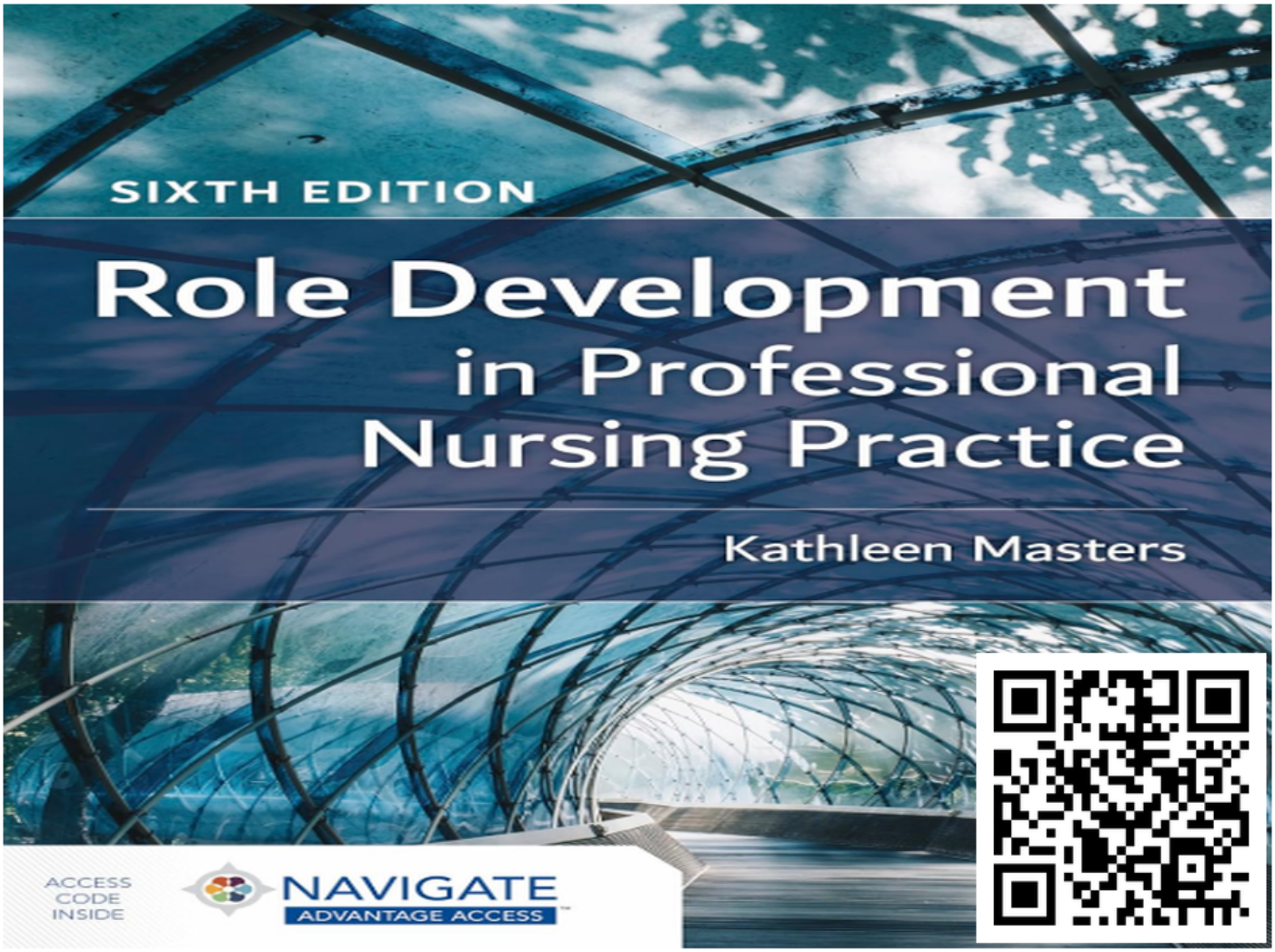
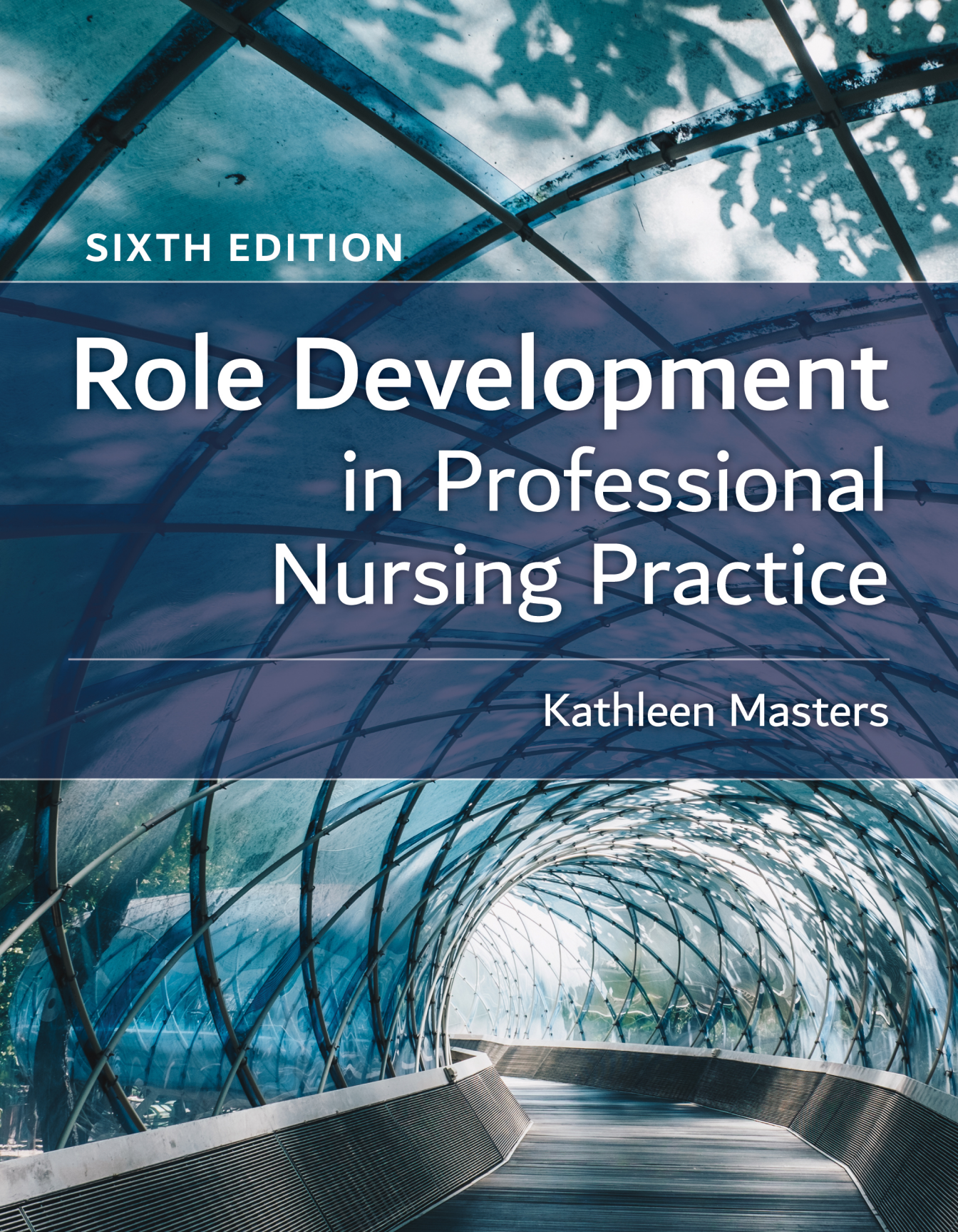
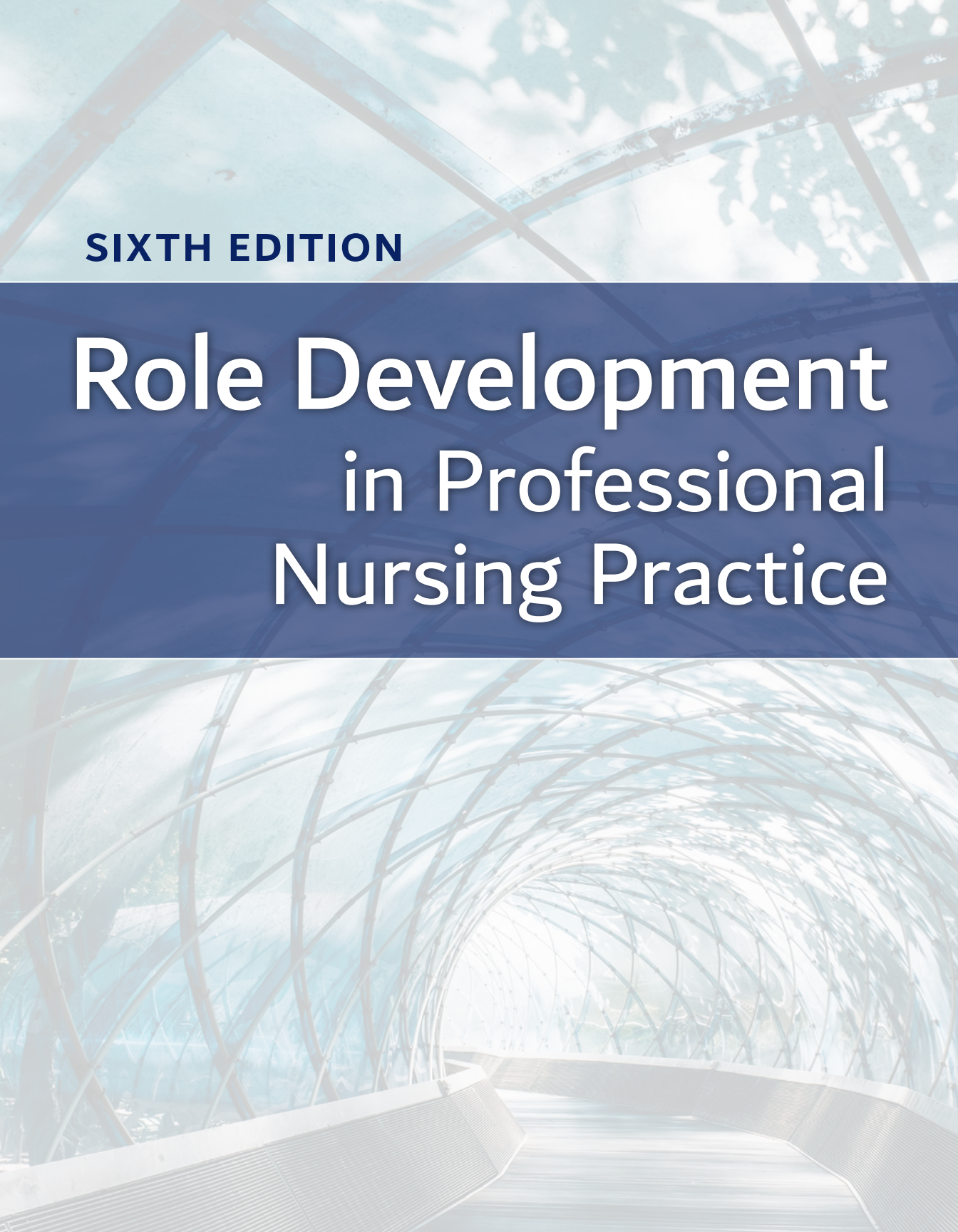
Role Development in Professional Nursing Practice 6th Edition PDF

Visit the link below to download the full version of the ebook

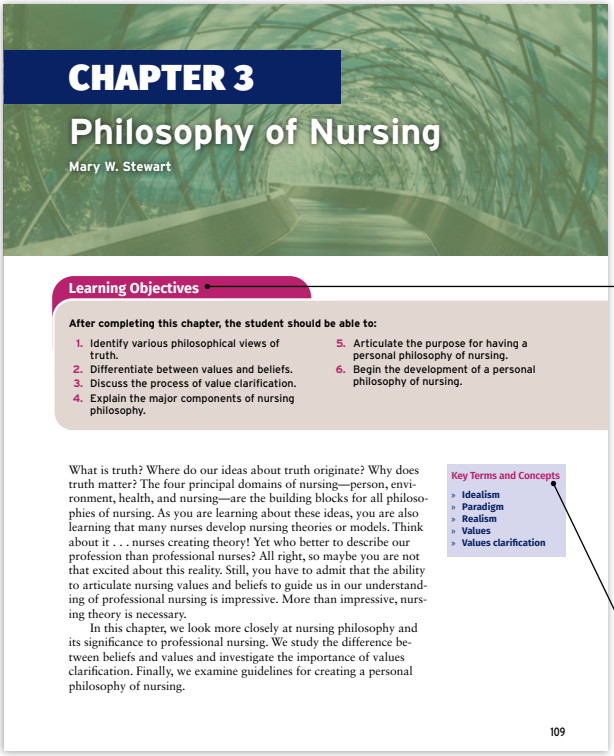



SIXTH EDITION
Role Development in Professional Nursing Practice
Kathleen Masters


SIXTH EDITION
Role Development
in Professional
Nursing Practice

The Pedagogy

Role Development in Professional Nursing Practice, Sixth Edition drives comprehension through various strategies that meet the learning needs of students while also generating enthusiasm about the topic. This interactive approach addresses different learning styles, making this the ideal text to ensure mastery of key concepts. The pedagogical aids that appear in most chapters include the following:



CHAPTER 3

Philosophy of Nursing

Mary W. Stewart

Learning Objectives

After completing this chapter, the student should be able to:

1. Identify various philosophical views of truth.
2. Differentiate between values and beliefs.
3. Discuss the process of value clarification.
4. Explain the major components of nursing philosophy.
5. Articulate the purpose for having a personal philosophy of nursing.
6. Begin the development of a personal philosophy of nursing.

What is truth? Where do our ideas about truth originate? Why does truth matter? The four principal domains of nursing—person, environment, health, and nursing—are the building blocks for all philosophies of nursing. As you are learning about these ideas, you are also learning that many nurses develop nursing theories or models. Think about it . . . nurses creating theory! Yet who better to describe our profession than professional nurses? All right, so maybe you are not that excited about this reality. Still, you have to admit that the ability to articulate nursing values and beliefs to guide us in our understanding of professional nursing is impressive. More than impressive, nursing theory is necessary.

In this chapter, we look more closely at nursing philosophy and its significance to professional nursing. We study the difference between beliefs and values and investigate the importance of values clarification. Finally, we examine guidelines for creating a personal philosophy of nursing.

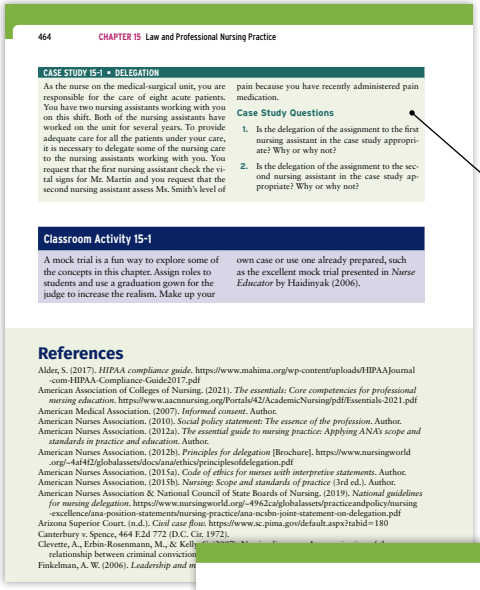
Key Terms and Concepts

- Idealism
- Paradigm
- Realism
- Values
- Values clarification

109

Learning Objectives
These objectives provide instructors and students with a snapshot of the key information they will encounter in each chapter. They serve as a checklist to help guide and focus study.

Key Terms and Concepts
Found in a list at the beginning of each chapter, these terms will create an expanded vocabulary.



464 CHAPTER 15 Law and Professional Nursing Practice

CASE STUDY 15-1 • DELEGATION

As the nurse on the medical-surgical unit, you are responsible for the care of eight acute patients. You have two nursing assistants working with you on this shift. Both of the nursing assistants have worked on the unit for several years. To provide adequate care for all the patients under your care, it is necessary to delegate some of the nursing care to the nursing assistants working with you. You request that the first nursing assistant check the vital signs for Mr. Martin and you request that the second nursing assistant assess Ms. Smith's level of pain because you have recently administered pain medication.

Case Study Questions

1. Is the delegation of the assignment to the first nursing assistant in the case study appropriate? Why or why not?
2. Is the delegation of the assignment to the second nursing assistant in the case study appropriate? Why or why not?

Classroom Activity 15-1

A mock trial is a fun way to explore some of the concepts in this chapter. Assign roles to students and use a graduation gown for the judge to increase the realism. Make up your own case or use one already prepared, such as the excellent mock trial presented in *Nurse Educator* by Haidinyak (2006).

References

Alder, S. (2017). *HIPAA compliance guide*. https://www.mahima.org/wp-content/uploads/HIPAAJournal-com-HIPAA-Compliance-Guide2017.pdf

American Association of Colleges of Nursing. (2021). *The essentials: Core competencies for professional nursing education*. https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

American Medical Association. (2007). *Informed consent*. Author.

American Nurses Association. (2010). *Social policy statement: The essence of the profession*. Author.

American Nurses Association. (2012a). *The essential guide to nursing practice: Applying ANA's scope and standards in practice and education*. Author.

American Nurses Association. (2012b). *Principles for delegation* [Brochure]. https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principlesofdelegation.pdf

American Nurses Association. (2015a). *Code of ethics for nurses with interpretive statements*. Author.

American Nurses Association. (2015b). *Nursing: Scope and standards of practice* (3rd ed.). Author.

American Nurses Association & National Council of State Boards of Nursing. (2019). *National guidelines for nursing delegation*. https://www.nursingworld.org/~4962ca/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/nursing-practice/ana-ncsbn-joint-statement-on-delegation.pdf

Arizona Superior Court. (n.d.). *Civil case flow*. https://www.sc.pima.gov/default.aspx?tabid=180

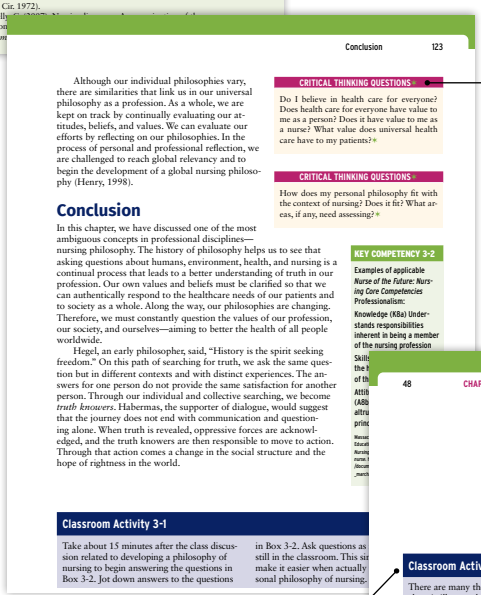
Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

Clevette, A., Erbin-Rosenmann, M., & Kelly, C. (2007). [illegible] relationship between criminal conviction[illegible]

Finkelman, A. W. (2006). *Leadership and m[illegible]*

Case Studies

Case studies encourage active learning and promote critical thinking skills in learners. Students can read about real-life scenarios and then analyze the situation they are presented with.



Conclusion 123

Although our individual philosophies vary, there are similarities that link us in our universal philosophy as a profession. As a whole, we are kept on track by continually evaluating our attitudes, beliefs, and values. We can evaluate our efforts by reflecting on our philosophies. In the process of personal and professional reflection, we are challenged to reach global relevancy and to begin the development of a global nursing philosophy (Henry, 1998).

CRITICAL THINKING QUESTIONS

Do I believe in health care for everyone? Does health care for everyone have value to me as a person? Does it have value to me as a nurse? What value does universal health care have to my patients?*

CRITICAL THINKING QUESTIONS

How does my personal philosophy fit with the context of nursing? Does it fit? What areas, if any, need assessing?*

Conclusion

In this chapter, we have discussed one of the most ambiguous concepts in professional disciplines—nursing philosophy. The history of philosophy helps us to see that asking questions about humans, environment, health, and nursing is a continual process that leads to a better understanding of truth in our profession. Our own values and beliefs must be clarified so that we can authentically respond to the healthcare needs of our patients and to society as a whole. Along the way, our philosophies are changing. Therefore, we must constantly question the values of our profession, our society, and ourselves—aiming to better the health of all people worldwide.

Hegel, an early philosopher, said, "History is the spirit seeking freedom." On this path of searching for truth, we ask the same question but in different contexts and with distinct experiences. The answers for one person do not provide the same satisfaction for another person. Through our individual and collective searching, we become *truth knowers*. Habermas, the supporter of dialogue, would suggest that the journey does not end with communication and questioning alone. When truth is revealed, oppressive forces are acknowledged, and the truth knowers are then responsible to move to action. Through that action comes a change in the social structure and the hope of rightness in the world.

KEY COMPETENCY 3-2

Examples of applicable *Nurse of the Future: Nursing Core Competencies* Professionalism:

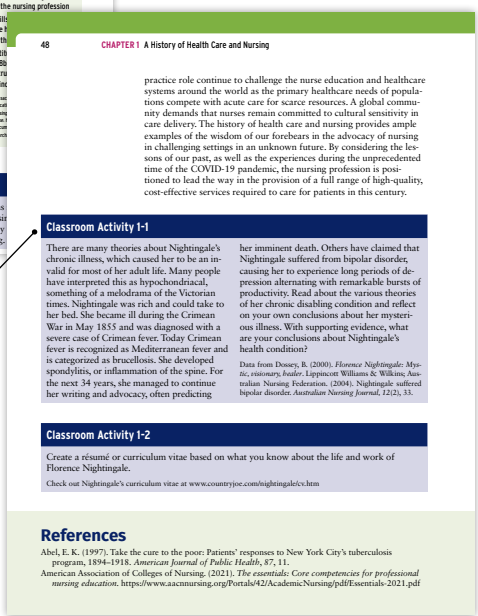
Knowledge (KBa) Understands responsibilities inherent in being a member of the nursing profession

Classroom Activity 3-1

Take about 15 minutes after the class discussion related to developing a philosophy of nursing to begin answering the questions in Box 3-2. Jot down answers to the questions in Box 3-2. Ask questions as still in the classroom. This su make it easier when actually sonal philosophy of nursing.

Critical Thinking Questions

Review key concepts with these questions in each chapter.



48 CHAPTER 1 A History of Health Care and Nursing

practice role continue to challenge the nurse education and healthcare systems around the world as the primary healthcare needs of populations compete with acute care for scarce resources. A global community demands that nurses remain committed to cultural sensitivity in care delivery. The history of health care and nursing provides ample examples of the wisdom of our forebears in the advocacy of nursing in challenging settings in an unknown future. By considering the lessons of our past, as well as the experiences during the unprecedented time of the COVID-19 pandemic, the nursing profession is positioned to lead the way in the provision of a full range of high-quality, cost-effective services required to care for patients in this century.

Classroom Activity 1-1

There are many theories about Nightingale's chronic illness, which caused her to be an invalid for most of her adult life. Many people have interpreted this as hypochondriacal, something of a melodrama of the Victorian times. Nightingale was rich and could take to her bed. She became ill during the Crimean War in May 1855 and was diagnosed with a severe case of Crimean fever. Today Crimean fever is recognized as Mediterranean fever and is categorized as brucellosis. She developed spondylitis, or inflammation of the spine. For the next 34 years, she managed to continue her writing and advocacy, often predicting her imminent death. Others have claimed that Nightingale suffered from bipolar disorder, causing her to experience long periods of depression alternating with remarkable bursts of productivity. Read about the various theories of her chronic disabling condition and reflect on your own conclusions about her mysterious illness. With supporting evidence, what are your conclusions about Nightingale's health condition?

Data from Dossey, B. (2000). *Florence Nightingale: Mystic, visionary, healer*. Lippincott Williams & Wilkins; Australian Nursing Federation. (2004). Nightingale suffered bipolar disorder. *Australian Nursing Journal*, 12(2), 33.

Classroom Activity 1-2

Create a résumé or curriculum vitae based on what you know about the life and work of Florence Nightingale.

Check out Nightingale's curriculum vitae at www.countryjoe.com/nightingale/cv.htm

References

Abel, E. K. (1997). Take the cure to the poor: Patients' responses to New York City's tuberculosis program, 1894–1918. *American Journal of Public Health*, 87, 11.

American Association of Colleges of Nursing. (2021). *The essentials: Core competencies for professional nursing education*. https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

Classroom Activities

Each chapter includes classroom activities that focus on how the information in the text applies to everyday practice. Students can answer questions in a group or as individuals.

SIXTH EDITION

Role Development in Professional Nursing Practice

Kathleen Masters, DNS, RN
Professor
College of Nursing and Health Professions
University of Southern Mississippi
Hattiesburg, Mississippi

JONES & BARTLETT
LEARNING

World Headquarters
Jones & Bartlett Learning
25 Mall Road
Burlington, MA 01803
978-443-5000
info@jblearning.com
www.jblearning.com

Jones & Bartlett Learning books and products are available through most bookstores and online booksellers. To contact Jones & Bartlett Learning directly, call 800-832-0034, fax 978-443-8000, or visit our website, www.jblearning.com.

Substantial discounts on bulk quantities of Jones & Bartlett Learning publications are available to corporations, professional associations, and other qualified organizations. For details and specific discount information, contact the special sales department at Jones & Bartlett Learning via the above contact information or send an email to specialsales@jblearning.com.

64599-6

Production Credits
Vice President, Product Management: Marisa R. Urbano
Vice President, Product Operations: Christine Emerton
Director, Product Management: Matt Kane
Product Manager: Joanna Gallant
Director, Content Management: Donna Gridley
Director, Project Management and Content Services: Karen Scott
Manager, Content Strategy: Carolyn Pershouse
Content Strategist: Christina Freitas
Content Coordinator: Andrew LaBelle
Project Manager: Kristen Rogers
Project Specialist: Belinda Thresher
Digital Project Specialist: Rachel DiMaggio
Director of Marketing: Andrea DeFronzo
Senior Marketing Manager: Jennifer Scherzay
Content Services Manager: Colleen Lamy
Product Fulfillment Manager: Wendy Kilborn
Composition: S4Carlisle Publishing Services
Project Management: S4Carlisle Publishing Services
Cover Design: Michael O'Donnell
Text Design: Michael O'Donnell
Senior Media Development Editor: Troy Liston
Rights & Permissions Manager: John Rusk
Rights Specialist: Maria Leon Maimone
Cover Image (Title Page, Part Opener, Chapter Opener): © Nuu Jeed/Shutterstock
Printing and Binding: LSC Communications

Library of Congress Cataloging-in-Publication Data
Names: Masters, Kathleen, editor.
Title: Role development in professional nursing practice / [edited by] Kathleen Masters.
Description: Sixth edition. | Burlington, Massachusetts : Jones & Bartlett Learning, [2023] | Includes bibliographical references and index.
Identifiers: LCCN 2021023588 | ISBN 9781284233421 (paperback)
Subjects: MESH: Nursing--trends | Nursing--standards | Professional Practice | Nurse's Role | Philosophy, Nursing | BISAC: MEDICAL / Nursing / General
Classification: LCC RT82 | NLM WY 16.1 | DDC 610.73--dc23
LC record available at https://lccn.loc.gov/2021023588

6048

Printed in the United States of America
25 24 23 22 21 10 9 8 7 6 5 4 3 2 1

Dedication

This book is dedicated to my Heavenly Father and to my loving family: my husband, Eddie; my two daughters, Rebecca and Rachel; their husbands Trevor and Grant; and my precious grandsons, Jasper and Josiah. Words cannot express my appreciation for the ongoing encouragement and support of my family throughout my career.

CONTENTS

PREFACE

Although the process of professional development is a lifelong journey, it is a journey that begins in earnest during the time of initial academic preparation. The goal of this book is to provide nursing students with a road map to help guide them along the professional nursing journey.

This book is organized into two units. The chapters in the first unit focus on the foundational concepts that are essential to the development of the individual professional nurse. The chapters in Unit II address issues related to professional nursing practice and the management of patient care, specifically in the context of quality and safety. In the *Sixth Edition,* the chapter content is conceptualized, when applicable, around nursing competencies, professional standards, and recommendations from national groups, such as Institute of Medicine reports. All chapters have been updated and several chapters have been expanded. The chapters included in Unit I provide the student nurse with a basic foundation in such areas as nursing history, theory, philosophy, socialization into the nursing role, professional development, the social context of nursing, and professional nursing competencies. The chapters in Unit II are more directly related to patient care management and, as stated previously, are presented in the context of quality and safety. Chapter topics include the role of the nurse in patient safety and quality improvement, evidence-based nursing practice, the role of the nurse in patient education and patient-centered care, informatics in nursing practice, the role of the nurse related to teamwork and collaboration, systems-based practice and leadership, ethics in nursing practice, and the law as it relates to patient care and nursing.

The *Sixth Edition* incorporates the revised *Nurse of the Future: Nursing Core Competencies: Registered Nurse* throughout each chapter. The 10 essential competencies that are intended to guide nursing curricula and practice emanate from the central core of the model that represents nursing knowledge (Massachusetts Department of Higher

Education, 2016) and are based on the American Association of Colleges of Nursing (AACN) *Essentials of Baccalaureate Education for Professional Nursing Practice*, National League for Nursing Council of Associate Degree Nursing competencies, Institute of Medicine recommendations, Quality and Safety Education for Nurses (QSEN) competencies, and American Nurses Association standards, as well as other professional organization standards and recommendations. The 10 competencies included in the model are patient-centered care, professionalism, informatics and technology, evidence-based practice, leadership, systems-based practice, safety, communication, teamwork and collaboration, and quality improvement. Essential knowledge, skills, and attitudes (KSAs) reflecting cognitive, psychomotor, and affective learning domains are specified for each competency. The KSAs identified in the model reflect the expectations for initial nursing practice following the completion of a prelicensure professional nursing education program (Massachusetts Department of Higher Education, 2016).

This new edition has key competencies integrated throughout the chapters that link examples of the *Nurse of the Future: Nursing Core Competencies* KSAs that are appropriate to the chapter content. The competency model is explained in detail in Chapter 4 and is available in its entirety online at https://www.mass.edu/nahi/documents/nofrn competencies_updated_march2016.pdf. The *Sixth Edition* also incorporates some of the applicable sub-competencies from re-envisioned AACN Essentials as key outcomes throughout each chapter to assist faculty with the alignment and tracking of curricular content. While not all inclusive, the key competencies and key outcomes incorporated throughout the chapters also demonstrate for students the link between expectations reflected in the competency model, the competencies embodied in the essentials document, and the chapter content. A brief overview of the re-envisioned, competency-focused AACN (2021) essentials document, *The Essentials: Core Competencies for Professional Nursing Education,* is included in Chapter 4.

This new edition continues to use case studies, congruent with Benner et al.'s (2010) Carnegie Report recommendations that nursing educators teach for "situated cognition" using narrative strategies to lead to "situated action," thus increasing the clinical connection in our teaching or that we teach for "clinical salience." In addition, critical thinking questions are included throughout each chapter to promote student reflection on the chapter concepts. Classroom activities are also provided based on chapter content.

Although the topics included in this textbook are not inclusive of all that could be discussed in relationship to the broad theme of role development in professional nursing practice, it is my prayer that the subjects herein make a contribution to the profession of nursing by

providing the student with a solid foundation and a desire to grow as a professional nurse throughout the journey that we call a professional nursing career. Let the journey begin.

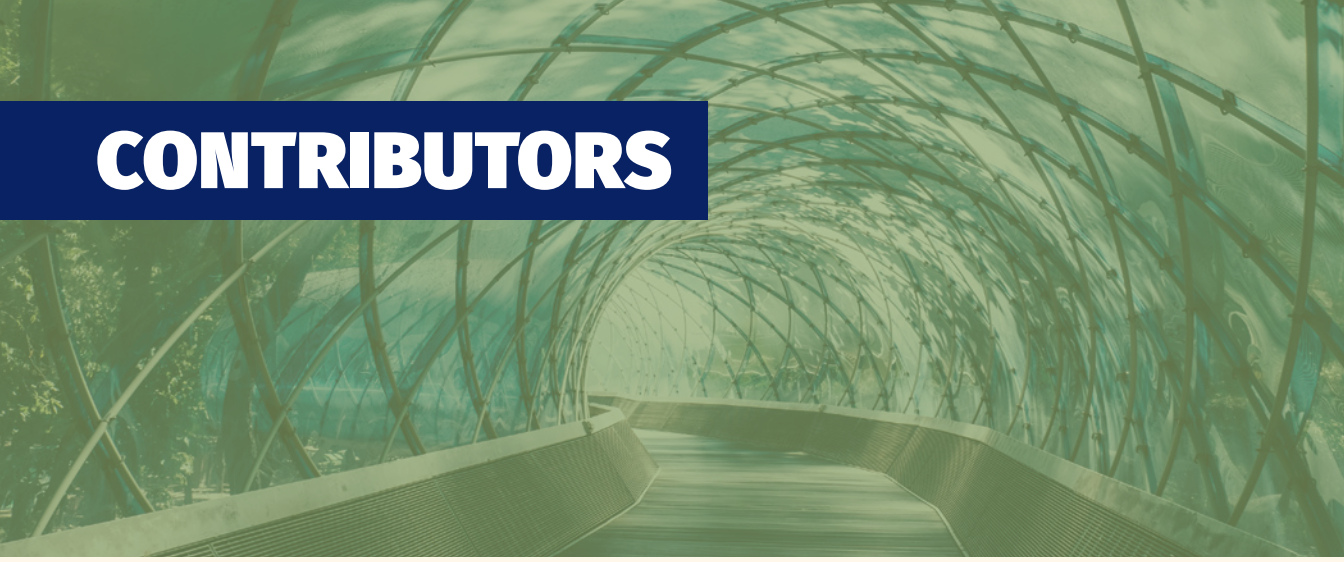
—Kathleen Masters

References

American Association of Colleges of Nursing. (2021). *The essentials: Core competencies for professional nursing education*. https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. Jossey-Bass.

Massachusetts Department of Higher Education. (2016). *Nurse of the future: Nursing core competencies*: *Registered nurse*. https://www.mass.edu/nahi/documents/nofrncompetencies_updated_march2016.pdf



CONTRIBUTORS

Janie B. Butts, PhD, RN
Professor (Retired)
University of Southern Mississippi
College of Nursing and Health Professions
Hattiesburg, Mississippi

Cynthia Chatham, DSN, RN
Associate Professor (Retired)
University of Southern Mississippi
College of Nursing and Health Professions
Long Beach, Mississippi

Mary Louise Coyne, DNSc, RN
Professor (Retired)
University of Southern Mississippi
College of Nursing and Health Professions
Long Beach, Mississippi

Kathleen Driscoll, JD, MS, RN
University of Cincinnati
College of Nursing
Cincinnati, Ohio

Melanie Gilmore, PhD, RN
Associate Professor (Retired)
University of Southern Mississippi
College of Nursing
Hattiesburg, Mississippi

Cathy K. Hughes, DNP, RN
Teaching Assistant Professor (Retired)
University of Southern Mississippi
College of Nursing and Health Professions
Hattiesburg, Mississippi

Karen Saucier Lundy, PhD, RN, FAAN
Professor Emeritus
University of Southern Mississippi
College of Nursing
Hattiesburg, Mississippi

Katherine E. Nugent, PhD, RN
Professor and Dean (Retired)
University of Southern Mississippi
College of Nursing
Hattiesburg, Mississippi

Karen L. Rich, PhD, RN
Associate Professor (Retired)
University of Southern Mississippi
College of Nursing and Health Professions
Long Beach, Mississippi

Jill Rushing, MSN, PhD(c), RN
Lecturer
University of Southern Mississippi
College of Nursing and Health Professions
Hattiesburg, Mississippi

Mary W. Stewart, PhD, RN
Professor and Director of PhD Program
University of Mississippi Medical Center
School of Nursing
Jackson, Mississippi

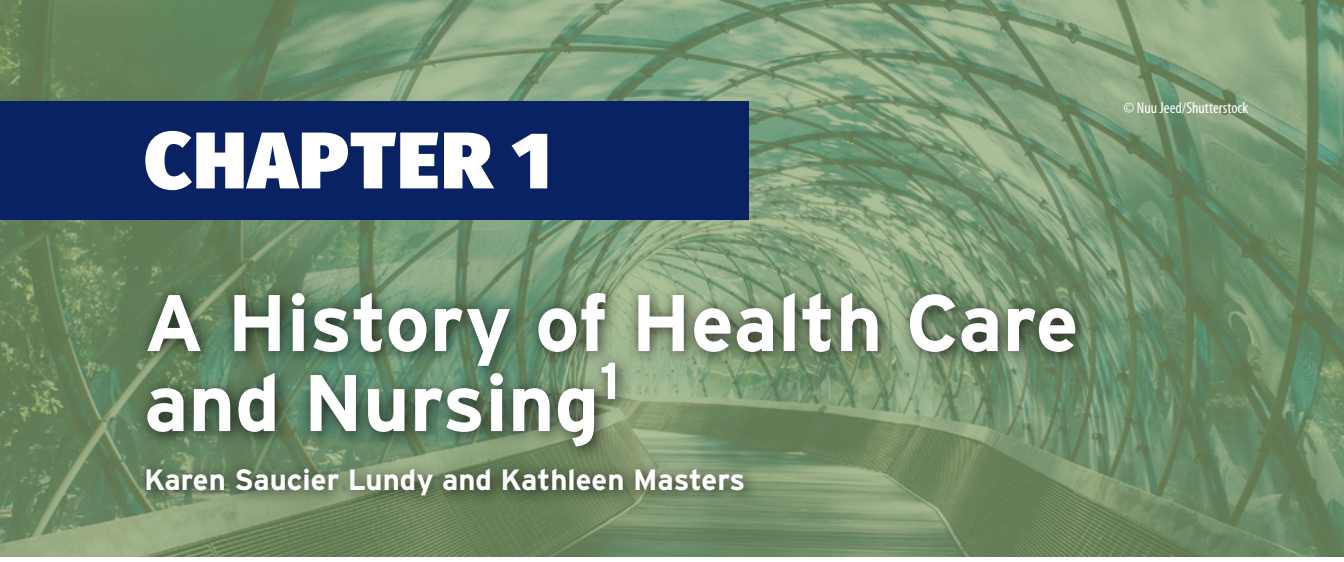
Sharon Vincent, DNP, RN, CNOR
University of North Carolina
College of Nursing
Charlotte, North Carolina

Editor

Kathleen Masters, DNS, RN
Professor
College of Nursing and Health Professions
University of Southern Mississippi
Hattiesburg, Mississippi

UNIT I

Foundations of Professional Nursing Practice



CHAPTER 1

A History of Health Care and Nursing[1]

Karen Saucier Lundy and Kathleen Masters

Learning Objectives

After completing this chapter, the student should be able to:

1. Identify social, political, and economic influences on the development of professional nursing practice.
2. Identify important leaders and events that have significantly affected the development of professional nursing practice.

Although no specialized nurse role per se developed in early civilizations, human cultures recognized the need for nursing care. The truly sick person was weak and helpless and could not fulfill the duties that were normally expected of a member of the community. In such cases, someone had to watch over the patient, nurse the patient, and provide care. In most societies, this nurse role was filled by a family member, usually female. As in most cultures, the childbearing woman had special needs that often resulted in a specialized role for the caregiver. Every society since the dawn of time had someone to nurse and take care of the mother and infant around the childbearing events. In whatever form the nurse took, the role was associated with compassion, health promotion, and kindness (Bullough & Bullough, 1978).

Classical Era

More than 4,000 years ago, Egyptian physicians and nurses used an abundant pharmacologic repertoire to cure the ill and injured.

Key Terms and Concepts

- ***American Journal of Nursing (AJN)***
- **American Nurses Association (ANA)**
- **Annie Goodrich**
- **Brown Report**
- **Chadwick Report**
- **Clara Barton**
- **Deaconesses**
- **Dorothea Lynde Dix**
- **Elizabeth Tyler**
- **Ethel Fenwick**
- **Florence Nightingale**
- **Frances Payne Bolton**
- **Frontier Nursing Service**
- **Goldmark Report**
- **Greek era**

[1] Note: This chapter is from Lundy, K. S., & Bender, K. W. (2009). History of community health and public health nursing. In K. S. Lundy & S. Janes (Eds.), *Community health nursing: Caring for the public's health* (2nd ed., pp. 62–99). Jones & Bartlett Learning.

- Henry Street Settlement
- International Council of Nurses (ICN)
- Isabel Hampton Robb
- Jane A. Delano
- Jeanne Mance
- Jessie Sleet Scales
- Lavinia Lloyd Dock
- Lillian Wald
- Margaret Sanger
- Mary Agnes Snively
- Mary Breckinridge
- Mary Brewster
- Mary D. Osborne
- Reformation
- Roman era
- Shattuck Report
- William Rathbone

The Ebers Papyrus lists more than 700 remedies for ailments ranging from snakebites to puerperal fever (Kalisch & Kalisch, 1986). Healing appeared in the Egyptian culture as the successful result of a contest between invisible beings of good and evil (Shryock, 1959). Around 1000 B.C., the Egyptians constructed elaborate drainage systems, developed pharmaceutical herbs and preparations, and embalmed the dead. The Hebrews formulated an elaborate hygiene code that dealt with laws governing both personal and community hygiene, such as contagion, disinfection, and sanitation through the preparation of food and water. The Jewish contribution to health is greater in sanitation than in their concept of disease. Garbage and excreta were disposed of outside the city or camp, infectious diseases were quarantined, spitting was outlawed as unhygienic, and bodily cleanliness became a prerequisite for moral purity. Although many of the Hebrew ideas about hygiene were Egyptian in origin, the Hebrews were the first to codify them and link them with spiritual godliness (Bullough & Bullough, 1978).

Disease and disability in the Mesopotamian area were considered a great curse, a divine punishment for grievous acts against the gods. Experiencing illness as punishment for a sin linked the sick person to anything even remotely deviant. Not only was the person suffering from the illness but was also branded by society as having deserved it. Those who obeyed God's law lived in health and happiness, and those who transgressed the law were punished with illness and suffering. The sick person then had to make atonement for the sins, enlist a priest or other spiritual healer to lift the curse, or live with the illness to its ultimate outcome (Bullough & Bullough, 1978). Nursing care by a family member or relative would be needed, regardless of the outcome of the sin, curse, disease-atonement-recovery, or death cycle. This logic became the basis for explanation of why some people "get sick and some don't" for many centuries and still persists to some degree in most cultures today.

The Greeks and Health

In Greek mythology, the god of medicine, Asclepius, cured disease. One of his daughters, Hygieia, from whom we derive the word *hygiene*, was the goddess of preventive health and protected humans from disease. Panacea, Asclepius' other daughter, was known as the all-healing "universal remedy," and today her name is used to describe any ultimate cure-all in medicine. She was known as the "light" of the day, and her name was invoked and shrines built to her during times of epidemics (Brooke, 1997).

During the **Greek era**, Hippocrates of Cos emphasized the rational treatment of sickness as a natural rather than a god-inflicted phenomenon. Hippocrates (460–370 B.C.) is considered the father of medicine

because of his arrangements of the oral and written remedies and diseases, which had long been secrets held by priests and religious healers, into a textbook of medicine that was used for centuries (Bullough & Bullough, 1978).

In Greek society, health was considered to result from a balance between mind and body. Hippocrates wrote a most important book, *Air, Water, and Places*, which detailed the relationship between humans and the environment. This is considered a milestone in the eventual development of the science of epidemiology as the first such treatise on the connectedness of the web of life. This topic of the relationship between humans and their environment did not recur until the development of bacteriology in the late 1800s (Rosen, 1958).

Perhaps the idea that most damaged the practice and scientific theory of medicine and health for centuries was the doctrine of the four humors, first spoken of by Empedocles of Acragas (493–433 B.C.). Empedocles was a philosopher and a physician, and as a result he synthesized his cosmologic ideas with his medical theory. He believed that the same four elements that made up the universe were found in humans and in all animate beings (Bullough & Bullough, 1978). Empedocles believed that man [sic] was a microcosm, a small world within the macrocosm, or external environment. The four humors of the body (blood, bile, phlegm, and black bile) corresponded to the four elements of the larger world (fire, air, water, and earth) (Kalisch & Kalisch, 1986). Depending on the prevailing humor, a person was sanguine, choleric, phlegmatic, or melancholic. Because of this strongly held and persistent belief in the connection between the balance of the four humors and health status, treatment was aimed at restoring the appropriate balance of the four humors through the control of their corresponding elements. Through manipulating the two sets of opposite qualities—hot and cold, wet and dry—balance was the goal of the intervention. Fire was hot and dry, air was hot and wet, water was cold and wet, and earth was cold and dry. For example, if a person had a fever, cold compresses would be prescribed; for a chill, the person would be warmed. Such doctrine gave rise to faulty and ineffective treatment of disease that influenced medical education for many years (Taylor, 1922).

Plato, in *The Republic*, details the importance of recreation, a balanced mind and body, nutrition, and exercise. A distinction was made among gender, class, and health as early as the Greek era; only males of the aristocracy could afford the luxury of maintaining a healthful lifestyle (Rosen, 1958).

In *The Iliad*, a poem about the attempts to capture Troy and rescue Helen from her lover, Paris, 140 different wounds are described. The mortality rate averaged 77.6%, the highest as a result of sword and spear thrusts and the lowest from superficial arrow wounds. There was considerable need for nursing care, and Achilles, Patroclus,

and other princes often acted as nurses to the injured. The early stages of Greek medicine reflected the influences of Egyptian, Babylonian, and Hebrew medicine. Therefore, good medical and nursing techniques were used to treat these war wounds: The arrow was drawn or cut out, the wound washed, soothing herbs applied, and the wound bandaged. However, in sickness in which no wound occurred, an evil spirit was considered the cause. The Greeks applied rational causes and cures to external injuries, whereas internal ailments continued to be linked to spiritual maladies (Bullough & Bullough, 1978).

Roman Era

During the rise and the fall of the **Roman era** (31 B.C.–A.D. 476), Greek culture continued to be a strong influence. The Romans easily adopted Greek culture and expanded the Greeks' accomplishments, especially in the fields of engineering, law, and government. For Romans, the government had an obligation to protect its citizens not only from outside aggression, such as warring neighbors, but also from inside the civilization, in the form of health laws. According to Bullough and Bullough (1978), Rome was essentially a "Greek cultural colony" (p. 20).

Galen of Pergamum (A.D. 129–199), often known as the greatest Greek physician after Hippocrates, left for Rome after studying medicine in Greece and Egypt and gained great fame as a medical practitioner, lecturer, and experimenter. In his lifetime, medicine evolved into a science; he submitted traditional healing practices to experimentation and was possibly the greatest medical researcher before the 1600s (Bullough & Bullough, 1978). He was considered the last of the great physicians of antiquity (Kalisch & Kalisch, 1986).

The Greek physicians and healers certainly made the most contributions to medicine, but the Romans surpassed the Greeks in promoting the evolution of nursing. Roman armies developed the notion of a mobile war nursing unit because their battles took them far from home where they could be cared for by wives and family. This portable hospital was a series of tents arranged in corridors; as battles wore on, these tents gave way to buildings that became permanent convalescent camps at the battle sites (Rosen, 1958). Many of these early military hospitals have been excavated by archaeologists along the banks of the Rhine and Danube rivers. They had wards, recreation areas, baths, pharmacies, and even rooms for officers who needed a "rest cure" (Bullough & Bullough, 1978). Coexisting were the Greek dispensary forms of temples, or the *iatreia*, which started out as a type of physician waiting room. These eventually developed into a primitive type of hospital, places for surgical clients to stay until they could be taken home by their families. Although nurses during the Roman era were usually family members, servants, or slaves, nursing had

strengthened its position in medical care and emerged during the Roman era as a separate and distinct specialty.

The Romans developed massive aqueducts, bathhouses, and sewer systems during this era. At the height of the Roman Empire, Rome provided 40 gallons of water per person per day to its 1 million inhabitants, which is comparable to our rates of consumption today (Rosen, 1958).

Middle Ages

Many of the advancements of the Greco-Roman era were reversed during the Middle Ages (A.D. 476–1453) after the decline of the Roman Empire. The Middle Ages, or the medieval era, served as a transition between ancient and modern civilizations. Once again, myth, magic, and religion were explanations and cures for illness and health problems. The medieval world was the result of a fusion of three streams of thought, actions, and ways of life—Greco-Roman, Germanic, and Christian (Donahue, 1985). Nursing was most influenced by Christianity with the beginning of **deaconesses**, or female servants, doing the work of God by ministering to the needs of others. Deacons in the early Christian churches were apparently available only to care for men, whereas deaconesses cared for the needs of women. The role of deaconesses in the church was considered a forward step in the development of nursing and in the 1800s would strongly influence the young **Florence Nightingale**. During this era, Roman military hospitals were replaced by civilian ones. In early Christianity, the *Diakonia*, a kind of combination outpatient and welfare office, was managed by deacons and deaconesses and served as the equivalent of a hospital. Jesus served as the example of charity and compassion for the poor and marginal of society.

Communicable diseases were rampant during the Middle Ages, primarily because of the walled cities that emerged in response to the paranoia and isolation of the populations. Infection was next to impossible to control. Physicians had little to offer, deferring to the church for management of disease. Nursing roles were carried out primarily by religious orders. The oldest hospital (other than military hospitals in the Roman era) in Europe was most likely the *Hôtel-Dieu* in Lyon, France, founded about 542 by Childebert I, king of Paris. The *Hôtel-Dieu* in Paris was founded around 652 by Saint Landry, bishop of Paris. During the Middle Ages, charitable institutions, hospitals, and medical schools increased in number, with the religious leaders as caregivers. The word *hospital*, which is derived from the Latin word *hospitalis*, meaning "service of guests," was most likely more of a shelter for travelers and other pilgrims as well as the occasional person who needed extra care (Kalisch & Kalisch, 1986). Early European hospitals were more like hospices or homes for the aged,

sick pilgrims, or orphans. Nurses in these early hospitals were religious deaconesses who chose to care for others in a life of servitude and spiritual sacrifice.

Black Death

During the Middle Ages, a series of horrible epidemics, including the Black Death or bubonic plague, ravaged the civilized world (Diamond, 1997). In the 1300s, Europe, Asia, and Africa saw nearly half their populations lost to the bubonic plague. Worldwide, more than 60 million deaths were attributed to this horrible plague. In some parts of Europe, only one-fourth of the population survived, with some places having too few survivors alive to bury the dead. Families abandoned sick children, and the sick were often left to die alone (Cartwright, 1972).

Nurses and physicians were powerless to avert the disease. Black spots and tumors on the skin appeared, and petechiae and hemorrhages gave the skin a darkened appearance. There was also acute inflammation of the lungs, burning sensations, unquenchable thirst, and inflammation of the entire body. Hardly anyone afflicted survived the third day of the attack. So great was the fear of contagion that ships carrying bodies of infected persons were set to sail without a crew to drift from port to port through the North, Black, and Mediterranean seas with their dead passengers (Cohen, 1989).

Medieval people knew that this disease was in some way communicable, but they were unsure of the mode of transmission (Diamond, 1997); hence the avoidance of victims and a reliance on isolation techniques. During this time, the practice of quarantine in city ports was developed as a preventive measure that is still used today (Bullough & Bullough, 1978; Kalisch & Kalisch, 1986).

The Renaissance

During the rebirth of Europe, political, social, and economic advances occurred along with a tremendous revival of learning. Donahue (1985) contends that the Renaissance has been "viewed as both a blessing and a curse" (p. 188). There was a renewed interest in the arts and sciences, which helped advance medical science (Boorstin, 1985; Bullough & Bullough, 1978). Columbus and other explorers discovered new worlds, and belief in a sun-centered rather than an Earth-centered universe was promoted by Copernicus (1473–1543). Sir Isaac Newton's (1642–1727) theory of gravity changed the world forever. Gunpowder was introduced, and social and religious upheavals resulted in the American and French revolutions at the end of the 1700s. In the arts and sciences, Leonardo da Vinci, known as one of the greatest geniuses of all time, made a number of anatomic drawings based on dissection experiences. These drawings have become classics in the progression of

knowledge about the human anatomy. Many artists of this time left an indelible mark and continue to exert influence today, including Michelangelo, Raphael, and Titian (Donahue, 1985).

The Reformation

Religious changes during the Renaissance influenced nursing perhaps more than any other aspect of society. Particularly important was the rise of Protestantism as a result of the reform movements of Martin Luther (1483–1546) in Germany and John Calvin (1509–1564) in France and Switzerland. Although the various sects were numerous in the Protestant movement, the agreement among the leaders was almost unanimous on the abolition of the monastic or cloistered career. The effects on nursing were drastic: Monastic-affiliated institutions, including hospitals and schools, were closed, and orders of nuns, including nurses, were dissolved. Even in countries where Catholicism flourished, royal leaders seized monasteries frequently.

Religious leaders, such as Martin Luther, who led the **Reformation** in 1517, were well aware of the lack of adequate nursing care as a result of these sweeping changes. Luther advocated that each town establish something akin to a "community chest" to raise funds for hospitals and nurse visitors for the poor (Dietz & Lehozky, 1963). Thus, the closures of the monasteries eventually resulted in the creation of public hospitals where laywomen performed nursing care. It was difficult to find laywomen who were willing to work in these hospitals to care for the sick, so judges began giving prostitutes, publicly intoxicated women, and poverty-stricken women the option of going to jail, going to the poorhouse, or working in the public hospital. Unlike the sick wards in monasteries, which were generally considered to be clean and well managed, the public hospitals were filthy, disorganized buildings where people went to die while being cared for by laywomen who were not trained, motivated, or qualified to care for the sick (Sitzman & Judd, 2014a).

In England, where there had been at least 450 charitable foundations before the Reformation, only a few survived the reign of Henry VIII, who closed most of the monastic hospitals (Donahue, 1985). Eventually, Henry VIII's son, Edward VI, who reigned from 1547 to 1553, endowed some hospitals, namely, St. Bartholomew Hospital and St. Thomas Hospital, which would eventually house the Nightingale School of Nursing in the later 1800s (Bullough & Bullough, 1978).

The Dark Period of Nursing

The last half of the period between 1500 and 1860 is widely regarded as "the dark period of nursing" because nursing conditions were at their worst (Donahue, 1985). Education for girls, which had been

provided by the nuns in religious schools, was lost. Because of the elimination of hospitals and schools, there was no one to pass on knowledge about caring for the sick. As a result, the hospitals were managed and staffed by municipal authorities; women entering nursing service often came from illiterate classes, and even then, there were too few to serve (Dietz & Lehozky, 1963). The lay attendants who filled the nursing role were illiterate, rough, inconsiderate, and often immoral and alcoholic. Intelligent women and men could not be persuaded to accept such a degraded and low-status position in the offensive municipal hospitals of London. Nursing slipped back into a role of servitude as menial, low-status work. According to Donahue (1985), when a woman could no longer make it as a gambler, prostitute, or thief, she might become a nurse. Eventually, women serving jail sentences for such crimes as prostitution and stealing were ordered to care for the sick in the hospitals instead of serving their sentences in the city jail (Dietz & Lehozky, 1963). The nurses of this era took bribes from clients, became inappropriately involved with them, and survived the best way they could, often at the expense of their assigned clients.

Nursing had, during this era, virtually no social standing or organization. Even Catholic sisters of the religious orders throughout Europe "came to a complete standstill" professionally because of the intolerance of society (Donahue, 1985, p. 231). Charles Dickens, in *Martin Chuzzlewit* (1844), created the enduring characters of Sairey Gamp and Betsy Prig. Sairey Gamp was a visiting nurse based on an actual hired attendant whom Dickens had met in a friend's home. Sairey Gamp was hired to care for sick family members but was instead cruel to her clients, stole from them, and ate their rations; she was an alcoholic and has been immortalized forever as a reminder of the world in which Florence Nightingale came of age (Donahue, 1985). The first hospital in the Americas, the *Hospital de la Purísima Concepción*, was founded some time before 1524 by Hernando Cortez, the conqueror of Mexico. The first hospital in the continental United States was erected in Manhattan in 1658 for the care of sick soldiers and slaves. In 1717, a hospital for infectious diseases was built in Boston; the first hospital established by a private gift was the Charity Hospital in New Orleans. A sailor, Jean Louis, donated the endowment for the hospital's founding (Bullough & Bullough, 1978).

During the 1600s and 1700s, colonial hospitals with little resemblance to modern hospitals were often used to house the poor and downtrodden. Hospitals called "pesthouses" were created to care for clients with contagious diseases; their primary purpose was to protect the public at large rather than to treat and care for the clients. Contagious diseases were rampant during the early years of the American colonies, often being spread by the large number of immigrants who brought these diseases with them on their long journey to America.

Medicine was not as developed as in Europe, and nursing remained in the hands of the uneducated. By 1720, average life expectancy at birth was only around 35 years. Plagues were a constant nightmare, with outbreaks of smallpox and yellow fever. In 1751, the first true hospital in the new colonies, Pennsylvania Hospital, was erected in Philadelphia on the recommendation of Benjamin Franklin (Kalisch & Kalisch, 1986).

By today's standards, hospitals in the 1800s were disgraceful, dirty, unventilated, and contaminated by infections; to be a client in a hospital actually increased one's risk of dying. As in England, nursing was considered an inferior occupation. After the sweeping changes of the Reformation, educated religious health workers were replaced with laypeople who were "down and outers" in prison or had no option left but to work with the sick (Kalisch & Kalisch, 1986).

The Industrial Revolution

During the mid-1700s in England, capitalism emerged as an economic system based on profit. This emerging system resulted in mass production, as contrasted with the previous system of individual workers and craftsmen. In the simplest terms, the Industrial Revolution was the application of machine power to processes formerly done by hand. Machinery was invented during this era and ultimately standardized quality; individual craftsmen were forced to give up their crafts and lands and become factory laborers for the capitalist owners. All types of industries were affected; this newfound efficiency produced profit for owners of the means of production. Because of this, the era of invention flourished, factories grew, and people moved in record numbers to work in the cities. Urban areas grew, tenement housing projects emerged, and overcrowding in cities seriously threatened individuals' well-being (Donahue, 1985).

Workers were forced to go to the machines, not the other way around. Such relocations meant giving up not only farming but also a way of life that had existed for centuries. The emphasis on profit over people led to child labor, frequent layoffs, and long workdays filled with stressful, tedious, unfamiliar work. Labor unions did not exist, and neither was there any legal protection against exploitation of workers, including children (Donahue, 1985). All these rapid changes and often threatening conditions created the world of Charles Dickens, where, as in his book *Oliver Twist*, children worked as adults without question.

According to Donahue (1985), urban life, trade, and industrialization contributed to these overwhelming health hazards, and the situation was confounded by the lack of an adequate means of social control. Reforms were desperately needed, and the social reform movement emerged in response to the unhealthy by-products of the Industrial Revolution. It was in this world of the 1800s that such

reformers as John Stuart Mill (1806–1873) emerged. Although the Industrial Revolution began in England, it quickly spread to the rest of Europe and to the United States (Bullough & Bullough, 1978). The reform movement is critical to understanding the emerging health concerns that were later addressed by Florence Nightingale. Mill championed popular education, the emancipation of women, trade unions, and religious toleration. Other reform issues of the era included the abolition of slavery and, most important for nursing, more humane care of the sick, the poor, and the wounded (Bullough & Bullough, 1978). There was a renewed energy in the religious community with the reemergence of new religious orders in the Catholic Church that provided service to the sick and disenfranchised.

Epidemics had ravaged Europe for centuries, but they became even more serious with urbanization. Industrialization brought people to cities, where they worked in close quarters (as compared with the isolation of the farm) and contributed to the social decay of the second half of the 1800s. Sanitation was poor or nonexistent, sewage disposal from the growing population was lacking, cities were filthy, public laws were weak or nonexistent, and congestion of the cities inevitably brought pests in the form of rats, lice, and bedbugs, which transmitted many pathogens. Communicable diseases continued to plague the population, especially those who lived in these unsanitary environments. For example, during the mid-1700s, typhus and typhoid fever claimed twice as many lives each year as did the Battle of Waterloo (Hanlon & Pickett, 1984). Through foreign trade and immigration, infectious diseases were spread to all of Europe and eventually to the growing United States.

The Chadwick Report

Edwin Chadwick became a major figure in the development of the field of public health in Great Britain by drawing attention to the cost of the unsanitary conditions that shortened the life span of the laboring class and threatened the wealth of Britain. Although the first sanitation legislation, which established a National Vaccination Board, was passed in 1837, Chadwick found in his classic study, *Report on an Inquiry into the Sanitary Conditions of the Labouring Population of Great Britain*, that death rates were high in large industrial cities, such as Liverpool. A more startling finding, from what is often referred to simply as the **Chadwick Report**, was that more than half the children of labor-class workers died by age 5, indicating poor living conditions that affected the health of the most vulnerable. Laborers lived only half as long as the upper classes.

One consequence of the report was the establishment in 1848 of the first board of health, the General Board of Health for England (Richardson, 1887). More legislation followed that initiated social

reform in the areas of child welfare, elder care, the sick, mentally ill persons, factory health, and education. Soon sewers and fireplugs, based on an available water supply, appeared as indicators that the public health linkages from the Chadwick Report had an effect.

The Shattuck Report

In the United States during the 1800s, waves of epidemics of yellow fever, smallpox, cholera, typhoid fever, and typhus continued to plague the population as in England and the rest of the world. As cities continued to grow in the industrialized young nation, poor workers crowded into larger cities and suffered from illnesses caused by the unsanitary living conditions (Hanlon & Pickett, 1984). Similar to Chadwick's classic study in England, Lemuel Shattuck, a Boston bookseller and publisher who had an interest in public health, organized the American Statistical Society in 1839 and issued a census of Boston in 1845. Shattuck's census revealed high infant mortality rates and high overall population mortality rates. In 1850, in his *Report of the Massachusetts Sanitary Commission*, Shattuck not only outlined his findings on the unsanitary conditions but also made recommendations for public health reform that included the bookkeeping of population statistics and development of a monitoring system that would provide information to the public about environmental, food, and drug safety and infectious disease control (Rosen, 1958). He also called for services for well-child care, school-age children's health, immunizations, mental health, health education for all, and health planning. The **Shattuck Report** was revolutionary in its scope and vision for public health, but it was virtually ignored during Shattuck's lifetime. Nineteen years later, in 1869, the first state board of health was formed (Kalisch & Kalisch, 1986).

And Then There Was Nightingale . . .

Florence Nightingale (**Figure 1-1**) was named one of the 100 most influential persons of the last millennium by *Life* magazine ("The 100 People Who Made the Millennium," 1997). She was one of only eight women identified as such. Of those eight women, including Joan of Arc, Helen Keller, and Elizabeth I, Nightingale was identified as a true "angel of mercy," having reformed military health care in the Crimean War and used her political savvy to forever change the way society views the health of the vulnerable, the poor, and the forgotten. She is probably one of the most written about women in history (Bullough & Bullough, 1978). *Florence Nightingale* has become synonymous with modern nursing.

Born on May 12, 1820, in her namesake city, Florence, Italy, Florence Nightingale was the second child in the wealthy English family of

Figure 1-1 Engraving from 1873 featuring the English reformer and founder of modern nursing, Florence Nightingale.

William and Frances Nightingale. As a young child, Florence displayed incredible curiosity and intellectual abilities not common to female children of the Victorian age. She mastered the fundamentals of Greek and Latin, and she studied history, art, mathematics, and philosophy. To her family's dismay, she believed that God had called her to be a nurse. Nightingale was keenly aware of the suffering that industrialization created; she became obsessed with the plight of the miserable and suffering people. Conditions of general starvation accompanied the Industrial Revolution, prisons and workhouses overflowed, and persons in all sections of British life were displaced. She wrote in the spring of 1842, "My mind is absorbed with the sufferings of man; it besets me behind and before. . . . All that the poets sing of the glories of this world seem to me untrue. All the people that I see are eaten up with care or poverty or disease" (Woodham-Smith, 1951, p. 31).

Nightingale's entire life would be haunted by this conflict between the opulent life of gaiety that she enjoyed and the misery of the world, which she was unable to alleviate. She was, in essence, an "alien spirit in the rich and aristocratic social sphere of Victorian England" (Palmer, 1977, p. 14). Nightingale remained unmarried, and at the age of 25, she expressed a desire to be trained as a nurse in an English hospital. Her parents emphatically denied her request, and for the next 7 years, she made repeated attempts to change their minds and allow her to enter nurse training. She wrote, "I crave for some regular occupation, for something worth doing instead of frittering my time away on useless trifles" (Woodham-Smith, 1951, p. 162). During this time, she continued her education through the study of math and science and spent 5 years collecting data about public health and hospitals (Dietz & Lehozky, 1963). During a tour of Egypt in 1849 with family and friends, Nightingale spent her 30th year in Alexandria with the Sisters of Charity of St. Vincent de Paul, where her conviction to study nursing was only reinforced (Tooley, 1910). While in Egypt, Nightingale studied Egyptian, Platonic, and Hermetic philosophy; Christian scripture; and the works of poets, mystics, and missionaries in her efforts to understand the nature of God and her "calling" as it fit into the divine plan (Calabria, 1996; Dossey, 2000).

The next spring, Nightingale traveled unaccompanied to the Kaiserswerth Institute in Germany and stayed there for 2 weeks, vowing to return to train as a nurse. In June 1851, Nightingale took her future into her own hands and announced to her family that she planned to return to Kaiserswerth and study nursing. According to Dietz and Lehozky (1963, p. 42), her mother had "hysterics" and scene followed scene. Her father "retreated into the shadows," and her sister, Parthe, expressed that the family name was forever disgraced (Cook, 1913). In 1851, at the age of 31, Nightingale was finally permitted to go to Kaiserswerth, and she studied there for 3 months with Pastor Fliedner. Her family insisted that she tell no one outside the family of her whereabouts, and her mother forbade her to write any letters from Kaiserswerth. While there, Nightingale learned about the care of the sick and the importance of discipline and commitment of oneself to God (Donahue, 1985). She returned to England and cared for her then ailing father, from whom she finally gained some support for her intent to become a nurse—her lifelong dream.

In 1852, Nightingale wrote the essay "Cassandra," which stands today as a classic feminist treatise against the idleness of Victorian women. Through her voluminous journal writings, Nightingale reveals her inner struggle throughout her adulthood with what was expected of a woman and what she could accomplish with her life. The life expected of an aristocratic woman in her day was one she grew to loathe, and she expressed this detestation throughout her writings (Nightingale, 1979). In "Cassandra," Nightingale put her

thoughts to paper, and many scholars believe that her eventual intent was to extend the essay to a novel. She wrote in "Cassandra," "Why have women passion, intellect, moral activity—these three—in a place in society where no one of the three can be exercised?" (Nightingale, 1979, p. 37). Although uncertain about the meaning of the name Cassandra, many scholars believe that it came from the Greek goddess Cassandra, who was cursed by Apollo and doomed to see and speak the truth but never to be believed. Nightingale saw the conventional life of women as a waste of time and abilities. After receiving a generous yearly endowment from her father, Nightingale moved to London and worked briefly as the superintendent of the Establishment for Gentlewomen During Illness hospital, finally realizing her dream of working as a nurse (Cook, 1913).

The Crimean Experience: "I Can Stand Out the War with Any Man"

Nightingale's opportunity for greatness came when she was offered the position of superintendent of the female nursing establishment of the English General Hospitals in Turkey by the secretary of war, Sir Sidney Herbert. Soon after the outbreak of the Crimean War, stories of the inadequate care and lack of medical resources for the soldiers became widely known throughout England (Woodham-Smith, 1951). The country was appalled at the conditions so vividly portrayed in the *London Times*. Pressure increased on Sir Sidney to react. He knew of one woman who was capable of bringing order out of the chaos and wrote a letter to Nightingale on October 15, 1854, as a plea for her service. Nightingale accepted the challenge and set sail with 38 self-proclaimed nurses with varied training and experiences, of whom 24 were Catholic and Anglican nuns. Their journey to Crimea took a month, and on November 4, 1854, the brave nurses arrived at Istanbul and were taken to Scutari the same day. Faced with 3,000 to 4,000 wounded men in a hospital designed to accommodate 1,700, the nurses went to work (Kalisch & Kalisch, 1986). They found 4 miles of beds 18 inches apart. Most soldiers were lying naked with no bedding or blanket. There were no kitchen or laundry facilities. The little light present took the form of candles in beer bottles. The hospital was literally floating on an open sewage lagoon filled with rats and other vermin (Donahue, 1985).

By taking the newly arrived medical equipment and setting up kitchens, laundries, recreation rooms, reading rooms, and a canteen, Nightingale and her team of nurses proceeded to clean the barracks of lice and filth. Nightingale was in her element. She set out not only to provide humane health care for the soldiers but also to essentially overhaul the administrative structure of the military health services (Williams, 1961).

Florence Nightingale and Sanitation

Although Nightingale never accepted the germ theory, she demanded clean dressings; clean bedding; well-cooked, edible, and appealing food; proper sanitation; and fresh air. After the other nurses were asleep, Nightingale made her famous solitary rounds with a lamp or lantern to check on the soldiers. Nightingale had a lifelong pattern of sleeping few hours, spending many nights writing, developing elaborate plans, and evaluating implemented changes. She seldom believed in the "hopeless" soldier, only one who needed extra attention. Nightingale was convinced that most of the maladies that the soldiers suffered and died from were preventable (Williams, 1961).

Before Nightingale's arrival and her radical and well-documented interventions based on sound public health principles, the mortality rate from the Crimean War was estimated to be from 42% to 73%. Nightingale is credited with reducing that rate to 2% within 6 months of her arrival at Scutari. She did this through careful, scientific epidemiologic research (Dietz & Lehozky, 1963). Upon arriving at Scutari, Nightingale's first act was to order 200 scrubbing brushes. The death rate fell dramatically once Nightingale discovered that the hospital was built literally over an open sewage lagoon (Andrews, 2003).

According to Palmer (1982), Nightingale possessed the qualities of a good researcher: insatiable curiosity, command of her subject, familiarity with methods of inquiry, a good background of statistics, and the ability to discriminate and abstract. She used these skills to maintain detailed and copious notes and to codify observations. Nightingale relied on statistics and attention to detail to back up her conclusions about sanitation, management of care, and disease causation. Her now-famous "cox combs" are a hallmark of military health services management by which she diagrammed deaths in the army from wounds and from other diseases and compared them with deaths that occurred in similar populations in England (Palmer, 1977).

Nightingale was first and foremost an administrator: She believed in a hierarchical administrative structure with ultimate control lodged in one person to whom all subordinates and offices reported. Within a matter of weeks of her arrival in the Crimea, Nightingale was the acknowledged administrator and organizer of a mammoth humanitarian effort. From her Crimean experience on, Nightingale involved herself primarily in organizational activities and health planning administration. Palmer contends that Nightingale "perceived the Crimean venture, which was set up as an experiment, as a golden opportunity to demonstrate the efficacy of female nursing" (Palmer, 1982, p. 4). Although Nightingale faced initial resistance from the unconvinced and oppositional medical officers and surgeons, she boldly defied convention and remained steadfastly focused on her mission to create a sanitary and highly structured environment for

her "children"—the British soldiers who dedicated their lives to the defense of Great Britain. Because of her insistence on absolute authority regarding nursing and the hospital environment, Nightingale was known to send nurses home to England from the Crimea for suspicious alcohol use and character weakness.

It was through this success at Scutari that she began a long career of influence on the public's health through social activism and reform, health policy, and the reformation of career nursing. Using her well-publicized successful "experiment" and supportive evidence from the Crimea, Nightingale effectively argued the case for the reform and creation of military health care that would serve as the model for people in uniform to the present (D'Antonio, 2002). Nightingale's ideas about proper hospital architecture and administration influenced a generation of medical doctors and the entire world, in both military and civilian service. Her work in *Notes on Hospitals*, published in 1860, provided the template for the organization of military health care in the Union Army when the U.S. Civil War erupted in 1861. Her vision for health care of soldiers and the responsibility of the governments that send them to war continues today; her influence can be seen throughout the previous century and into this century as health care for the women and men who serve their country is a vital part of the well-being not only of the soldiers but also of society in general (D'Antonio, 2002).

Returning Home a Heroine: The Political Reformer

When Nightingale returned to London, she found that her efforts to provide comfort and health to the British soldier succeeded in making heroes of both herself and the soldiers (Woodham-Smith, 1951). Both had suffered from negative stereotypes: The soldier was often portrayed as a drunken oaf with little ambition or honor, and the nurse as a tipsy, self-serving, illiterate, promiscuous loser. After the Crimean War and the efforts of Nightingale and her nurses, both returned with honor and dignity, never again downtrodden and disrespected.

After her return from Crimea, Nightingale never made a public appearance, never attended a public function, and never issued a public statement (Bullough & Bullough, 1978). She single-handedly raised nursing from, as she put it, "the sink it was" into a respected and noble profession (Palmer, 1977). As an avid scholar and student of the Greek writer Plato, Nightingale believed that she had a moral obligation to work primarily for the good of the community. Because she believed that education formed character, she insisted that nursing must go beyond care for the sick; the mission of the trained nurse must include social reform to promote the good. This dual mission of nursing—caregiver and political reformer—has shaped the profession

as we know it today. LeVasseur (1998) contends that Nightingale's insistence on nursing's involvement in a larger political ideal is the historic foundation of the field and distinguishes us from other scientific disciplines, such as medicine.

How did Nightingale accomplish this? She effected change through her wide command of acquaintances: Queen Victoria was a significant admirer of her intellect and ability to effect change, and Nightingale used her position as national heroine to get the attention of elected officials in Parliament. She was tireless and had an amazing capacity for work. She used people. Her brother-in-law, Sir Harry Verney, was a member of Parliament and often delivered her "messages" in the form of legislation. When she wanted the public incited, she turned to the press, writing letters to the *London Times* and having others of influence write articles. She was not above threats to "go public" by certain dates if an elected official refused to establish a commission or appoint a committee. And when those commissions were formed, Nightingale was ready with her list of selected people for appointment (Palmer, 1982).

Nightingale and Military Reforms

The first real test of Nightingale's military reforms came in the United States during the Civil War. Nightingale was asked by the Union to advise on the organization of hospitals and care of the sick and wounded. She sent recommendations back to the United States based on her experiences and analysis in Crimea, and her advisement and influence gained wide publicity. Following her recommendations, the Union set up a sanitary commission and provided for regular inspection of camps. She also expressed a desire to help with the Confederate military, but unfortunately had no channel of communication with them (Bullough & Bullough, 1978).

The Nightingale School of Nursing at St. Thomas: The Birth of Professional Nursing

The British public honored Nightingale by endowing 50,000 pounds sterling in her name upon her return to England from Crimea. The money had been raised from the soldiers under her care and donations from the public. This Nightingale Fund eventually was used to create the Nightingale School of Nursing at St. Thomas, which was to be the beginning of professional nursing (Donahue, 1985). Nightingale, at the age of 40, decided that St. Thomas Hospital was the place for her training school for nurses. While the negotiations for the school went forward, she spent her time writing *Notes on Nursing: What It Is and What It Is Not* (Nightingale, 1860). The small book of 77 pages, written for the British mother, was an instant success. An expanded

library edition was written for nurses and used as the textbook for the students at St. Thomas. The book has since been translated into many languages, although it is believed that Nightingale refused all royalties earned from the publication of the book (Cook, 1913; Tooley, 1910). The nursing students chosen for the new training school were handpicked; they had to be of good moral character, sober, and honest. Nightingale believed that the strong emphasis on morals was critical to gaining respect for the new "Nightingale nurse," with no possible ties to the disgraceful association of past nurses. Nursing students were monitored throughout their 1-year program both on and off the hospital grounds; their activities were carefully watched for character weaknesses, and discipline was severe and swift for violators. Accounts from Nightingale's journals and notes reveal instant dismissal of nursing students for such behaviors as "flirtation, using the eyes unpleasantly, and being in the company of unsavory persons." Nightingale contended that "the future of nursing depends on how these young women behave themselves" (Smith, 1934, p. 234). She knew that the experiment at St. Thomas to educate nurses and raise nursing to a moral and professional calling was a drastic departure from the past images of nurses and would take extraordinary women of high moral character and intelligence. Nightingale knew every nursing student, or probationer, personally, often having the students at her house for weekend visits. She devised a system of daily journal keeping for the probationers; Nightingale herself read the journals monthly to evaluate their character and work habits. Every nursing student admitted to St. Thomas had to submit an acceptable "letter of good character," and Nightingale herself placed graduate nurses in approved nursing positions.

One of the most important features of the Nightingale School was its relative autonomy. Both the school and the hospital nursing service were organized under the head matron. This was especially significant because it meant that nursing service began independently of the medical staff in selecting, retaining, and disciplining students and nurses (Bullough & Bullough, 1978). Nightingale was opposed to the use of a standardized government examination and the movement for licensure of trained nurses. She believed that schools of nursing would lose control of educational standards with the advent of national licensure, most notably those related to moral character. Nightingale led a staunch opposition to the movement by the Royal British Nurses' Association (RBNA) for licensure of trained nurses, one the RBNA believed critical to protecting the public's safety by ensuring the qualification of nurses by licensure exam. Nightingale was convinced that qualifying a nurse by examination tested only the acquisition of technical skills, not the equally important evaluation of character (Nutting & Dock, 1907; Woodham-Smith, 1951).

Taking Health Care to the Community: Nightingale and Wellness

Early efforts to distinguish hospital from community health nursing are evidence of Nightingale's views on "health nursing," which she distinguished from "sick nursing." She wrote two influential papers, one in 1893, "Sick-Nursing and Health-Nursing" (Nightingale, 1893), which was read in the United States at the Chicago Exposition, and the second, "Health Teaching in Towns and Villages" in 1894 (Monteiro, 1985). Both papers praised the success of prevention-based nursing practice. Winslow (1946) acknowledged Nightingale's influence in the United States by being one of the first in the field of public health to recognize the importance of taking responsibility for one's health. According to Palmer (1982), Nightingale was a leader in the wellness movement long before the concept was identified. Nightingale saw the nurse as the key figure in establishing a healthy society. She saw a logical extension of nursing in acute hospital settings to the community. Clearly, through her *Notes on Nursing*, she visualized the nurse as "the nation's first bulwark in health maintenance, the promotion of wellness, and the prevention of disease" (Palmer, 1982, p. 6).

William Rathbone, a wealthy ship owner and philanthropist, is credited with the establishment of the first visiting nurse service, which eventually evolved into district nursing in the community. He was so impressed with the private duty nursing care that his sick wife had received at home that he set out to develop a "district nursing service" in Liverpool, England. At his own expense, in 1859, he developed a corps of nurses trained to care for the sick poor in their homes (Bullough & Bullough, 1978). He divided the community into 16 districts; each was assigned a nurse and a social worker that provided nursing and health education. His experiment in district nursing was so successful that he was unable to find enough nurses to work in the districts. Rathbone contacted Nightingale for assistance. Her recommendation was to train more nurses, and she advised Rathbone to approach the Royal Liverpool Infirmary with a proposal for opening another training school for nurses (Rathbone, 1890; Tooley, 1910). The infirmary agreed to Rathbone's proposal, and district nursing soon spread throughout England as successful health nursing in the community for the sick poor through voluntary agencies (Rosen, 1958). Ever the visionary, Nightingale contended that the goal is to care for the sick in their own homes (Attewell, 1996). A similar service, health visiting, began in Manchester, England, in 1862 by the Manchester and Salford Sanitary Association. The purpose of placing health visitors in the home was to provide health information and instruction to families. Eventually, health

visitors evolved to provide preventive health education and district nurses to care for the sick at home (Bullough & Bullough, 1978).

Although Nightingale is best known for her reform of hospitals and the military, she was a great believer in the future of health care, which she anticipated should be preventive in nature and would more than likely take place in the home and community. Her accomplishments in the field of "sanitary nursing" extended beyond the walls of the hospital to include workhouse reform and community sanitation reform. In 1864, Nightingale and William Rathbone once again worked together to lead the reform of the Liverpool Workhouse Infirmary, where more than 1,200 sick paupers were crowded into unsanitary and unsafe conditions. Under the British Poor Laws, the most desperately poor of the large cities were gathered into large workhouses. When sick, they were sent to the workhouse infirmary. Trained nursing care was all but nonexistent. Through legislative pressure and a well-designed public campaign describing the horrors of the workhouse infirmary, reform of the workhouse system was accomplished by 1867. Although not as complete as Nightingale had wanted, nurses were in place and being paid a salary (Seymer, 1954).

The Legacy of Nightingale

A great deal has been written about Nightingale—an almost mythic figure in history. She truly was a beloved legend throughout Great Britain by the time she left Crimea in July 1856, just four months after the war. Longfellow immortalized this "Lady with the Lamp" in his poem "Santa Filomena" (Longfellow, 1857). However, when Nightingale returned to London after the Crimean War, she remained haunted by her experiences related to the soldiers dying of preventable diseases. She was troubled by nightmares and had difficulty sleeping in the years that followed (Woodham-Smith, 1983). Nightingale became a prolific writer and a staunch defender of the causes of the British soldier, sanitation in England and India, and trained nursing.

As a woman, she was not able to hold an official government post, nor could she vote. Historians have had varied opinions about the exact nature of the disability that kept her homebound for the remainder of her life. Recent scholars have speculated that she experienced posttraumatic stress disorder (PTSD) from her experiences in Crimea; there is also considerable evidence that she suffered from the painful disease brucellosis (Barker, 1989; Young, 1995). She exerted incredible influence through friends and acquaintances, directing from her sick room sanitation and poor law reform. Her mission to "cleanse" spread from the military to the British Empire; her fight for improved sanitation both at home

and in India consumed her energies for the remainder of her life (Vicinus & Nergaard, 1990).

According to Monteiro (1985), two recurrent themes are found throughout Nightingale's writings about disease prevention and wellness outside the hospital. The most persistent theme is that nurses must be trained differently and instructed specifically in district and instructive nursing. She consistently wrote that the "health nurse" must be trained in the nature of poverty and its influence on health, something she referred to as the "pauperization" of the poor. She also believed that above all, health nurses must be good teachers about hygiene and helping families learn to better care for themselves (Nightingale, 1893). She insisted that untrained, "good intended women" could not substitute for nursing care in the home. Nightingale pushed for an extensive orientation and additional training, including prior hospital experience, before one was hired as a district nurse. She outlined the qualifications in her paper "On Trained Nursing for the Sick Poor," in which she called for a month's "trial" in district nursing, a year's training in hospital nursing, and 3 to 6 months training in district nursing (Monteiro, 1985).

The second theme that emerged from her writings was the focus on the role of the nurse. She clearly distinguished the role of the health nurse in promoting what we today call self-care. In the past, philanthropic visitors in the form of Christian charity would visit the homes of the poor and offer them relief (Monteiro, 1985). Nightingale believed that such activities did little to teach the poor to care for themselves and further "pauperized" them—dependent and vulnerable—keeping them unhealthy, prone to disease, and reliant on others to keep them healthy. The nurse then must help the families at home manage a healthy environment for themselves, and Nightingale saw a trained nurse as being the only person who could pull off such a feat.

By 1901, Nightingale lived in a world without sight or sound, leaving her unable to write. Over the next 5 years, Nightingale lost her ability to communicate and most days existed in a state of unconsciousness. In November 1907, Nightingale was honored with the Order of Merit by King Edward VII, the first time it was ever given to a woman. After 50 years, in May 1910, the Nightingale Training School of Nursing at St. Thomas celebrated its jubilee. There were now more than 1,000 training schools for nurses in the United States alone (Cook, 1913; Tooley, 1910).

Nightingale died in her sleep around noon on August 13, 1910, and was buried quietly and without pomp near the family's home at Embley, her coffin carried by six sergeants of the British Army. Only a small cross marks her grave at her request: "FN. Born 1820. Died 1910" (Brown, 1988). The family refused a national funeral and burial at Westminster Abbey out of respect for Nightingale's last wishes. She had lived for 90 years and 3 months.

Continued Development of Professional Nursing in the United Kingdom

Although Florence Nightingale opposed registration, based on the belief that the essential qualities of a nurse could not be taught, examined, or regulated, registration in the United Kingdom began in the 1880s. The Hospitals Association maintained a voluntary registry that was an administrative list. In an effort to protect the public led by **Ethel Fenwick**, the Royal British Nurses' Association (RBNA) was formed in 1887, with its charter granted in 1893 to unite British nurses and to provide registration as evidence of systematic training. Finally, in 1919, nurse registration became law. It took 30 years and the tireless efforts of Fenwick, who was supported by other nursing leaders such as Isla Stewart, Lucy Osbourne, and Mary Cochrane, to achieve mandated registration (Royal College of Nursing, n.d.).

Another milestone in British nursing history was the founding in 1916 of the College of Nursing as the professional organization for trained nurses. Known now as the Royal College of Nursing, the organization has focused for over a century on professional standards for nurses in their education, practice, and working conditions. Although the principles of a professional organization and those of a trade union have not always fit together easily, the Royal College of Nursing has pursued its role as both the professional organization for nurses and the trade union for nurses (McGann et al., 2009). Today the Royal College of Nursing is recognized as the voice of nursing by the government and the public in the United Kingdom (Royal College of Nursing, n.d.).

The Development of Professional Nursing in Canada

Marie Rollet Hebert, the wife of a surgeon-apothecary, is credited by many with being the first person in present-day Canada to provide nursing care to the sick as she assisted her husband after arriving in Quebec in 1617; however, the first trained nurses arrived in Quebec to care for the sick in 1639. These nurses were Augustinian nuns who traveled to Canada to establish a medical mission to care for the physical and spiritual needs of their patients, and they established the first hospital in North America, the *Hôtel-Dieu de Québec*. These nuns also established the first apprenticeship program for nursing in North America. **Jeanne Mance** came from France to the French colony of Montreal in 1642 and founded the *Hôtel Dieu de Montréal* in 1645 (Canadian Museum of History, n.d.).

The hospital of the early 19th century did not appeal to the Canadian public. They were primarily homes for the poor and were staffed by those of a similar class rather than by nurses (Mansell, 2004). The decades of the 1830s and 1840s in Canada were characterized by an influx of immigrants and outbreaks of diseases, such as cholera. There is evidence that it was difficult, especially in times of outbreak, to find sufficient people to care for the sick. Little is known of the hospital "nurses" of this era, but the descriptions are unflattering and working in the hospital environment was difficult. Early midwives did have some standing in the community and were employed by individuals, although there is record of charitable organizations also employing midwives (Young, 2010).

During the Crimean War and American Civil War, nurses were extremely effective in providing treatment and comfort not only to battlefield casualties but also to individuals who fell victim to accidents and infectious disease; however, it was in the North-West Rebellion of 1885 that Canadian nurses performed military service for the first time. At first, the nursing needs identified were for such duties as making bandages and preparing supplies. It soon became apparent that more direct participation by nurses was needed if the military was to provide effective medical field treatment. Seven nurses, under the direction of Reverend Mother Hannah Grier Coome, served in Moose Jaw and Saskatoon, Saskatchewan. Although their tour of duty lasted only 4 weeks, these women proved that nursing could, and should in the future, play a vital role in providing treatment to wounded soldiers. In 1899, the Canadian Army Medical Department was formed, followed by the creation of the Canadian Army Nursing Service. Nurses received the relative rank, pay, and allowances of an army lieutenant. Nursing sisters served thereafter in every military force sent out from Canada, from the South African War to the Korean War (Veterans Affairs Canada, n.d.). In 1896, Lady Ishbel Aberdeen, wife of the governor-general of Canada, visited Vancouver. During this visit, she heard vivid accounts of the hardship and illness affecting women and children in rural areas. Later that same year at the National Council of Women, amid similar stories, a resolution was passed asking Lady Aberdeen to found an order of visiting nurses in Canada. The order was to be a memorial to the 60th anniversary of Queen Victoria's ascent to the throne of the British Empire; it received a royal charter in 1897. The first Victorian Order of Nurses (VON) sites were organized in the cities of Ottawa, Montreal, Toronto, Halifax, Vancouver, and Kingston. Today the VON delivers over 75 different programs and services, such as prenatal education, mental health services, palliative care services, and visiting nursing, through 52 local sites staffed by 4,500 healthcare workers and over 9,016 volunteers (VON, n.d.).

By the mid to late 19th century, despite previous negativity, nursing came to be viewed as necessary to progressive medical interventions.

To make the work of the nurse acceptable, changes had to be made to the prevailing view of nursing. In the 1870s, the ideas of Florence Nightingale were introduced in Canada. Dr. Theophilus Mack imported nurses who had worked with Nightingale and founded the first training school for nurses in Canada at St. Catharine's General Hospital in 1873. Many hospitals appeared across Canada from 1890 to 1910, and many of them developed training schools for nurses. By 1909, there were 70 hospital-based training schools in Canada (Mansell, 2004).

In 1908, **Mary Agnes Snively**, along with 16 representatives from organized nursing bodies, met in Ottawa to form the Canadian National Association of Trained Nurses (CNATN). By 1924, each of the nine provinces had a provincial nursing organization with membership in the CNATN. In 1924, the name of the CNATN was changed to the Canadian Nurses Association (CNA). CNA is currently a federation of 11 provincial and territorial nursing associations and colleges representing nearly 150,000 registered nurses (CNA, n.d.).

In 1944, the CNA approved the principle of collective bargaining. In 1946, the Registered Nurses Association of British Columbia became the first provincial nursing association to be certified as a bargaining agent. By the 1970s, other provincial nursing organizations gained this right. Between 1973 and 1987, nursing unions were created. Today each of the 10 provinces has a nursing union in addition to a professional association (Ontario Nurses' Association, n.d.). One of the best known of these professional associations is the Registered Nurses' Association of Ontario (RNAO). Established in 1925 to advocate for health public policy, promote excellence in nursing practice, increase nursing's contribution to shaping the healthcare system, and influence decisions that affect nurses and the public they serve, the RNAO is the professional association representing registered nurses, nurse practitioners (NPs), and nursing students in Ontario (RNAO, n.d.). Through the RNAO, nurses in Canada have led the world in systematic implementation of evidence-based practice and have made their best practice guidelines available to all nurses to promote safe and effective care of patients.

As Canadians entered the decade of the 1960s, there was serious concern about the healthcare system. In 1961, all Canadian provinces signed on to the Hospital Insurance and Diagnostic Services Act. This legislation created a national universal health insurance system. The same year, the Royal Commission on Health Services was established and presented four recommendations. One of the recommendations was to examine nursing education. Prior to this, the CNA had requested a survey of nursing schools across Canada with the goal of assessing how prepared the schools were for a national system of accreditation. The findings of this survey, paired with the commission's recommendation, led to the establishment of the Canadian Nurses Foundation (CNF) in 1962. The CNF (2014) provides funding for

nurses to further their education and for research related to nursing care. The Canadian Association of Schools of Nursing (n.d.) is the organization that promotes national nursing education standards and is the national accrediting agency for university nursing programs in Canada.

Canadian nursing associations agreed that starting in the year 2000, the basic educational preparation for the registered nurse would be the baccalaureate degree, and all provinces and territories launched a campaign known as EP 2000, which later became EP 2005. The baccalaureate degree earned from a university is the accepted entry level into nursing practice in Canada (Mansell, 2004).

Nursing in Canada transformed itself to meet the needs of a changing Canadian society and in doing so was responsible for a shift from nursing as a spiritual vocation to a secular but indispensable profession. Nurses' willingness to respond in times of need, whether economic crisis, epidemic, or war, contributed to their importance in the healthcare system (Mansell, 2004). Currently in Canada there are three regulated nursing groups that include the registered nurse (RN), the licensed practical nurse (LPN) or registered practical nurse, and the registered psychiatric nurse (RPN) (National Nursing Assessment Services, 2021).

The Development of Professional Nursing in Australia

In the earliest days of the colony, the care of the sick was performed by untrained convicts. Male attendants undertook the supervision of male patients, and female attendants undertook duties with the female patients. Attention to hygiene standards was almost nonexistent. In 1885, the poor health and living conditions of disadvantaged sick persons in Melbourne prompted a group of concerned citizens to meet and form the Melbourne District Nursing Society. This society was formed to look after sick poor persons at home to prevent unnecessary hospitalization. Home visiting services also have a long history in Australia, with Victoria being the first state to introduce a district nursing service in 1885, followed by South Australia in 1894, Tasmania in 1896, New South Wales in 1900, Queensland in 1904, and Western Australia in 1905 (Australian Bureau of Statistics, 1985).

Australian nurses were involved in military nursing as civilian volunteers as early as the 1880s (University of Melbourne, 2015); however, involvement of Australian women as nurses in war began in 1898 with the formation of the Australian Nursing Service of New South Wales, which was composed of 1 superintendent and 24 nurses. Based on the performance of the nurses, the Australian Army Nursing Service was formed in 1903 under the control of the federal government. The Royal Australian Army Nursing Corps had its beginnings

in the Australian Army Nursing Service (Australian Government Department of Veterans Affairs, n.d.). Since that time, Australian nurses have dealt with war, the sick, the wounded, and the dead. They have served in Australia, in war zones around the world, in field hospitals, on hospital ships anchored offshore near battlefields, and on transports (Australian War Memorial, n.d.; Biedermann et al., 2001). Other military opportunities for nurses include the Royal Australian Navy and the Royal Australian Air Force.

Nursing registration in Australia began in 1920 as a state-based system. Prior to 1920, nurses received certificates from the hospitals where they trained, the Australian Trained Nurses' Association (ATNA), or the Royal British Nurses' Association in order to practice. Today nurses and midwives are registered through the Nursing and Midwifery Board of Australia (NMBA), which is made up of member state and territorial boards of nursing and supported by the Australian Health Practitioner Regulation Agency. State and territorial boards are responsible for making registration and notification decisions related to individual nurses or midwives (NMBA, n.d.).

Around the turn of the 20th century, to create a formal means of supporting their role and to improve nursing standards and education, the nurses of South Australia formed the South Australian branch of ATNA. From this organization the Australian Nursing and Midwifery Federation in South Australia (ANMFSA) evolved (ANMFSA, 2012). The Australian Nursing and Midwifery Accreditation Council (ANMAC) is now the independent accrediting authority for nursing and midwifery under Australia's National Registration and Accreditation Scheme. The ANMAC is responsible for protecting and promoting the safety of the Australian community by promoting high standards of nursing and midwifery education through the development of accreditation standards, accreditation of programs, and assessment of internationally qualified nurses and midwives for migration (ANMAC, 2016).

In the late 1920s, two nurses, Evelyn Nowland and a Miss Clancy, began working separately on the idea of a union for nurses and were brought together by Jessie Street, who saw the improvement of nurses' wages and conditions as a feminist cause. What is now the New South Wales Nurses and Midwives' Association (NSWNMA) was registered as a trade union in 1931 (NSWNMA, 2014). Through the amalgamation of various organizations, there is now one national organization to represent registered nurses, enrolled nurses, midwives, and assistants doing nursing work in every state and territory throughout Australia: the Australian Nursing and Midwifery Federation (ANMF). The organization was established in 1924 and serves as a union for nurses with an ultimate goal of improving patient care. The ANMF is now composed of eight branches: the Australian Nursing and Midwifery Federation (South Australia branch), the NSWNMA, the Australian Nursing and Midwifery Federation Victorian Branch, the Queensland Nurses

Union, the Australian Nursing and Midwifery Federation Tasmanian Branch, the Australian Nursing and Midwifery Federation Australian Capital Territory, the Australian Nursing and Midwifery Federation Northern Territory, and the Australian Nursing and Midwifery Federation Western Australia Branch (ANMF, 2015).

Early Nursing Education and Organization in the United States

Formal nursing education in the United States did not begin until 1862, when Dr. Marie Zakrzewska opened the New England Hospital for Women and Children, which had its own nurse training program (Sitzman & Judd, 2014b). Many of the first training schools for nursing were modeled after the Nightingale School of Nursing at St. Thomas in London. They included the Bellevue Training School for Nurses in New York City; the Connecticut Training School for Nurses in New Haven, Connecticut; and the Boston Training School for Nurses at Massachusetts General Hospital (Christy, 1975; Nutting & Dock, 1907). Based on the Victorian belief in the natural abilities of women to be sensitive, possess high morals, and be caregivers, early nursing training required that applicants be female. Sensitivity, high moral character, purity of character, subservience, and "ladylike" behavior became the associated traits of a "good nurse," thus setting the "feminization of nursing" as the ideal standard for a good nurse. These historical roots of gender- and race-based caregiving continued to exclude males and minorities from the nursing profession for many years and still influence career choices for men and women today. These early training schools provided a stable, subservient, White female workforce because student nurses served as the primary nursing staff for these early hospitals. Minority nurses found limited educational opportunities in this climate. The first Black nursing school graduate in the United States was Mary P. Mahoney. She graduated from the New England Hospital for Women and Children in 1879 (Sitzman & Judd, 2014b).

Nursing education in the newly formed schools was based on accepted practices that had not been validated by research. During this time, nurses primarily relied on tradition to guide practice rather than engaging in research to test interventions; however, scientific advances did help to improve nursing practice as nurses altered interventions based on knowledge generated by scientists and physicians. During this time, a nurse, Clara Maass, gave her life as a volunteer subject in the research of yellow fever (Sitzman & Judd, 2014b).

CRITICAL THINKING QUESTIONS

Some nurses believe that Florence Nightingale holds nursing back and represents the negative and backward elements of nursing. This view cites as evidence that Nightingale supported the subordination of nurses to physicians, opposed registration of nurses, and did not see mental health nurses as part of the profession. After reading this chapter, what do you think? Is Nightingale relevant in the 21st century to the nursing profession? Why or why not?

A significant report, known simply as the **Goldmark Report**, *Nursing and Nursing Education in the United States*, was released in 1922 and advocated for the establishment of university schools of nursing to train nursing leaders. The report, initiated by Nutting in 1918, was an exhaustive and comprehensive investigation into the state of nursing education and training resulting in a 500-page document. Josephine Goldmark, social worker and author of the pioneering research of nursing preparation in the United States, stated,

> From our field study of the nurse in public health nursing, in private duty, and as instructor and supervisor in hospitals, it is clear that there is need of a basic undergraduate training for all nurses alike, which should lead to a nursing diploma. (Goldmark, 1923, p. 35)

The first university school of nursing was developed at the University of Minnesota in 1909. Although the new nurse training school was under the college of medicine and offered only a 3-year diploma, the Minnesota program was nevertheless a significant leap forward in nursing education. *Nursing for the Future*, or the **Brown Report**, authored by Esther Lucille Brown in 1948 and sponsored by the Russell Sage Foundation, was critical of the quality and structure of nursing schools in the United States. The Brown Report became the catalyst for the implementation of educational nursing program accreditation through the National League for Nursing (Brown, 1936, 1948). As a result of the post–World War II nursing shortage, an associate degree in nursing was established by Dr. Mildred Montag in 1952 as a 2-year program for registered nurses (Montag, 1959). In 1950, nursing became the first profession for which the same licensure exam, the State Board Test Pool, was used throughout the nation to license registered nurses. This increased mobility for the registered nurse resulted in a significant advantage for the relatively new profession of nursing ("State Board Test Pool Examination," 1952).

The Evolution of Nursing in the United States: The First Century of Professional Nursing

The Profession of Nursing Is Born in the United States

Early nurse leaders of the 20th century included **Isabel Hampton Robb**, who in 1896 founded the Nurses' Associated Alumnae, which in 1911 officially became known as the **American Nurses Association (ANA)**; and **Lavinia Lloyd Dock**, who became a militant suffragist linking women's

roles as nurses to the emerging women's movement in the United States. Mary Adelaide Nutting, Lavinia L. Dock, Sophia Palmer, and Mary E. Davis were instrumental in developing the first nursing journal, the ***American Journal of Nursing (AJN)*** in October 1900. Through the ANA and the *AJN*, nurses then had a professional organization and a national journal with which to communicate with one another (Kalisch & Kalisch, 1986).

State licensure of trained nurses began in 1903 with the enactment of North Carolina's licensure law for nursing. Shortly thereafter, New Jersey, New York, and Virginia passed similar licensure laws for nursing. Over the next several years, professional nursing was well on its way to public recognition of practice and educational standards as state after state passed similar legislation.

Margaret Sanger worked as a nurse on the Lower East Side of New York City in 1912 with immigrant families. She was astonished to find widespread ignorance among these families about conception, pregnancy, and childbirth. After a horrifying experience with the death of a woman from a failed self-induced abortion, Sanger devoted her life to teaching women about birth control. A staunch activist in the early family planning movement, Sanger is credited with founding Planned Parenthood of America (Sanger, 1928).

By 1917, the emerging new profession saw two significant events that propelled the need for additional trained nurses in the United States: World War I and the influenza epidemic. Nightingale and the devastation of the Civil War had well established the need for nursing care in wartime. Mary Adelaide Nutting, now professor of nursing and health at Columbia University, chaired the newly established Committee on Nursing in response to the need for nurses as the United States entered the war in Europe. Nurses in the United States realized early that World War I was unlike previous wars. It was a global conflict that involved coalitions of nations against nations and vast amounts of supplies and demanded the organization of all the nations' resources for military purposes (Kalisch & Kalisch, 1986). Along with **Lillian Wald** and **Jane A. Delano**, director of nursing in the American Red Cross, Nutting initiated a national publicity campaign to recruit young women to enter nurses' training. The Army School of Nursing, headed by **Annie Goodrich** as dean, and the Vassar Training Camp for Nurses prepared nurses for the war as well as home nursing and hygiene nursing through the Red Cross (Dock & Stewart, 1931). The committee estimated that there were at most about 200,000 active "nurses" in the United States, both trained and untrained, which was inadequate for the military effort abroad (Kalisch & Kalisch, 1986).

At home, the influenza epidemic of 1917 to 1919 led to increased public awareness of the need for public health nursing and public education about hygiene and disease prevention. The successful campaign

INDEX

Note: Page numbers followed by *b*, *f*, and *t* indicate material in boxes, figures, and tables, respectively.

D