteopaths to hospital staffs, whom she considered "dangerous cultists" who did "unlawful, inhuman things." When the bill was being discussed, she sat in the gallery and personally lobbied one of the senators. "This is not a denominational question," she argued, "nor a political question, but a humane question concerned with suffering humanity which is looking to us for protection."²⁶ Some might say that Sr. John Gabriel's verbal attacks were extreme, but none who knew her would dare to say she was not speaking sincerely.

She also worked to raise the standards of nursing education, and she lobbied against exploitation of nursing students. One judge said, "She took a man's name in religion, and I said of her that she was the ablest man in Olympia."²⁷ Her masculine name helped her transcend the usual female stereotype, and this minimized gender limitations.²⁸ This was particularly helpful in the male-dominated realm of public policy. The battles Sr. John Gabriel chose to fight were related to her special interests: hospitals and the nursing profession. So rather than be distracted by addressing issues of gender discrimination that were predominant within American society and the Catholic church of that era, she chose instead to align herself, however subtly, with the gender who wielded the greatest power, particularly those who led hospital associations. Sister John Gabriel retired in 1938.

The Power of Politics

In 1946, the boards of both the American Nurses Association (ANA) and the National Association of Colored Graduate Nurses (NACGN) endorsed the principle of one integrated professional association fighting for the rights, the respect, the prerogatives and the

privileges of all registered nurses in the United States. And on January 26, 1951 – with great fanfare – the NACGN formally dissolved.²⁹ As many nurses at the time understood, but what many today have forgotten, the official desegregation of the ANA marked only the beginning, not the end, of the battle for the professional integration of nursing. State associations (not individual nurses), were the ANA's constituent members, and battle lines had already been drawn in many Southern states even as the national celebrations started. The last southern state to desegregate, Georgia, finally capitulated in 1961; and the last southern district, New Orleans, finally accepted African American nurses as members in 1964.³⁰

This historical vignette focuses on the battle for desegregation in one such southern state, North Carolina. On one level, this story might be told in a fairly straightforward manner: the desegregation of the North Carolina State Nurses Association (NCSNA) presented no immediate threat to white supremacy and the Jim Crow laws that supported it. The model established after negotiations between the respective white and African American state nursing organizations included high dues to impede black membership and a new organizational structure that planned educational presentations in desegregated venues but social gatherings in those that prohibited black clients. But the stories surrounding the desegregation of the NCSNA in 1949 might also suggest an understanding of power as complicated calculus of competing interests with eyes turned toward a wider world. North Carolina's African American nurses agreed to this model because they believed in the importance of nurses as leaders race relations in what they acknowledged would be incremental assaults on white supremacy in their particular communities.³¹

These women's willingness to defer outright equality for some measure of limited visibility was controversial. It was a trade-off some African American physicians were willing to make in other southern states, but one to which that North Carolina's physicians were not willing to accede.³² A meeting of African American nurses in November of 1948 acknowledged the presence of some opposition within their ranks; but as important was the recognition of the “progressive step” that they were about to take. This would not be a blind step: “we realize,” the the president of their formal association wrote, “that there may be a few difficulties in such matters as meeting places where social customs are rigidly observed....” But she also characterized such differences are “minor,” and looked forward to a future in which white and African American women “will approach such difficulties (together) as professional women.”³³ They formally dissolved their own association on June 25, 1949. They achieved one objective. Newspapers ran the headline: “Nurses Make Historic Decision.”³⁴

North Carolina's African American nurses understood power as a process. They placed their emphasis on the recognition of the power of their professionalism. This was an effective strategy. As one sociologist who had studied the day-to-day workings of race relations at the Presbyterian Hospital in Chicago noted in 1960, the status of professional was the African American nurse's strongest weapon against discrimination: if things were to run smoothly, the hospital hierarchy and nursing's occupational place within that hierarchy had to be respected irrespective of the race of the individual nurse.³⁵

The processes around desegregation in North Carolina, not surprisingly, were quite tenuous and unstable. But the rhetorical power inherent in the achievement of some semblance of desegregation was critically important for the attendant power and visibility it brought them within nursing and, more importantly, within their own communities. A decade later, Marie B. Noell, the executive director of the NCSNA, would tell of how North Carolina nurses were still first among equals – about how, in desegregation they were always “way ahead” of the communities in which they lived and practiced.³⁶ And a decade later, Estelle Riddle,

one of the architects of nursing's desegregation strategy, would look back in public pride while privately lamenting the lack of progress in real integration among American nurses. Other African American leaders were now looking to nursing, she would write in *Crisis*, to find out why and how they “did” it – because no other all-Negro organization, she pointed out, had as yet taken the “all important step of dissolving its national body.”³⁷

Power, Patients, and the Possibilities of Context

Critical care units are places where patients are situated at the fulcrum of nursing care and technology. At first glance, the machines and equipment may seem to dominate the space with their noise, size, and sense of the foreign. But, the machines and the devices within an intensive care unit can be distracting—they obscure the larger system that, in fact, constitutes how we understand critical care.³⁸ If we only “look” at the technology, nurses seem to be disenfranchised, as having little power to shape patient care. To the untrained eye, nurses are invisible. Focusing only on the machines ignores the architectural concept of critical care (as a distinct space and place) and the context that defines the time period and explains why grouping together sick patients during the 1950s proved to be a useful, but expensive type of care.

An historical perspective provides broader explanatory power and acknowledges the place of technology to the critical care enterprise. History empowers the patient within that system of care, as well as the providers of care, the family, and the contextual factors that shape how that care is defined, rationed, and prioritized by making visible all of these components in the analysis. At the same time, the historian places technology within this context – not as the driving force but as part of a larger system of care of the critically ill. From this more complex understanding of hospital care in the 1950s, nurses become key to the organization of services: grouping patients together by acuity and complexity in the new critical care units of the 1950s was more closely related to the need for nursing observation and care than the presence of machines.³⁹ As Donna Diers famously proclaimed, “Nursing is what is intensive in intensive care.”⁴⁰

There are many historical narratives that can illustrate this more nuanced and complicated understanding. One of the earliest critical care units developed at a small community hospital in Chestnut Hill, Pennsylvania in 1954.⁴¹ This intimate space, small by modern standards, was intended primarily for surgical patients who required vigilant observation after undergoing increasingly technical procedures. These critically ill patients could not be safely cared for on the general floors, especially at night when professional nurse staffing was traditionally thin, or if private duty nurses unavailable. Grouping critically ill patients together in order to observe them was an idea that came from wartime experience and the private discussions between a hospital administrator and his friend in the local Blue Cross organization. It was new and special only because of the intensity of the nursing care patients received and the dedicated space for providing this care. This was a very simple idea— a very sick patient needed a skilled nurse to keep watch and know when to initiate treatment and to summon medical help. There were no special machines, no complex technology. Nursing practice in conjunction with medical therapeutics was powerful, and a critical factor in the popularity and growth of modern hospitals.⁴²

The success of critical care was so dramatic that it became a solution for many other problems facing hospitals, physicians, nurses, and patients. The units became a place to concentrate equipment, try out new technology and provide support for physicians experimenting with new surgical procedures or medical therapies—the higher intensity nursing care and the growing expertise of the nurses who practiced there made the units places of safety and security. Many hospitals negotiated generous reimbursement

supplements to support the care provided in the units, and until the late 1970s, very few policy makers questioned the expense.⁴³

Critical care as a broadly rendered historical construct and architectural space illustrates the complexity of health care change and offers powerful lessons that can guide policy makers. For example, we tend to see innovation as orderly and controlled, but the development of critical care depended on chance, personal relationships, and the entrepreneurship of nurses and physicians willing to try new models of care. It also shows the importance of understanding the various social, political, and economic forces that shaped this hospital's response to the care of the acutely ill patient. To see the development of this type of care as the result of technology gives a very skewed view of how institutions, the public, and health care providers make decisions. The process of deciding how to care for vulnerable, acutely ill patients was not always rational or logical, but relied on individual relationships, a workforce of nurses and physicians willing to experiment, the availability of space in hospitals of the 1950s, and the ability and willingness of the public to pay for these services.⁴⁴

Conclusion

The examples presented above are all different ways of illustrating the power and possibilities of nursing practice. The diversity of the settings within which nurses in these cases practice is indeed a foundation of our strength, and illustrates our main argument about the importance of perspective. We take our evidence from a wide variety of sources; develop our arguments based on the data we find; and demonstrate that nurses' power comes not only from their work at the bedside but also as actors in larger social and political arenas. We each have our own historical lens. From our perspective, nurses are indeed powerful and resourceful, and the illustration of their power stems less from the source of their training program than their ability to work within locations to shape their own practices. Their education is important, but what most stands out is nurses' ability to capture opportunities to creatively apply their skills, knowledge, and a keen sense of the possibilities. In each of our cases, a nurse or nurses generated opportunities for themselves and other nurses and, often in the case of substantive resistance within and outside the profession, leveraged them to some level of social and political advantage. Of course, our cases do not cover the universe of nurses' experiences, and other data may show how various forces such as physician obstruction, lack of resources, among other things did indeed keep nurses from higher status and practice opportunities. But what these histories also show are the variability in nurses' ability to chart their destiny, and that nurses' inability to advance in one area is not necessarily true in the larger sense.

The data for generating a coherent explanation of nurses' place in modern society can be found in many places and can be constructed into multiple narratives. One need only consider the relatively new places for nurses within our health care system as nurse-midwives, nurse anesthetists, and in other advanced practice roles and the new kinds of power they wield within certain contexts.⁴⁵ Caution must be used then to prevent the danger that comes when one particular history told from one particular perspective becomes reified as the only history.⁴⁶ For example, concluding that nursing failed because it did not or could not follow recommendations for a baccalaureate standard for entry into practice lacks a broader historical perspective that embeds particular reports that urge such a standard firmly within a circumscribed set of political, social, and economic realities that may or may not reflect the prerogatives and the possibilities of nursing practice. As these cases show, nurses were powerful across other kinds of places: in the clinical spaces where they interacted with patients; across institutions as they provided leadership and strategic thinking about their own welfare and the patients they served; and in political arenas where they negotiated the

difficult path between the ideal and the real. In our analyses, data becomes valuable evidence only when their contextual underpinnings are acknowledged and integrated into the analysis.

Nursing's history should do as much. Its importance to our current health care debate rests in its ability to remind us that practice and education are political entities. We structure our practice based on overt and covert power structures, and our consciousness of the power of education is certainly never absent. But ultimately, how we use history to understand a broader range of concepts and events in practice and in politics is our challenge and our opportunity. Resisting its call is our loss.

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