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PREFACE

THIS monograph is one of a series dealing with the present status of certain established or emerging professions in the United States. The studies were originally planned for publication as chapters of a single volume comparing conditions in the professions. This plan was abandoned, however, since it seemed probable that they would serve a wider purpose if issued separately. Social Work as a Profession, the first of the series to be published, appeared in May, 1935 and a revised edition was issued in May, 1936. The Professional Engineer was published in July, 1936.

Although there is a large body of literature on the professions, it is often so scattered and sometimes so difficult to obtain that much of it is not used by professional people themselves and even less of it is known to the laity. In these monographs, therefore, significant data obtained from interviews, questionnaires, books, periodicals, and unpublished studies have been assembled and interpreted in such fashion, it is hoped, that the information may be readily utilized by vocational counselors and those who are striving to make the professions contribute more widely to the welfare both of their members and of society.

Because it is possible, within the compass of a small volume to present only a fraction of the material relating to the given subject, those facts have been chosen that seem to explain the reasons why a particular group has reached
NURSING AS A PROFESSION

its present degree of effectiveness. No one would dispute the assumption, for example, that today adequate preparation constitutes one of the most important elements of successful practice. So vital is formal training that a large proportion of each monograph has been devoted to a discussion of its evolution and the problems incident to it. Similarly, since professional associations are capable of doing much to raise standards of practice and of determining what the relation of a group to the society it serves shall be, the most important of the national associations are described at some length.

It is generally recognized that one of the most serious problems of the professions is the lack of an accurate determination of the number of persons who are needed in a specific group, and the lack of a form of control that would regulate the numbers to be admitted in the interests of the public and of the group. A corollary to this problem is the uneven distribution of professional service in the various sections of the United States, and the widespread lack of agencies for counseling new members of these professions about selecting localities in which to settle.

There is also the equally important problem of the inability of large numbers of persons receiving low incomes, especially in rural areas, to purchase as much professional service as they need. Even when service is paid for by the government or private philanthropy rather than by the individual, its quantity and quality vary in a marked fashion from one locality to another. In the face of these difficulties, there have been set down such data as could be obtained on the number of persons engaged in a particular profession, their distribution and earnings, and the demand for their service as compared with the need for it. Experiments in new ways of providing service have been noted, in so far as these experiments may result in more satisfactory working conditions for the members of the groups described and in extended service for the public.

Each study ends with a survey of recent trends within the profession under consideration. These trends indicate the ability of the group to adjust itself to the ever changing conditions in our social life.
AS RECENTLY as three-quarters of a century ago there was little manifestation of scientific enlightenment in the care of the sick in hospitals in the United States. Hospitals had had their origin in the eighteenth century in institutions hastily opened upon the outbreak of epidemics of infectious diseases, or in almshouses that often sheltered indiscriminately the insane, feebleminded, criminals, "paupers," and indigent sick. The tale that M. Adelaide Nutting and Lavinia L. Dock have told so feelingly in A History of Nursing,1 of the Philadelphia almshouse, begun in 1731, and of the Bellevue "pesthouse," opened in New York City in 1794, is a record of conditions that existed in other institutions until well into the nineteenth century. By 1870 some of the worst abuses had disappeared and the concept of institutions devoted exclusively to the care of the sick had become fairly general. But dirt, disorder, vermin, and infection were still found everywhere, and the attendants hired to care for patients were still men and women drawn from the degenerate classes in society.

The transition from such conditions to the order and cleanliness of the modern hospital and to present-day methods of nursing has been wrought in so brief a period that the progress is one of the remarkable accomplishments of

1 G. P. Putnam's Sons, New York, 4 vols.—vols. 1 and 2 published in 1907, and vols. 3 and 4 in 1912.
contemporary civilization. Many causes have contributed to this great transformation: medicine, both as a science and an art, has made great forward strides; the science of hygiene and sanitation has been developed within this period; as a result of new knowledge both the medical profession and the laity have demanded of public and private medical institutions increasingly higher standards. While recognition should be given to those causes that have directly or indirectly resulted in the improvement of hospitals and the care of the sick, tribute must be paid to nurses themselves for the major part they have played in creating the techniques and establishing the standards of modern nursing care.

IS NURSING A PROFESSION?

In 1915 Dr. Abraham Flexner read a paper before the National Conference of Charities and Correction in which he set down certain criteria that have ever since formed a basis for judging whether an occupation has attained professional status or not. According to his interpretation of the professions, (1) they involve essentially intellectual operations accompanied by large individual responsibility; (2) they are learned in nature, and their members are constantly resorting to the laboratory and seminar for a fresh supply of facts; (3) they are not merely academic and theoretical, however, but are definitely practical in their aims; (4) they possess a technique capable of communication through a highly specialized educational discipline; (5) they are self-organized, with activities, duties, and responsibilities which completely engage their participants and develop group consciousness; and finally (6) they are likely to be more responsive to public interest than are unorganized and isolated individuals, and they tend to become increasingly concerned with the achievement of social ends.¹

There have been marked differences of opinion as to whether nursing could meet these criteria. Dr. Flexner was under the impression in 1915 that it could not. He was well aware of the conviction of the nurse that her position is one of great responsibility; that she must possess knowledge, skill, and power of judgment; and that the chances of securing women with these qualifications will improve as the status of nursing is raised. He believed, however, that only in the public health field did the nurse assume the degree of original and final responsibility that should characterize a profession. Among those who do not regard nursing as a profession some maintain that its training period is frequently not even an apprenticeship of the highest type. They insist that student nurses have altogether too little supervision and too little opportunity to work intimately with graduate nurses skilled in technique and theory.

On the other hand, nursing is widely spoken of as a profession by physicians, educators, law-makers, and laypeople, and was so-called even in the early years of its development. Although the term may be employed loosely

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in many instances, the fact that it is extensively used is indicative that nursing has traveled far in that direction. Most nurses themselves consider their calling a profession. In fact, a special committee of the American Nurses' Association not long ago prepared for the federal government a brief in which it is maintained that nursing today can meet all of Dr. Flexner's six criteria. In their argument they quote Homer Folks as saying, "While society has usually taken centuries to develop a profession, this generation has seen two new professions—nursing and social work—become fully established."

The most helpful approach to the question of the status of nursing is, perhaps, the evolutionary one. Some occupations developed into professions hundreds of years ago; others are only now in the developmental process and further growth will be necessary before they can be measured beside the older and better established ones. Trained nursing made its appearance relatively very late, but it has forged ahead so rapidly that it appears definitely on the way toward professional maturity.

One of the marked indications of this trend is the inclination that nurses have shown to accept new duties and to extend their activities to new fields. They have broadened the scope of their work to such a degree that at present they may be grouped into six fairly distinct categories. First, there are the nurses who, as hospital executives, act either as superintendents of nurses or as superintendents of hospitals. In small institutions, the executive often assumes both of these responsibilities. In a second group are the nurses who are members of the faculties of schools of nursing: principals, teachers, and supervisors. The superintendent of nurses is frequently the principal of the school. Another group are employed as public health, visiting, and school nurses. In a fourth class are nurses who are trained for specialized service in assisting surgeons in operating and delivery rooms, or who have been prepared for caring for communicable, mental, or children's diseases, or for work in obstetrics. Head nurses of hospital wards constitute a fifth group. They are expected to assume responsibility for ward administration and for seeing that nursing is properly performed by staff nurses and students. In hospitals that maintain schools of nursing, they are usually expected to give clinical instruction to students. Finally, as the sixth group, there is the great body of trained nurses composed of general practitioners. In spite of the fact that their work is less highly specialized than is that of most of the nurses of the other groups, their functions have become broader in scope as nursing has evolved. Besides performing the tasks that lie within the exclusive province of nursing, they have increasingly had delegated to them authority for carrying out duties and


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making judgments that were formerly undertaken byphysicians. They nurse the sick in the home and in the hospital. If they are engaged by the patient, they are called private-duty or special-duty nurses; if they are employees of a hospital, they are known as general-duty, staff, floor, or ward nurses.

Although there are many nurses, particularly in the last group, who, because of inadequate education, training, or ability, cannot assume responsibilities of professional grade, these six classes constitute the personnel of professional nursing. All nurses included in these categories have been graduated from schools of nursing and most of them have been licensed by state boards of examiners. Thus they are spoken of either as graduate nurses or registered nurses (R.N.'s).

In addition to these graduate nurses, there are large numbers of other nurses (usually called practical nurses) and attendants, who are untrained or have been trained to perform only the more simple and routine tasks in nursing. In spite of the fact that they render valuable services in caring for the sick, they clearly do not fall within the professional group and hence are not considered in the subsequent discussion.

Aside from the differentiation of its functions, there are further indications that nursing has progressed far toward professionalism. Later pages will point to the marked growth of group consciousness; the rapid development of public health nursing; the establishing of departments of nursing in colleges and universities; the raising of educa-

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tional requirements for admission to most nursing schools; the strengthening of curricula; and the recent closing of many small and weak training institutions. These signs seem to show that nursing is moving in the same general direction as have medicine, dentistry, law, and teaching. As is the case in several of the older professions, the personnel of each type of nursing service exhibits varying degrees of ability to accept responsibility. Such a situation, however, does not preclude recognition of professional status for the group as a whole.

PREPARATION FOR NURSING
ITS ORIGIN IN THE UNITED STATES

The organized system of training for nursing that now prevails in the United States may be said to date from 1872 or 1873. It was preceded, however, by many efforts to provide some small amount of preparation for the care of the sick. The first recorded attempt to give hospital attendants any instruction was made in New York City by Dr. Valentine Seaman. He has been credited with establishing in 1798 in the New York Hospital the first training school for nurses. Although his ideas were far in advance of his period, the course of teaching that he outlined did not at all resemble a training school as the term came later to be defined.

The next endeavor to prepare an intelligent nursing personnel had its origin at the Philadelphia Dispensary, where in 1839 plans were formulated for instructing women in obstetrical nursing in homes. "Females of settled, good
habits, quiet and patient dispositions, and with a sense of responsibility" were sought. Prospective nurses were taught by the physicians in the lying-in department of the dispensary. They were supervised, when on duty, by the "lady visitor of the district." After they had served satisfactorily in six obstetrical cases, they were given certificates and were then eligible for calls to private duty. Between 1839 and 1850 the Nurse Society that had been established in connection with the Dispensary had employed 50 women who had taken the obstetrical course of training. "Most of them had an honourable record. Only one was dropped for misconduct and four for intoxication." In 1850 the Nurse Society opened a nurses' home and school. Applicants for training were admitted as "pupil-nurses" and were first instructed in cooking. They then received a short course of theoretical instruction from the physicians, after which they were sent out to care for cases in homes. Although the Society desired to extend its service to medical and surgical cases, there were practically no calls from other than obstetrical cases, and there is no record that any training was given in medical and surgical nursing except for some lectures and demonstrations in bandaging. Interesting as is the history of this Nurse Society, its instruction was very rudimentary. It was not until 1897 that the course of study was extended to one year, and even then nurses were sent out on private duty cases after three months of hospital service.

The Woman's Hospital in Philadelphia and the New England Hospital for Women and Children in Roxbury, Massachusetts, were two other institutions that made early provision for training. The former was opened to pupils in 1861, but none came until two years later and there was little progress before 1872. An endowment then enabled the Woman's Hospital to extend its course, and very gradually it developed a modern training program.

The New England Hospital for Women and Children can lay better claim than its predecessors to the use of the term "training school." In 1862 the brilliant German-Polish physician, Marie E. Zakrzewska, was asked to establish there a system of preparation for nursing. The training provided by her and her assistants was more thorough in method and higher in standards of practical work than had been the case elsewhere. Although the training was not entirely along the lines of later schools of nursing, it was of a high order and 32 women were taught during a period of ten years. In 1872, when the Hospital moved to Roxbury, a modern school of nursing was introduced. The course was one year in length and a certificate was given upon completion of the course. Arrangements were made for the practical study of nursing in the medical, surgical, and maternity wards, and for training in night duty. A course of lectures was offered by physicians connected with the institution.

The Civil War greatly influenced the history of nursing in America. It gave many women freedom to participate in affairs outside the home, it taught them how to work together, and it impressed upon them the vital importance of good nursing. It is estimated that as many as 2,000
women were engaged in nursing and hospital administration during the conflict. As the result of an appeal to President Lincoln by organized groups of women and of physicians in the North, the Sanitary Commission was created. It was the forerunner of the Red Cross. The Commission attempted to prevent needless suffering and to minimize sickness by hygienic precautions. Several of its leaders were well acquainted with Florence Nightingale's work during the Crimean War and even had her counsel and advice.

When the Civil War was over, women returned from hospital and nursing service to begin a campaign for the reformation of public hospitals. A modern system of training for nurses was one of the early results of that reformation. During the year 1873, within seven months, three very important new schools of nursing were opened. They were the Bellevue in New York, the New Haven in the city of New Haven, and the Massachusetts General in Boston. With the founding of this trio of schools, the concept of formal training for nurses was at last securely launched. During the next two decades there was an active reorganization of hospitals and rapid introduction of nursing service. Volunteer hospital or training school committees, composed largely or entirely of women, entered one institution after another, assumed administrative responsibility for the nursing service, and obtained capable and interested women to do the nursing and train more nurses. It was a period of adventure and of pioneering in a nascent profession, and reform was carried on with the zeal and enthusiasm that generally accompany pioneer movements.¹

**Number of Schools, of Students, and of Graduates**

By 1880 the number of schools of nursing had grown to 15, with 157 graduates in that year. Few indeed did these schools appear beside the 100 medical schools with their 3,200 graduates. Before the end of the century, however, schools of nursing had increased to more than 400, by 1910 to more than 1,100, and by 1930 to more than 1,900. The movement, once it had begun, gathered speed, and went on for five decades with perilous swiftness. Only during the five years just passed has a salutary recession begun. The yearly number of graduates grew from 157 in 1880 to nearly 3,500 in 1900, over 8,000 in 1910, 15,000 in 1920, and over 25,000 in 1930.² The reasons for this great expansion and its results will be discussed in later pages.

² Burgess, May Ayres, Nurses, Patients, and Pocketbooks: Report of a Study of the Economics of Nursing. Conducted by the Committee on the Grading of Nursing Schools. Published by the Committee, New York, 1928, pp. 34-35. (The work of the Committee on the Grading of Nursing Schools extended over the years 1926-1934, and resulted in a long series of publications. The Committee consisted of seven to nine members-at-large, one to three nurse consultants, and two representatives of each of the following organizations: American Nurses' Association, National League of Nursing Education, National Organization for Public Health Nursing, American Medical Association (in the earlier years), American College of Surgeons, American Hospital Association, and American Public Health Association. Dr. William Darrach was chairman of the committee and Dr. May Ayres Burgess was director.)
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Schools of nursing have been established in every section of the country, although the development has been greater in some areas than in others. In 1930–1931, 1,844 institutions, including 7 in the Philippines and 2 in Puerto Rico, responded to the request for statistical information issued by the federal Office of Education. Every state in the Union, with the exception of Nevada, reported schools. The number ranged from two in New Mexico to 154 in Pennsylvania. Only six states, including Nevada, had fewer than 10 schools. Seven had more than 50 but fewer than 100, and four states, Illinois, Massachusetts, New York and Pennsylvania, exceeded 100. Twenty states reported schools of nursing in hospitals for the insane. Seven states and the District of Columbia maintained only one such school, while Massachusetts had 11, and New York, 14.1

In these 1,844 schools of nursing, there were over 100,000 students in 1930–1931 and almost 26,000 nurses were graduated in that year. Less than one per cent of the students and only 361 of the graduates were men. Training courses for men nurses were reported by 42 general hospitals and 23 hospitals for the mentally ill. Of the 98,000 students in general hospitals, only one-half of one per cent were men, but of the 2,500 students in hospitals for the mentally ill, 11 per cent were men. Although it is generally agreed that there is a considerable need, both in psychiatric and general nursing of male patients, for men nurses who can give skilled care for which the hospital orderly or attendant has insufficient training, nursing remains more than 99 per cent an occupation of women. In teaching and social work, as well as in nursing, women are in the numerical ascendancy. Only in the last, however, is the profession almost exclusively in their hands.

The growth of nursing schools has been very different from that of medical schools. Medical school expansion reached its apex in this country in 1906 with 162 institutions, and an average of 156 students to each school. Thereafter, with the introduction of effective control by the medical profession, the number decreased rapidly. At present there are only 77 medical schools recognized by the Council on Medical Education and Hospitals of the American Medical Association, but the average number of students has been increasing slowly since 1920. In 1935 this average was 263. The 5,191 graduates of that year, however, were 263 fewer than those of 1906.1 The contrasting trends in the increase of nurses and of physicians since 1900 is shown in Table 1.

Had nursing schools been of the same average size as medical schools, only 352, instead of the 1,844 in existence in 1930, would have been needed to provide for the 100,000 students who were in training in that year. The following section discusses the facts presented by the Committee on the Grading of Nursing Schools and the National


TABLE I.—RATIO OF NURSES AND OF PHYSICIANS TO POPULATION IN THE UNITED STATES, 1900, 1910, 1920, AND 1930

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
<th>Graduate and student nurses</th>
<th>Physicians</th>
<th>Per 100,000 population:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1900</td>
<td>1910</td>
<td>1920</td>
<td>1930</td>
</tr>
<tr>
<td></td>
<td>75,994,575</td>
<td>91,972,266</td>
<td>105,710,620</td>
<td>122,775,046</td>
</tr>
<tr>
<td>Nurses</td>
<td>11,804</td>
<td>82,327</td>
<td>140,128</td>
<td>294,189</td>
</tr>
<tr>
<td>Physicians</td>
<td>152,002</td>
<td>153,132</td>
<td>144,977</td>
<td>153,803</td>
</tr>
</tbody>
</table>

The table is prepared from federal census data and follows a similar table in Burgess' Nurses, Patients, and Pocketbooks. Osteopaths, first reported separately in census occupation statistics in 1920, are excluded from the figures for physicians in 1920 and 1930. This accounts for only part of the decline in the number of physicians from 1910 to 1920.

SIZE OF SCHOOLS AND OF HOSPITALS CONDUCTING SCHOOLS OF NURSING

It is reported that in January, 1935, the median school of nursing had a student body of only 39. Among the total body of schools enrolments ranged from 1 to 304 students, and there were 45 with fewer than 10 students each.

Such a predominance of small institutions for vocational training exists in no other profession, and it presents educational problems of a serious nature. The National League of Nursing Education maintains that the majority of that half of the schools having a student body of 39 or fewer, and many of those with larger enrolments are either providing inadequate educational facilities for their students or are paying a disproportionate amount per capita for the facilities that they furnish. Frequently lectures and classroom instruction have to be given in very small sections in order that a necessary number of students may be on nursing duty. Frequently, too, first, second, and third-year students are taught together with the result that there is very little correlation between theory and practice.

Small hospitals present a problem in nursing education as well as small numbers of students. Half of the nursing schools in the United States are connected with hospitals that had a daily average in January, 1935, of 75 patients or fewer, and one-fourth with hospitals of 48 or fewer patients. Only 39 per cent as yet are allied with hospitals that have 100 or more patients. The Committee on Education of the National League of Nursing Education in 1932 declared that it is generally agreed that unless hospitals have a daily average of about 100 patients and a fairly active service, it is almost impossible for them to maintain schools of acceptable standards. This average is required

in the Scandinavian countries as a minimum for hospitals attempting to maintain registered nursing schools.\(^1\)

In recognition of the weakness of training in very small hospitals, the National League of Nursing Education has long refused to admit to its membership nurses graduated from schools connected with hospitals having a daily average of fewer than 30 patients. The National Organization for Public Health Nursing and the American Red Cross Nursing Service have gone farther and refuse membership to graduates from schools whose hospitals have fewer than 50 patients. It is probable that these national bodies will raise their requirements to a higher level in the near future.

Many persons have earnestly advocated a continuation of the small school in areas where no large schools exist on the ground that if there were no such institutions, numerous communities would go unnursed. They have also recommended, from time to time, the lowering of standards of admission, and even reduction of the length of the training course. They have gone on the assumption that the smaller the investment in education, the more readily would the nurse charge less for her services and the better supplied would be the rural districts. The same arguments have been advanced by those who believe that rural medical colleges should be established with relatively low entrance requirements and a short period of training. But experience has shown that the poorly trained nurse or doctor is little more inclined than the better prepared colleague to stay in rural practice or to charge lower fees. Moreover, the responsibilities of both doctors and nurses in rural districts present a special need for adequate preparation.\(^1\)

The solution of the problem of sufficient medical and nursing facilities for rural sections will probably be achieved only when better salaries, better working conditions, a more satisfactory social life, and a great extension of public health services can be provided.

Although there are still many hospitals operating schools of nursing that are so crippled financially or so small that they cannot provide suitable educational facilities and clinical experience, the number is much less than it was six years ago. The closing of training units has been due in part to the reports of the Committee on the Grading of Nursing Schools which showed how serious was the problem of hundreds of small schools both from the point of view of the preparation that the student received and of the future of professional standards.\(^2\) It has also been due, perhaps in larger degree, to the economic depression, which prevented many graduate nurses from earning even a bare maintenance in private-duty work. As a consequence of this situation, nurses were glad to accept staff positions in hospitals at salaries considerably below what they would have considered sufficient in 1929. Hospitals, therefore, decided in many instances that they could give up their training school with no financial loss, or even with an actual

\(^1\) National League of Nursing Education, Committee on Education: A Curriculum for Schools of Nursing. The League, New York, 1932, pp. 20–21.

saving. Some of the weaker hospitals were forced to close, and thus the number of training schools was further reduced. Between May, 1929, and May, 1936, the net reduction in accredited schools was 486 according to figures submitted by the National League of Nursing Education. At the later date there were 1,399 on the lists of accredited institutions of the various states. This represents a decrease since 1929 of 25 per cent. Although data concerning reduction in number of students are not available for the entire period, the League states that their number dropped 20 per cent between 1932 and 1935, while the graduates of 1934 were 12 per cent fewer than those of 1932.

ENTRANCE REQUIREMENTS

Another favorable trend in nursing education is the progress that is being made in raising standards for admission to training. Although they are still low when compared with the entrance requirements of medical, dental, and law schools, the gain that has been achieved in the last few years is remarkable.

By 1911 about 40 per cent of the training schools were demanding completion of four years of high school for entrance. Between 1911 and 1918, however, on account of the rapid expansion of nursing and the urgent demand for student nurses, the proportion of schools making such requirements for admission dropped to 28 per cent. When students with acceptable qualifications did not present themselves, institutions could see no alternative but to reduce further the standards of admission. As a result, many students were allowed to enter and were graduated who were unqualified in ability and education for even minor positions in a profession of nursing.

Although this period that saw the reduction of entrance requirements in many schools was discouraging, a counter movement was appearing. There was an increase of schools previously requiring only a grammar school education that now began to demand one or two years of high school work. Schools demanding one year of high school grew from 24 per cent in 1911 to 43 per cent in 1918, those demanding two years grew from 3 to 16 per cent, while those requiring no high school experience declined from 33 to 13 per cent. These changes raised the educational level of the average student nurse in some degree, but not sufficiently to make provision for adequate preparation of the superintendents, supervisors, and teachers who were needed in the expansion already under way in the profession.

Table 2 shows the advance in requirements for admission between 1918 and 1931 in those schools that reported to the United States Office of Education. Although some institutions that are not accredited by state boards of exami-

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TABLE 2.—PERCENTAGE DISTRIBUTION OF SCHOOLS OF NURSING ACCORDING TO EDUCATIONAL REQUIREMENTS FOR ADMISSION, 1918, 1920, 1927, AND 1931

<table>
<thead>
<tr>
<th>Extent of education required for admission</th>
<th>Per cent of all schools in group</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1918</td>
</tr>
<tr>
<td>All schools except those in Hospitals for Mental Diseases</td>
<td></td>
</tr>
<tr>
<td>Eighth grade</td>
<td>12.1</td>
</tr>
<tr>
<td>One year of high school</td>
<td>42.7</td>
</tr>
<tr>
<td>Two years of high school</td>
<td>16.5</td>
</tr>
<tr>
<td>Three years of high school</td>
<td>2.6</td>
</tr>
<tr>
<td>Complete high school course</td>
<td>28.1</td>
</tr>
<tr>
<td>Complete school of nursing courseb</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
</tr>
<tr>
<td>Number of schools</td>
<td>1,592</td>
</tr>
</tbody>
</table>

Schools in Hospitals for Mental Diseases

| Eighth grade                              | 53.8 | 22.7 | 8.0  | 4.6  |
| One year of high school                   | 58.5 | 54.6 | 64.0 | 13.6 |
| Two years of high school                  | 3.1  | 4.5  | 20.0 | 7.6  |
| Three years of high school                | 2.6  | 1.3  | 9.1  |      |
| Complete high school course               | —    | 18.2 | 67   | 63.6 |
| Complete school of nursing courseb        | —    | —    | —    | 1.5  |
| Total                                     | 100.0| 100.0| 100.0| 100.0|
| Number of schools                         | 78   | 88   | 73   | 66   |


† Schools in this category are graduate nursing schools.
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the general population has leaped forward at a much greater rate than have standards of nursing education. Forty-five years ago, if a girl were a high school graduate she was far above the average in educational training. Today she is only slightly above it. Graduation from high school is beginning to be a standard requirement for many occupations for which graduation from grammar school sufficed fifteen years ago.1

Just as academic requirements for admission were very low until recently, so other requirements were not greatly emphasized by the average school. Even now many institutions are doing little, either through co-operation with high school principals and teachers or through personal interviews and tests, to determine whether or not the applicant for admission is intellectually, physically, and emotionally suited for nursing.

The number of student nurses who fail to complete the course of training is extremely large. From a study of available state statistics of nursing schools made in 1930, Claribel Wheeler concluded that among the 10 states submitting reports the proportion of students who resigned or were discharged ranged from 21 to 69 per cent of those matriculated.2 As an example of this waste of effort, H. Lenore Bradley writes of an institution where 109 students out of 222 who had been enrolled over a four-year period either left or were dropped by the school. The 109

1 Committee on the Grading of Nursing Schools: Nurses, Production, Education, Distribution and Pay, 1930, pp. 31-34.

students averaged 5.4 months of attendance.1 Such a situation works great hardship on the student and it is expensive for the hospital. Among the various reasons, such as low educational requirements, poorly planned curricula, and long hours of arduous work, which have been advanced to explain this problem, the lack of criteria for determining the applicant's fitness for nursing is considered one of the most important.

CURRICULUM

The length of training in the average school of nursing is three years. During the preliminary period (or preclinical period as it is now coming more correctly to be called), that continues for four months in some schools and six in others, most of the students' time is devoted to classroom work in subjects such as anatomy, physiology and hygiene, bacteriology, chemistry, dietetics, materia medica, and the principles and practice of nursing. Thereafter, a relatively small number of hours weekly is given to formal instruction, as attention is centered upon clinical experience gained by the student through the nursing of patients under the direction of supervisors and head nurses. Schools make arrangements for providing their students with training in each department or service operated by the hospital with which the school is connected. The length of time prescribed for training in the several departments varies widely, however, from institution to institution, and even from student to student within the same school. Those hospitals that

3 "What Price Selection of Students?" In American Journal of Nursing, June, 1933, p. 557.
maintain too few services to prepare the prospective nurse for the more customary forms of sickness generally maintain affiliation with one or more institutions to which they send their students for specified periods.

Although this general plan of training has long been characteristic of the average school, there are wide differences in details, the reasons for which will appear in the subsequent discussion. Until 1917 little attention was given to the desirability of any standardization of the course of study. In that year the Committee on Education of the National League of Nursing Education first published a Curriculum for Schools of Nursing, a document that is now in its seventh edition and is at present undergoing its second complete revision. It offers a program that the League recommends as the foundation for the building of nursing education. There are detailed suggestions about the proportion of theory to practice, the subjects that should be taught in the course of formal instruction and the time allotted to each, the types of clinical instruction necessary for basic training, and methods that may be utilized for securing the needed variety of practical experience. The book was originally prepared in the hope of stimulating the schools to introduce more basic theory into their courses and its contribution to nursing education has been significant. In contrast to the extensive literature concerning the curriculum in most fields of education, the several editions of this book are the only comprehensive publications dealing with courses of study for schools of nursing.

Theory. The failure of the schools to institute well-planned and integrated curricula with some degree of standardization was stressed by the Committee for the Study of Nursing Education that made its report in 1923. In the estimation of Josephine Goldmark and the physicians, nurses, and public health officials who assisted her with the study, the greatest problem in nursing education was that of the insufficiency in amount and diversity of theoretical work offered by schools of nursing. After a survey of 22 institutions, the Committee recommended that the three-year period of training be reduced to two years and four months, by eliminating the repetition of duties of little or no educational value. It suggested that 840 hours of theoretical instruction be given during the course, 270 of which should be classroom and laboratory work during the preclinical period of four months. In the two subsequent clinical years, it recommended seven and one-half hours of instruction each week, except for the two summer terms of three months each. During these six months it assumed that there would be no formal instruction. Although the suggestion of 840 hours of theoretical work appeared to the Committee to be a moderate proposal, it found that among the 22 schools whose curricula it examined, only 8 offered more than 600 hours during the three-year course and only 1 exceeded the 840 hours recom-

1 Committee for the Study of Nursing Education: Nursing and Nursing Education in the U.S. Macmillan Company, New York, 1923. pp. 470-472.
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mended. The average number of hours of theoretical work in the 22 schools was 578.

In the curriculum revised by the National League of Nursing Education in 1927, 885 hours of classroom theory and 6,252 hours of practice were recommended. Thus, for the entire course, it was proposed that one-eighth of the time be devoted to class instruction and seven-eighths to practice. Most of the theory, however, was planned for the first four months. After the preclinical period of basic work, it was suggested that one-twelfth of the students’ time be spent in the classroom and eleven-twelfths in practicing the actual nursing of patients.

Since these recommendations appear to educators in the nursing field to err on the side of too little theoretical instruction, the figure for amount of theory will be raised in the forthcoming revision of the curriculum. Yet probably only about 22 schools out of each 100, as late as 1932, gave as much as 885 hours of classroom theory. The ratio of theory to practice still differs greatly from school to school. It was reported in 1931 that there were a few institutions in which one hour of theory was presented for every three hours of practice; in some others there was only one hour of theory for every sixteen hours of practice. Isabel M. Stewart declared in 1927 that there was probably no school of nursing in New York State that gave in its whole curriculum as many hours of theory as a good medical school gives to anatomy, and that the theoretical courses offered, moreover, were superficial, particularly those in the sciences. During the last few years a definite beginning has been made by many schools in altering this situation.

Regardless of much recent improvement, the limited time that schools of nursing still devote to the sciences is entirely inadequate if measured by college or university standards. Four or more are usually offered in the preclinical period. The amount of knowledge of highly specialized subjects that can be thus acquired is relatively little. Many representatives of the health services, including physicians, long believed that the nurse needed little scientific training. There are still some who insist that too much attention is being given to formal instruction and too little to the learning of techniques. But the majority of physicians, nurses, and educators, who have contributed to the discussion of professional training for nursing, emphasize the desirability of substantial basic preparation in the sciences.

Clinical Experience. More diversified and carefully planned opportunities for clinical experience are likewise considered essential. Many students have been obliged to spend time in repeating already familiar tasks that should have been devoted to acquiring various skills, learning to

1 Committee on the Grading of Nursing Schools, The Second Grading of Nursing Schools, 1932, p. 53.
3 "Outlining the New Technique for Nursing School Curricula," in Modern Hospital, October, 1927, pp. 152-176.
4 For a discussion of both sides of this question, see Dr. Paul Keller’s article, "The Doctor’s Viewpoint toward the Education of the Nurse," in Bulletin of the American Hospital Association, July, 1932, pp. 111-119.
recognize new symptoms, and thinking about new problems. They have also often been obliged to spend such a disproportionate amount of time in one department that training in other equally important departments has been seriously curtailed.\(^1\)

Of the various services maintained by hospitals, student nurses received in 1932 the longest training in the surgical department. The medical service was second, obstetrics third, operating room fourth, pediatrics fifth, and diet kitchen sixth. Usually little attention was given to other services. A comparison of the length of time that the typical student spent on each of several services and the length of time that the National League of Nursing Education recommends is as follows:\(^2\)

<table>
<thead>
<tr>
<th>Hospital service</th>
<th>Months spent by typical student, 1932</th>
<th>Months recommended by National League of Nursing Education, 1935</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical and operating room</td>
<td>10.3</td>
<td>6</td>
</tr>
<tr>
<td>Medical</td>
<td>5.6</td>
<td>4</td>
</tr>
<tr>
<td>Obstetric and delivery room</td>
<td>3.9</td>
<td>3</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>3.3</td>
<td>3</td>
</tr>
<tr>
<td>Communicable and tuberculosis</td>
<td>3.3</td>
<td>3</td>
</tr>
<tr>
<td>Pediatric and neurological</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Out-patient department</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Eye, ear, nose, throat, skin,</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>metabolism, other specialties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet kitchen</td>
<td>1.6</td>
<td>1</td>
</tr>
</tbody>
</table>

Since 1932 a good many schools have attempted to provide some preparation in those services that they had formerly neglected. Yet, as late as 1935, over 40 per cent were said to offer no training in communicable diseases, and 45 per cent no preparation in nervous and mental diseases.\(^3\) One of the fields, with almost endless possibilities, where the R.N. has thus far done very little, is that of mental hygiene and the care of the mentally ill. The great majority of schools of nursing long felt no responsibility for preparing their students for this work. The lack of effective demand for psychiatric nursing may have deterred some of them from introducing such courses, but it is now recognized that a knowledge of mental hygiene and experience in caring for patients with personality difficulties are essential even in general nursing. Preventive medicine, also, has had a very small role in the plan of instruction in most schools. Clara B. Rue asks the pointed question: “Is it because such education is not considered fundamental in the training of the nurse or because the nursing staff is not abreast of progress in scientific thought? Certainly many people would agree that preventive medicine is one of the most important fields in which instruction should be given.”\(^4\)

Recently the Committee on Nursing Organization of the New York Hospital asked the National Organization for Public Health Nursing to make a study of ways in which emphasis could be laid on factors pertaining to health and prevention of disease within the curriculum of the school of nursing conducted by that institution. The report sub-

\(^1\) Newman, Edna S., “Correlation of the Nursing Load with the Theoretical Program.” In American Journal of Nursing, August, 1934, pp. 974–975.
\(^3\) Ibid., p. 39.
mitted by the N.O.P.H.N., as it calls itself, recommended that, wherever possible, the student be brought first into contact with the relatively normal or slight deviations from the normal, and that her subsequent experience be given as a progression from this to the more serious conditions that require hospital care. The Organization was of the opinion that the student should obtain a clear picture of the social, physical, and psychological factors that affect the cause, prevention, development, and treatment of disease, and the nurse's part in relation to each. In order to achieve this end, it suggested, not only class work and field visits in public health nursing early in the training course, but a four months' community health service in the senior year. This experience would bring the clinical picture, the human factors, and the community situation together in their true relationships, and would also give the student an opportunity to participate in the process of promoting health in homes where she could observe the relation of the individual to his family and his environment. If such a plan were generally introduced into schools of nursing, it would result in an extensive reorganization of the curriculum and a reorientation of point of view regarding the role of nursing.

Clinical Experience in Specialized Hospitals. Many hospitals that concern themselves with specialties are not in a position to offer the basic and diversified training which nurses need as a foundation for general practice. As late as 1932 over 50 per cent of the training institutions were unable to furnish sufficient practical experience in one or more of the major services, and were, therefore, obliged to send their students away for periods of affiliation with other schools that ranged from a few weeks to a year or more. While a system of affiliation is generally recognized as desirable for students from strong and well-organized schools that do not have hospital facilities in some particular services, it is often utilized by schools incapable of providing any considerable variety of clinical training. The Committee on the Grading of Nursing Schools expressed the opinion that schools of this latter kind should not exist. They believed that no hospital ought to undertake to operate a school of nursing unless it can give at least two years of sound and varied preparation. The one exception that they recognized is that of schools connected with specialized hospitals which are operated for affiliation only.

Since hospitals for the mentally ill are highly specialized institutions, there is a question whether they are warranted in maintaining schools. But if they do not, the problem arises of how they will obtain nursing service. They have to offer such meager salaries in return for strenuous work that they cannot easily induce graduate nurses to come to them. Moreover, many nurses trained in general hospitals know so little about psychiatric nursing that they are not fitted for care of the mentally ill.
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At the end of 1933 there were more than 330,000 patients in residence in 170 state hospitals and 1 federal hospital for the mentally ill, besides some 60,000 patients in city and county hospitals for mental disease, in private institutions, and in the government hospitals for veterans. And yet for these 330,000 patients in state and federal institutions there were, according to the report of the Census Bureau, only 2,534 graduate women nurses and 460 graduate men nurses. Thus the ratio was one graduate nurse to every 110 patients. Serious as this situation may seem, there has been some improvement since 1930, when the ratio was but one graduate nurse to 153 patients. The late Mrs. Anne How pointed out that in 1930 there were six states in which the mental hospitals were without a single graduate nurse, and six others in which there was only one. In 42 of the 48 states in the Union the entire number was 530. In the six states with the largest number of graduate nurses, 1,340 R.N.'s were employed. Even that number, large as it appeared relatively, was inadequate. Mrs. How concluded that there should be at least one graduate nurse for every 60 mental patients, or approximately 5,000. Consequently, she suggested that each state should work toward the development of one good school of nursing connected with the state hospital for the mentally ill.


2 "Nursing Needs in the State Mental Hospitals (from the Standpoint of the Superintendent of Nurses)." In American Journal of Nursing, August, 1933, pp. 795-797.

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On account of the specialized nature of these hospitals, many people do not believe that training schools operated by such institutions could be made comparable in quality to the better schools in general hospitals. But they would agree with Mrs. How, that where schools are conducted by mental hospitals, extended affiliation with strong schools in general hospitals is needed to give the student nurse a well-rounded experience. They would also recommend that general training precede the specialized psychiatric training.

FACULTY

The level of nursing education depends in large measure upon the faculty which is responsible for planning and directing that education. Unfortunately the profession of nursing has had no suitable system for preparing teachers and administrators for its schools, and a large majority of the present institutions have not had sufficient financial resources for supporting an adequate faculty. Members of the hospital nursing service have often had to function both as an educational and service staff, and their work in the latter capacity has of necessity overbalanced their educational contribution. This has obtained to such a degree that the National League of Nursing Education declares that the term faculty can be used only by courtesy in a large proportion of nursing schools even today.

In a majority of schools the same graduate nurse acts as principal of the school and as superintendent of nurses. The question has often been asked how the average super-

3 The Nursing School Faculty. The League, 1933, p. 7.
intend can find the time necessary for administering a school of nursing. But in addition to these responsibilities, she is sometimes obliged in very small institutions to be the superintendent of the hospital and even the sole instructor. The Committee on the Grading of Nursing Schools pointed to the inevitable weakness of training under such circumstances.1

One of the achievements of the last decade has been the introduction of more teaching assistance. In 1935 nearly 90 per cent of the hospitals conducting schools had one full-time classroom instructor and 37 per cent had two or more.2 This is a decided improvement over the situation even as late as 1932, but the exact extent to which the teaching load has been lightened is not known. In 1932 the average instructor taught four subjects and assisted with one other; frequently she was obliged to present subjects as different from one another as the sciences and the principles and practice of nursing.3

Since students learn techniques from others besides classroom instructors, the Committee on the Grading of Nursing Schools assumed that day and night supervisors, and head nurses of floors or wards should be considered clinical teachers, and should be prepared to act in such a capacity. In its estimation, however, the majority of nurses occupying these positions had not had sufficient academic background or specialized training to justify their inclusion in the faculty. The Committee showed that in 1932 among all the nurses, from the principal of the school to the head nurse of a floor or ward, who entered into a teaching relation with the students, 29 per cent had had less than four years of high school, 51 per cent had only finished high school, and but 20 per cent had had as much as one year in college. The younger teachers were, however, generally coming to their task with more educational preparation than the older ones. When the figures were analyzed according to type of position, it was shown that classroom instructors had received far better education than clinical instructors. Even so, in 1932, 5 per cent of the classroom instructors had not finished high school, and 30 per cent had had only the four years of high school. On the other hand, 27 per cent were college graduates and 38 per cent had had some, but less than four years of college work.

Of hospital nurses who act in the capacity of teachers, night supervisors are the most poorly prepared. This is perhaps due to the fact that the position carries such a small salary that it does not attract the more competent nurses.4 Although night duty is considered by many students as one of the most important parts of their training, it is asserted that in many hospitals the bedside night staff consists solely of student nurses. Blanche Pfefferkorn, studying night

1 Committee on the Grading of Nursing Schools, Results of the First Grading Study of Nursing Schools. Section 2, What Students Learn. February, 1931, p. 80.
3 Committee on the Grading of Nursing Schools, The Second Grading of Nursing Schools, 1932, p. 50.
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nursing in the acute medical or surgical wards of seven selected hospitals in 1932, found that six out of the seven wards were staffed solely by student nurses, and three solely by students who had been in the school less than a year.1

It must not be forgotten that the faculty of a nursing school is made up in large part of physicians who are on the staff of the hospital. Usually they are unpaid. If they do receive anything, it is generally three or five dollars a lecture. Reports concerning their teaching are frequently unfavorable. Many emergencies arise when the lecturer is late for class, does not appear at all, or else is unprepared. If the school could find a way to pay adequately for what it requires, it would be in a better position to insist that lectures be given as scheduled, that they be prepared beforehand, and that they deal with the material that nurses and not medical students need to learn. Moreover, it would be able to choose physicians on the basis of their ability as teachers.2

RELATION OF THE SCHOOL OF NURSING TO THE HOSPITAL

Preceding sections have pointed to various factors, such as low educational standards, weak curricula, and poorly prepared teachers, that have retarded the advance of nurs-


2 Committee on the Grading of Nursing Schools: Results of the First Grading Study of Nursing Schools. Section 3, Who Control the Schools? April, 1931, pp. 14, 18-22.

ing education. It is generally agreed, however, that the basic problem of professional training lies in the relation of the nursing school to the hospital. This relationship has had a fundamental influence on the nature and the development of the schools, and has been responsible for many of the ills already mentioned.

Schools of nursing that appeared in the United States following the Civil War patterned themselves after Florence Nightingale’s famous school at St. Thomas’ Hospital in London, which had been established solely for the education of nurses and not to provide nursing service for the hospital. Since it had, as an endowment, the national gift presented to Miss Nightingale in honor of her work in the Crimean War, it was financially independent. Lectures, classes, and practical work under supervision were furnished to two groups of students. One group was trained for the practice of nursing; the other was prepared to serve as teachers of nursing and as hospital executives.3

American schools that were founded as independent institutions learned to their regret that funds were hard to raise and suitable relations with hospitals were difficult to achieve. Consequently, when hospitals began to recognize the merit of these schools and offered them affiliation, it seemed as if this were a solution of their problems. Thus, the early schools, as well as most of the institutions that were later established, became integral parts of hospitals. Their administrators believed that if the hospital could be

3 Committee for the Study of Nursing Education: Nursing and Nursing Education in the United States, p. 193.
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supplied with efficiently organized student nursing service, good training for their students would be assured. Education came to be considered as a more or less certain by-product of the student system of caring for the sick. Experience has shown, however, that participation in a good nursing service does not necessarily guarantee the student a well-rounded educational training. M. Adelaide Nutting pointed to this difficulty twenty years ago when she said:

The training school for nurses becomes an institution established by the hospital with one large main purpose and what we might call one subsidiary purpose in mind. The first purpose is clear-cut and imperative. The nursing work of the hospital, its most important task, must be done: the training school, through its students, can do it. The primary function of all training schools is that of carrying on the regular nursing work of the hospital. It is not anywhere the education of the nurse. That education is the subsidiary, secondary purpose of the hospital in establishing a training school, and it follows, as a matter of course, that it can be carried out only in so far as it is compatible with the main purpose of nursing the patients through the students of the school.

More recently the Committee for the Study of Nursing Education, the Committee on the Grading of Nursing Schools, the National League of Nursing Education, and

3 Nursing and Nursing Education in the United States, pp. 194-196.
4 Nursing Schools Today and Tomorrow, pp. 83-95.
5 Burgess, Elizabeth C., "What Are Nurses Going to Do About..."
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nurses, including students from affiliated schools, averaged 296 a month for the year 1930. The annual cost per nurse was $662, if interest, depreciation, and insurance on the nurses' home were added to maintenance. For ordinary maintenance alone, the cost was $546. It was estimated that if the training school were closed, $133,800 in expenses might be eliminated. To replace the students, however, 199 graduate nurses would have been needed. Their salary of $80 a month and maintenance would cost the hospital $1,365 a year each, or approximately $271,600. The increase in yearly expense would thus amount to about $137,800.

In April, 1933, the American Journal of Nursing published a report by Dr. Rufus Rorem concerning the cost of nursing service in 30 selected hospitals, in which 250 graduate nurses, 1,400 undergraduate nurses, and 340 special-duty graduate nurses were at work. He found that if the 1,400 undergraduates had been replaced by 900 graduates at an average salary and maintenance of $1,500 a year, and the number of graduate nurses previously employed had remained unchanged, the cost to the 30 hospitals would have increased by $370,000 annually. If the shift had been made, however, the number of special-duty nurses employed by patients could have been decreased by about 40 per cent, representing a saving to patients of $217,000.

Dr. Rorem argued that the cost of nursing to the patient should be considered. He deemed it unjustifiable for the hospital to economize through the use of student nurses if patients were thereby obliged to employ a large amount of special-duty nursing.

In spite of the fact that these studies indicate that the hospitals examined save money by operating schools, an investigation for the Duke Endowment seemed to prove that in North Carolina in hospitals of fewer than 20 patients it was less expensive to use graduate service. Of 208 hospitals that contributed data on this point to the study on Grading of Nursing Schools, 37 believed that they would save money by giving up their schools, while 171 thought that they would lose money. The question of whether the hospital would gain or lose apparently depended, not so much upon the number of patients, as upon the replacement value that was put on student service. Hospitals that believed they would gain by closing their schools estimated that 10 students could be replaced by about three and one-half graduates, while hospitals that concluded that they would lose, estimated that every 10 students should be replaced by six graduates.

In Nursing Schools Today and Tomorrow, the Committee on the Grading of Nursing Schools discusses this problem in relation to four hypothetical hospitals, having

1 Patterson, Teel, and Dennis, Study of the Yearly Expense of Training School for Nurses at Massachusetts General Hospital, pp. 1, 7-8.
2 "Is Student Nursing a Real Economy?" In American Journal of Nursing, April, 1933, pp. 370-374.
3 Nursing Schools Today and Tomorrow, pp. 108, 117.
4 Davis, G. L., "$33,000 Loss in 12 Hospitals Due to Nursing Schools." In Hospital Management, August, 1931, p. 21.
5 Burgess, May Ayres, "What the Cost Study Showed." In American Journal of Nursing, April, 1933, pp. 427-428.
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25, 50, 75, and 100 patients daily. The costs that would be eliminated if the schools of these four hospitals were relinquished, and those that would be added if nursing service were put on a graduate level are estimated. Computations are made, not on the basis of different numbers of graduates needed to replace undergraduates, but on the basis of a low, medium, and relatively high salary scale for graduate nurses. If R.N.'s and maids were paid $600 and $400 a year, respectively, and were provided maintenance, the Committee concludes that a graduate nursing service would be cheaper for all four schools. If, however, salaries were raised to $900 and $500, only the hospital with the 25 daily patients would save, while the other three would lose slightly. If annual salaries were raised still further to $1,200 and $600, all hospitals would lose by relinquishing their schools.

The foregoing data are too few and too subject to error to furnish conclusive evidence about the saving or loss to hospitals in operating schools. This is, however, a crucial topic and one to which hospitals are likely to devote much attention in the future. Because of its intimate relation to the adequacy of the training course, the National League of Nursing Education, in co-operation with the Division on Nursing of the Council of the American Hospital Association, is now making a study of the cost of operating schools of nursing.

UNIVERSITY SCHOOLS OF NURSING

Aside from the training provided by schools operated by hospitals, basic curricula in nursing are also given in a number of departments or schools controlled by colleges and universities. Although Teachers College of Columbia University has offered advanced work to graduate nurses since 1899, the University of Minnesota at Minneapolis was the first institution of higher learning to arrange for a basic curriculum. In 1910 it introduced a three-year course leading to a diploma in nursing. Nine years later it instituted an additional five-year course designed to lead to the bachelor's degree and a diploma in nursing. This curriculum required two years of academic work, two years of clinical preparation during which experience was obtained in the several hospitals with which the University was affiliated, and a fifth year that combined general and professional courses.

An unpublished study made in 1935 by Lucile Petry at Teachers College, Columbia University, indicated that combined programs of basic nursing education and general collegiate education leading to a bachelor's degree had been established since 1916 in at least 66 schools of nursing, while in 27 additional schools similar arrangements were then being planned or were under consideration. Twenty-four schools of nursing having degree-conferring courses were integral parts of colleges or universities, but a majority were not organizationally related to the collegiate institutions with which they were co-operating. The 1,600 students enrolled in undergraduate degree courses in 1935 were about twice as many as had previously completed such courses. Miss Petry's study suggests that too often in these combined programs the academic and professional
elements are only loosely related. Some, however, are closely integrated programs in which all parts of the course are selected to meet the professional needs of the nurse. Such courses frequently lead to the professional degree of bachelor of science in nursing or bachelor of science in nursing education.

It will be useful to trace the development of one collegiate department of nursing in greater detail, in order to see how the universities are attempting to solve some of the problems of professional education. The evolution of training in what is now the School of Nursing Education of the University of Washington in Seattle presents an instructive picture of what is going on in more or less the same way in several other universities. In 1916 the dean of women, who wished to make more vocational opportunities available to young women, was instrumental in organizing a pre-nursing course in the pre-medical department of the University. In 1921 a department of nursing education, offering both a five-year nursing course and a public health nursing course, was created, and affiliations with various hospitals were arranged. As a result of this plan the student nurse profited from a more unified type of curriculum, better instruction, and more adequate library and laboratory facilities than formerly. She also benefited from a decrease in the number of hours of duty, and from an increase in the number of graduate nurses who supervised and instructed her on the wards. The outstanding difficulty that arose was the lack of a common point of view and complete understanding between the university and the hospitals. University instruction tended to become too theoretical, and the hospitals felt that frequently instructors and supervisors made too little effort to help students apply the knowledge gained in the classroom to clinical situations.

A reorganization of the course, therefore, was considered necessary, and in 1931 with the erection of the Harborview Hospital, a county hospital of 450 beds, new plans were formed. This institution agreed to have no other school of nursing, and to permit an advisory committee, representing both the University and the Hospital, to assist in shaping the policies of the school. The University assumed responsibility for all educational functions, while the Hospital became responsible for the nursing service rendered patients both by students and by the regular staff nurses. Under the plan that was put into operation, classes, whether given at the University or at the Hospital, were organized on a university basis. All instructors, teaching supervisors, and medical lecturers in the Hospital were members of the University faculty and were paid from a fund for education, to which the Hospital contributed $12 a month for each student enrolled. The Hospital also provided maintenance for the students. The hospital division of the department of nursing had a budget of its own and an accounting system planned to show the actual expense involved in operating the division and also the income received from student services. The financing of all

1 In 1934 the Providence Hospital was accredited by the University as a second institution for clinical practice.
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classes at the University was cared for through the usual channels of the University. A grant from the Rockefeller Foundation permitted the appointment of additional faculty members needed in the department. Later the University, convinced of the value of the program, included their salaries in its budget.

The curriculum of the basic undergraduate course is now four years in length. It includes six quarters in residence at the University, with classes in English, chemistry, physics, bacteriology, nutrition, physiology, anatomy, psychology, sociology, and the history of nursing. This is a heavy schedule of courses to be studied in only one and one-half years. Although the amount and the quality of work done is probably greatly superior to that of the preclinical period in many training schools, the same question arises of whether an adequate knowledge of so many sciences can be acquired in so short a period.

After the student has completed the work on the university campus, she enters the hospital division, where she has two and one-half years of classes and training in the more usual clinical subjects, as well as in psychiatric nursing, communicable diseases, out-patient and public health nursing. Training in the practice of nursing is planned in detail just as is the more formal classroom instruction. Nursing education and nursing service are administered by two directors rather than by one, in order to increase the effectiveness of both functions and to insure a teaching program of university standard and regularity. An attempt is made to give orderly and comprehensive preparation in each department of the Hospital. The director of nursing education for the hospital division formulates a general outline of subject material to be covered during a quarter. The teaching supervisors of the several departments, in conference with the medical staff and head nurses, arrange a specific program for each week, the content of which is determined by the clinical cases available at the time.

Supervisors act both in a teaching and administrative capacity for the purpose of correlating theory and practice. Among other teaching functions, the supervisor conducts in one hour each week, for students in her division, a class devoted to a summary and discussion of the weekly student project and the medical bedside clinic. Some of her responsibility for ward teaching is delegated by the supervisor to the head nurse in charge of the wards. Each head nurse has the charge of a unit of from 30 to 35 beds, and in addition to supervising the work of the general-duty nurses, she generally has three students to whom she gives a half-hour demonstration or group conference daily, and a half-hour of individual guidance. During the remaining thirty-two hours of weekly ward duty, students are expected to put this instruction into practice. In most instances they remain for a minimum of one month under each head nurse. Changes in assignments of patients are made every week. The period of training is twelve weeks on each of eight major services, and less on the others.

It is the aim of this basic undergraduate curriculum that leads to the degree of bachelor of science in nursing to prepare women who will be better qualified than formerly to
cope with the problems of modern nursing. This is done by giving them fundamental courses in science, literature, economics, psychology, and sociology; by so arranging the clinical teaching that there will be a thorough application of these subjects to the field of nursing; and by emphasizing throughout the curriculum principles of the prevention of disease and methods for giving health instruction to the public.

Advanced work is also provided at the University of Washington for graduate nurses in the fields of public health nursing, nursing administration, and nursing education. For the R.N. who has had no university training the course is two years; for the nurse who has had the required work in the social sciences, it is one. This post-graduate curriculum is designed to present the most modern methods of nursing, to give a broader background, and to offer preparation for teaching and supervisory positions.1

The School of Nursing of Vanderbilt University, in Nashville, Tennessee, is another independent, self-governing, professional school within a university. It is largely indebted to the General Education Board for its building and equipment, and to the related Rockefeller Foundation for maintenance. For educational purposes it is closely allied with three units of the University: the School of Medicine, Vanderbilt University Hospital, and the College of Arts and Sciences. One portion of its program is of particular significance, namely, its effort both in the basic and advanced professional courses to prepare young women for rural community nursing service. Besides the usual work offered by schools of nursing, the curriculum provides for instruction in community health nursing, social science, social case work and other subjects that emphasize the social aspects of health and the prevention of disease. Experience in rural nursing is obtained through the Rutherford County Health Department, which serves as a teaching center for the School. The Department is not only physically well equipped but it maintains a personnel of two public health physicians, five public health nurses, a sanitary engineer, and two clerks. Training for students in public health nursing consists of lectures, demonstrations, conferences, and observation of the organization and types of service rendered in the homes, the schools, and the health center of this rural county. During the latter part of the student’s course, she is assigned a definite number of families to whom she renders nursing service under guidance and close supervision.2

Among other universities that have concerned themselves with the education and the professional preparation of nurses, two now require the baccalaureate degree for admission. They are Yale and Western Reserve. In 1923 the former was given a temporary endowment by the Rockefeller Foundation3 and the latter by Mrs. Chester C.

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1 Soule, Elizabeth S., and Adams, Henrietta N., "Nursing Education at the University of Washington." Reprinted from Methods and Problems of Medical Education, Rockefeller Foundation, New York, 1922.


3 In 1929 the Rockefeller Foundation assured the permanency of the school at Yale University by an endowment of $1,000,000.
Bolton, who was much interested in nursing education. Both endowments were for the purpose of experimenting with a curriculum of nursing. Through these gifts, for the first time in the history of the education of nurses, ample funds were available for the study of problems and the development of a content of nursing education in accordance with present-day needs in the fields both of curative and preventive medicine.

The conditions upon which the gift of the Rockefeller Foundation to Yale University depended were specific. The course was to be given in the shortest possible period through entire elimination of non-nursing procedures, theory was to be correlated with practical experience, and emphasis throughout the course was to be placed on preventive medicine. The curriculum was planned to cover twenty-eight months (now thirty) and to lead to the degree of bachelor of nursing. Two years of college preparation with academic credits in elementary chemistry, psychology, and the biological sciences were required for admission. Beginning with the academic year 1934–1935, standards of admission were raised to their present level, and the master's instead of the bachelor's degree was made the type of recognition to be conferred upon completion of the course.

The underlying theory of disease as well as social, psychological, and hygienic factors are basic parts of the content of the curriculum in the Yale School of Nursing. The case method is used for clinical experience. Students are assigned the care of one or more patients rather than a series of nursing procedures. It is believed that in this way the student will not only learn the required skills but will attain more complete understanding of the physical and mental needs of the patient and be stimulated to a greater responsibility for achieving the best results possible. Services in the New Haven General Hospital are supplemented by observation and assistance in the dispensary clinics, the Visiting Nurse Association, and other health and welfare groups. A period of two months is devoted to the study of mental diseases in an institution of outstanding reputation. Work in pediatrics is offered in a nursery school directed by child psychologists, where students may observe the development of hygienic habits in the well child. The curriculum provides 5,050 hours of work, of which 14 percent are in theory, 5.5 percent in laboratory work, and 80.5 percent in practice.1

Many difficulties have arisen to limit the contribution of departments of nursing operated by universities. Even though connected with institutions of higher learning, these departments have sometimes found that their students were expected to provide such a substantial part of the nursing service of the hospitals with which they were affiliated that educational objectives have had to be sacrificed. Professor Stewart has made the statement that, while sound pedagogical leadership, funds, and freedom seem to be

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1 Western Reserve University also began in 1934–1935 to make the undergraduate academic degree a requirement for admission.

three of the primary essentials for the development of any real educational program, nursing schools must also command good clinical facilities. The perplexing question still persists of how to work out a satisfactory system of cooperation between the school and the hospital.\(^1\)

One problem that gives university departments particular concern is that of the three-year curriculum, which is frequently offered side by side with the five-year curriculum, because universities have found it impossible to recruit enough five-year students to provide the affiliated hospitals with the required nursing service. The great preponderance of students enroll in the shorter course rather than in the one leading to a baccalaureate degree. As a result, departments are forced to spend time and energy on instruction on the lower educational level, and are frequently required to teach students with varying amounts of preparation in the same courses.

The founding of university departments of nursing was hailed as a great forward step. It was felt that they would attract the more competent young women who had been repelled by the inferior teaching of the average schools and the subordination of education to the needs of the hospital. Because the courses were planned primarily as sound preparation for the different fields of nursing, it was thought that they would ultimately have a great influence in raising the standards of the profession.\(^2\) It is too soon to evaluate what these schools are accomplishing in that direction. Just as preparation for the more firmly established professions has largely passed under the aegis of the university, so it seems logical to suppose that the university will assume increasing responsibility for the training of nurses. The development of any type of professional education is slow, however, and the evolution of nursing education in the university has been no exception. Many of the leading teachers and executives in nursing share with Annie W. Goodrich the optimistic belief that such schools of nursing as are required will ultimately find their place among other professional units within the university.\(^3\)

**POST-GRADUATE COURSES**

Courses for graduate nurses are of two types: those that are designed to give preparation in the clinical specialties such as psychiatric, pediatric, and obstetrical nursing, and those that are planned to prepare nurses for teaching, administrative work, and public health nursing. In general, the first type is offered by schools of nursing operated by hospitals, while the second type has developed in colleges and universities.

Work of a post-graduate nature made its appearance more than forty years ago. Teachers College of Columbia University, as has already been mentioned, was one of the early pioneers. Courses in hospital economy were established for the Study of Nursing Education: Nursing and Nursing Education in the United States, Macmillan Company, New York, 1923, pp. 484-485.


\(^2\) Cleveland Hospital and Health Foundation, Cleveland Hospital and Health Survey, Part 9, Nursing, 1920, pp. 710-712; Committee for the Study of Nursing Education: Nursing and Nursing Education in the United States, Macmillan Company, New York, 1923, pp. 484-485.

\(^3\) "Nursing." In the Survey, January 1, 1928, p. 289.
lished there in 1899 in order to meet the needs of graduate nurses who wished to fit themselves to be superintendents of nurses and instructors. In 1910 the courses were endowed by a trustee of the College, thus making it possible to create a Department of Nursing and Health. In this way some provision was made for the preparation of administrators and teachers, and for the training of women as visiting nurses and for community health work.  

Since the turn of the century the number of hospitals and of educational institutions that have made plans for post-graduate training has increased slowly. The number at present is hard to determine, for they are so scattered and their offerings vary to such a degree both in kind and in quality that it is difficult to undertake any accurate classification. It is known, however, that there are colleges or universities in 14 states that make some attempt to prepare graduate nurses for teaching and administrative positions, and that a larger number offer courses in public health nursing. The 16 institutions now having courses in public health nursing which are approved by the National Organization for Public Health Nursing include schools of nursing, departments of nursing education, schools of social work and medical schools. They are as follows:

University of California, Department of Hygiene
Columbia University, Teachers College, Department of Nursing Education
Fordham University, School of Social Service

1 Teachers College of Columbia University, Nursing Education Bulletin, New York, 1933-1934, p. 3.

As yet, post-graduate work has been used primarily to supplement the deficiencies of weak undergraduate schools. In spite of the great need for women capable of assuming large responsibility and for nurses prepared in several of the specialties, there have been but few efforts to provide instruction on the higher levels. What has been achieved is important, but nursing educators consider it altogether too little. They realize that a wide program of publicity will be necessary to convince nurses that continuous education is essential. In their estimation many more courses
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will have to be offered in those areas where there are large numbers of nurses and the financial burden that such courses now make on the individual nurse will have to be alleviated in some way. They also point to a general need for extensive reorganization of the post-graduate curriculum in order that it may be primarily educational in purpose.\(^1\)

The National League of Nursing Education has recently recommended that post-graduate work be of three types: supplementary courses, courses for reorientation or review, and specialized courses. The supplementary course is for the purpose of making up deficiencies in basic preparation. It is intended primarily for graduates of over-specialized or small schools but not for graduates of poor schools. It is designed to be on the same educational level as a good basic course, and to cover the more general ground in both theory and practice. Reorientation or review is planned especially for the practicing nurse, who can be released from her position only for a brief time but who needs to brush up on old knowledge and obtain a survey of some of the newer developments. The institute or the short course of the extension type is especially adapted to such a purpose, and is also helpful in stimulating interest in a more substantial type of educational program. The League suggests that the time devoted to this kind of work should range from a few days to about two weeks. Practical experience is impossible, but observation and demonstration

\(^1\) Stewart, Isabel M., "Postgraduate Education—Old and New." In American Journal of Nursing, April, 1933, p. 361.

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can supplement discussions and lectures. Specialized post-graduate courses, in the League's estimation, should be restricted to nurses with broad general education, adequate professional training and administrative ability, who are prepared to make a thorough study of some clinical subject or of nursing administration and education. These courses should be on a senior college level or higher, and should entitle the student to the degree of bachelor or master of science.\(^1\)

NATIONAL ORGANIZATIONS

AMERICAN NURSES' ASSOCIATION

There are four national organizations that interest themselves in professional standards of nursing and of nursing education. The largest of these is the American Nurses' Association, founded in 1896. It is concerned chiefly with promoting the professional and educational advancement of nurses; with elevating the standards of nursing education; with establishing and maintaining a code of ethics among nurses; and with bringing nurses and nurses' associations into communication with one another. Through its national office and its 48 affiliated state associations and corresponding units in the District of Columbia, Puerto Rico, and Hawaii, it promotes legislation concerning nurses, nursing, and health. It constantly examines the problems of the individual nurse, as well as those affecting the profession as a whole. The office at its headquarters in New York City endeavors to keep its constituency in

\(^1\) Ibid., pp. 363-365.
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formed of professional developments through field service, correspondence, biennial conventions, and the monthly publication of the American Journal of Nursing.

A Nursing Information Bureau has recently been established as an activity of the Association in co-operation with the National League of Nursing Education and the National Organization for Public Health Nursing. This Bureau is attempting to disseminate "such information about nursing as may lead the public to demand a sounder preparation for and a wider and more discriminating use of nursing service." It prepares vocational guidance literature, arranges for radio broadcasts and popular articles about nursing, and has recently published a reference handbook, Some Facts about Nursing, intended to aid those who write or speak on professional problems.

Personal membership in the Association, which was more than 120,000 in December, 1935, consists of the active resident members in good standing of the constituent state and territorial nurses' associations. Members of the state associations must be registered nurses graduated from schools of nursing that offer a continuous course of training of not less than two years in a general hospital or make provision for an equivalent training in one or more hospitals. For women, who comprise almost all of the membership, the course must have included practical experience in caring for men, women, and children, together with theoretical and clinical instruction in medical, surgical, obstetrical, and pediatric nursing. The training for men nurses must have included practical experience in caring for men, together

with theoretical and practical instruction in medical, surgical, and urological nursing.¹

NATIONAL LEAGUE OF NURSING EDUCATION

A second organization is of special interest to that part of the nursing profession engaged in administration, executive work, and the training of student nurses. The National League of Nursing Education, located in New York City, was established in 1893 for the purpose of bringing together superintendents of nurses from the existing schools. At a later time all nurses who hold advisory, executive, or teaching positions in schools of nursing, hospitals, or public health agencies and who are members of the American Nurses' Association were made eligible for membership. Since 1932, besides carrying on its own program, it has functioned as the Educational Department of the American Nurses' Association.

The League is chiefly concerned with the preparation of nurses for the various branches of nursing and with the promotion of better nursing service for the public. It formulates standards of organization for national, state, and local leagues; defines objectives which it believes good schools of nursing should strive to attain; sets up standards and plans of organization for nursing service in hospitals; offers advisory service to state boards of nurse examiners on educational matters; accepts responsibility for vocational

guidance, and so on. One of its chief functions is that of making studies of special aspects of nursing and surveys of community situations. Among its most important publications are A Curriculum for Schools of Nursing that has already been mentioned, The Nursing School Faculty, and An Activity Analysis of Nursing. In co-operation with the Division on Nursing of the Council of the American Hospital Association it has prepared a Manual of the Essentials of Good Hospital Nursing Service. Its efforts have resulted in initiating studies by other agencies, the most notable of which was the study of the Committee on the Grading of Nursing Schools.

Although membership in the League at the end of 1935 was slightly more than 4,100, a recent estimate of potential membership indicates that not more than 14 per cent of those who are eligible belong to it. Dr. Burgess declared in 1932 that it was a matter for considerable concern when 31 out of every 100 superintendents of nurses and 47 out of every 100 instructors were not associated with the League. If these nurses, she inquired, who are responsible for guiding nursing education, are not members of their own national educational body, is it any wonder that their schools are in so many cases not schools at all?1

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

This Organization, established in 1912 with headquarters in New York City, is composed of public health nurses, laymen, and agencies engaged in public health nursing. Its broad objective is to assist public health nurses in the United States and the board and committee members of agencies employing them, to bring health to individuals and families in the simplest, most effective, and most progressive manner. It states its aims more specifically as follows:

To foster, develop and promote public health nursing activities throughout the country;

To serve as a standard-making body in policies and practices of public health nursing;

To serve in an advisory capacity to all those engaged or interested in public health nursing;

To secure adequate preparation and educational opportunity for the public health nurse—for her job and in her job;

To assist in securing qualified workers for positions, and suitable positions for workers;

To assist in the integration of public health nursing into the total social and health programs;

To promote understanding of the service of public health nursing among federal departments, national, state and local health and social agencies and the general public.1

The individual membership of the organization, which was almost 8,000 at the end of 1935, is composed largely of public health nurses. Eleven per cent, however, were health officers, doctors, board and committee members, and volunteer workers. Lay members are particularly welcome, since their active and intelligent co-operation is es-

1 Committee on the Grading of Nursing Schools, The Second Grading of Nursing Schools, 1914, p. 24.

sent to the success of public health nursing agencies and to the furtherance of the public health movement. Of equal importance with the individual membership is the corporate membership which is designed for agencies that employ public health nurses. Nearly 300 agencies held such membership in 1935.

Besides serving continuously for a quarter of a century in an advisory capacity and acting as a clearing house of information, the N.O.P.H.N. has:

Set down minimum qualifications for public health nursing positions;

Outlined essential objectives in this field, defining the educational preparation necessary to attain them;

Interpreted public health nursing, its standards and goals, to federal, state, and local authorities concerned with unemployment and relief programs;

Maintained cooperative relationships and affiliations with other national agencies—both professional and lay—in order that a better understanding of local services and aims might be created, adequate representation and leadership for the movement assured, and standards maintained in the face of enforced economies;

Carried on statistical studies for the purpose of supplying reliable information to those requesting it, and for obtaining data fundamental for further developments in public health nursing and for evaluating what has already been accomplished;

Built up a strong partnership between the professional and non-professional groups, to the end that public health nursing in the community might be strengthened;

Published textbooks, manuals, a monthly magazine, study outlines, leaflets and pamphlets for use of all groups in this field.¹

A most significant contribution of the Organization to information concerning the status of public health nursing in the United States is the Survey of Public Health Nursing issued in 1934. The recommendations contained in it are designed to serve as a basis for widespread improvement. A manual of public health nursing, including techniques, program, and procedure, and a manual for board members giving the principles of organization and administration of public health nursing services are extensively used. So, too, is the official monthly magazine, Public Health Nursing.

The association sponsors and helps to finance the Joint Vocational Service, a vocational and placement bureau operated for public health nurses and social workers.

Recently the National Organization for Public Health Nursing, the American Nurses' Association, and the National League of Nursing Education have established a Joint Committee on Community Nursing Service. This Committee is composed of nurses and lay persons appointed by the three national organizations, together with the executive directors of the organizations, and the editors of the American Journal of Nursing and Public Health Nursing. An executive secretary has been chosen to give her full time to the Committee's program of assisting communities in analyzing their nursing problems and the work of their existing nursing agencies, and in formulating a

¹Ibid., pp. 3–4.
more satisfactory and better co-ordinated plan for offering nursing service. 1

ASSOCIATION OF COLLEGIATE SCHOOLS OF NURSING

The newest of the national organizations is the Association of Collegiate Schools of Nursing. The first steps toward its formation were taken in 1932 when a group of representatives of university schools of nursing met informally to discuss ways and means of dealing with some of the problems arising out of new relationships between schools of nursing and institutions of higher education. Although the group expressed its gratification over the rapidly increasing number of schools entering into such a relationship, it was concerned about the lack of direction and control of the movement as a whole. It agreed that the time had come to define more clearly the purposes and standards that should govern such developments.

A committee was accordingly appointed, which arranged a conference at Teachers College, Columbia University in 1933. A provisional organization was formed of 21 institutions, whose representatives agreed to join together on an informal and temporary basis pending the formulation of plans for a permanent association. At a meeting at Western Reserve University in May, 1935, the organization was fully launched. Its objects as stated in the constitution are:

- To develop nursing education on a professional and collegiate level;
- To promote and strengthen relationships between schools of nursing and institutions of higher education;
- To promote study and experimentation in nursing service and nursing education.

Membership is restricted to schools or departments of nursing that have definitely committed themselves to the task of developing their curricula on a collegiate and professional basis as part of a system of higher education. There are two kinds of membership, active and associate. Whether a school is permitted to become an active or an associate member depends upon the degree to which it has become identified with a college or university. Schools granted active membership are not only constituent parts of an institution of higher education, but their organization is expected to accord with that of other professional schools in the same institution. Associate membership is reserved for schools that have not yet achieved full integration with an institution of higher learning, but have established affiliation or some other relationship that makes the facilities of the college or university available to the school.

Because of the variation in the types of curricula offered by schools applying for membership, it has been necessary for the Association to formulate entrance requirements for schools offering combined academic and basic professional programs, and for those offering combined academic and advanced professional programs. The latter are usually designed for graduate nurses who are preparing themselves for...
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for specialized work as teachers, supervisors, or administra-
tors of nursing schools, or as public health nurses. At the end of 1935 the 21 members of the Association were as follows:

Active Members

*Combined academic and basic professional programs:*
  - Skidmore College, School of Nursing, Saratoga, New York
  - Yale University, School of Nursing, New Haven, Connecticut

*Combined academic and advanced professional programs:*
  - Catholic University, Department of Nursing Education, Washington, D.C.
  - Columbia University, Teachers College, Department of Nursing Education, New York City
  - George Peabody College for Teachers, Department of Nursing Education, Nashville, Tennessee
  - St. Louis University, School of Nursing, St. Louis, Missouri
  - Syracuse University, Department of Public Health Nursing, Syracuse, New York
  - University of Oregon, Medical School, Department of Nursing Education, Portland, Oregon
  - University of Virginia, School of Nursing Education, Charlottesville, Virginia
  - Washington University, School of Nursing, St. Louis, Missouri

*Combined academic and both basic and advanced professional programs:*
  - University of California, School of Nursing, Berkeley, California
  - Simmons College, School of Nursing, Boston, Massachusetts
  - Vanderbilt University, School of Nursing, Nashville, Tennessee

Associate Members

*Combined academic and basic professional programs:*
  - Duke University, School of Nursing, Durham, North Carolina
  - University of Michigan, School of Nursing, Ann Arbor, Michigan
  - University of Oregon, Medical School, Department of Nursing Education, Portland, Oregon
  - Rochester University, School of Nursing, Rochester, New York
  - St. Louis University, School of Nursing, St. Louis, Missouri
  - Washington University, School of Nursing, St. Louis, Missouri

Although a substantial number of schools are exhibiting marked interest in its program, this Association does not consider size as important as the development of sound standards. It wishes to bring together only those institutions that are free to control and able to support their educational policies. Relatively few schools, aside from the charter members, are in a position as yet to meet the requirements that are listed under such headings as organization, financial support and budget, faculty and teaching staff, teaching and administrative load, curriculum, facilities, requirements for admission and graduation, system of records, and student health and living conditions.1

DEMAND FOR AND SUPPLY OF NURSES

Although the number of graduate nurses increased with great rapidity after 1880, such an expansion of hospital building began with the second decade of the twentieth century that it created an urgent demand for more nursing service. Inasmuch as the new hospitals wished to operate as inexpensively as possible, they continued the custom of opening schools of nursing in order to benefit from the assistance of students. Institutions with established reputations and large resources had little difficulty in satisfying their own need for pupil nurses, but the great majority complained that they could not secure the number or the kind of applicants necessary to carry on their nursing services. Few of them weighed the advisability of utilizing graduate nurses or paid attendants; instead they established the precedent of admitting to training vast numbers of unqualified young women.

Between 1914 and 1919 the World War and the epidemic of influenza greatly complicated the whole nursing situation. The only field which was reasonably well supplied was that of private duty, which probably contained some 75 per cent of the graduate nurses. In addition to Red Cross detachments that had already been sent to Europe, the United States Army and Navy called in 1917 for 10,000 and later for 30,000 graduate nurses. In the meantime the volume of work in hospitals and public health organizations at home increased rather than diminished.

As a result of these demands, the number of young women entering nursing schools was increased in 1917 and 1918 by perhaps 25 per cent over the immediately preceding years.

With the conclusion of the war and the passing of the epidemic of influenza, there was no longer an inadequate supply of nurses. Nevertheless, until about 1930, great numbers of women continued to pour into the schools, and went out after the completion of their training to attempt to find work. Numbers increased with such rapidity that the federal census of 1930 showed over 294,000 graduate and student nurses, or nearly twice the number in 1920.

This great increase led to a critical situation even before the depression. In 1928, 363 nurses’ registries filed returns with the Committee on the Grading of Nursing Schools. The majority stated very definitely that there were too many nurses. Three hundred and twenty-five did not want any more nurses to move to their cities. Evidence indicated that hospitals were increasingly able to fill their own needs for special-duty nurses from their alumnae, and outside registries that had existed largely by catering to hospitals were finding it difficult to place nurses on their waiting lists. Some hospitals were no longer able to keep even their own alumnae occupied and yet enrolments in their training schools were permitted to grow larger. Many of the registries indicated that the over-supply was not a recent occurrence.

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During the 1920’s the largest group of nurses were in private duty, as they are still. A study of 1,409 private-duty nurses was made in New York State in one week in February, 1926, when the load of sickness was heavy and the demand for nurses great. It showed that despite all the illness, 12 per cent of the nurses did not work at all during the week, 25 per cent worked three days or less, and 53 per cent worked every day without stopping. If private-duty nurses were not busily employed in the winter of 1926, one can well imagine that at some periods of the year, even under the most fortunate economic conditions, a large percentage of them can find no work of any nature. The nursing of some diseases is to a large extent a seasonal occupation, and a sufficient number of nurses must be prepared to meet the increase of illness in winter, the fortuitous circumstance of epidemics, and so on.

In spite of the over-supply of nurses in the late 1920’s, there was constant complaint that it was impossible to get a nurse. Dr. Burgess’ study is particularly illuminating in explaining this seeming paradox. She estimated from reports obtained from physicians closely in contact with private-duty nursing that on a given day in March, 1927, the typical physician had three patients who needed nurses but only two had them. Of the one-third which did not have the needed nursing service, it was found that 45 per cent could not afford it, 29 per cent were cared for by relatives or friends, 13 per cent did not wish a nurse, and 7 per cent were cared for by visiting nurses, while only 6 per cent wanted a nurse but could not find one. Three-fourths of all the physicians who made reports stated that it was more difficult for their patients to pay for a nurse than it was to obtain a competent one.

Beginning with 1929 the economic depression so aggravated the situation that much attention was focused on the problem of over-production. H. Lenore Bradley’s article in the American Journal of Nursing, in June, 1933, gave evidence of how great was the over-supply of nurses in New York State. She pointed to the fact that New York had 40,000 registered nurses, 30,000 of whom classified themselves as actively engaged in nursing. During a period of ten years their number had increased 220 per cent, while the population had increased only 21 per cent. Besides the 30,000 registered nurses, some 22,000 other persons were nursing for pay. Miss Bradley suggested that if 30,000 were taken as indicative of a desirable nursing supply (a figure that is probably too high if measured by the effective demand for service) and if one estimated that about 5 per cent of the registered nurses would have to be replaced each year, then approximately 1,500 graduates would be needed annually. Instead, 2,800 students were finishing the course in nursing each year. Thus unemployment was being aggravated by the production of 1,300 annual graduates over and above the number needed for replacement.

2 Nurses, Patients, and Pocketbooks, pp. 131-132.

1 "What Price Selection of Students?" p. 357.
Although the number completing training decreased appreciably throughout the country subsequent to 1930, the number of patients able to pay for nursing service declined even more rapidly as the result of the economic situation. Consequently, many nurses found themselves unable to earn a living, and some were obliged to resort to work relief. Various schemes for increasing the demand for nursing care were tried. Hourly nursing service and more nursing in homes were fostered in some localities, both in the city and in the country. A considerable number of alumnae associations of schools of nursing adopted recommendations that their unemployed members should contribute a month of work each in exchange for maintenance so that hospitals might reduce the size of student classes.

The eight-hour day for nurses that has been put into effect in a large number of hospitals appears to be the most constructive change growing out of the recent emergency. Although the private-duty nurse has been obliged to take a reduction in salary in order that the patient may not have to pay more for three nurses than he formerly paid for two, the excessively long hours of duty have been reduced, the patient is better cared for, and more nurses are able to obtain work. Reports from hospitals where the plan has been instituted are distinctly reassuring.


The unemployment situation for nurses is now much less critical than it was three years ago. In fact, some hospitals asserted during the winter of 1936 that they could not get enough nurses to meet their needs. The low salary scale in effect in many hospitals appears to have kept nurses who could find other employment from accepting institutional positions. It is the opinion of many representatives of the health professions that not until more extensive and far-reaching alterations are made, will the problem of the supply of and demand for nurses be permanently remedied to any marked degree. Thousands of nurses have been out of work and yet a significant proportion of the American people have been in need of their assistance. Large numbers have gone through a period of training, yet many of them have been inadequately prepared for private duty, and most of them have received little preparation for other types of service.

Some of the nursing problems can be remedied by the profession itself. Improvement, in fact, is under way, and is likely to continue. But the basic question of how the needs of all the people for nursing service can be met is part of the entire problem of the extension of health service. This problem is an economic and educational one, the roots of which are intertwined with those of our whole social life.

In one of the recent studies sponsored by the Committee on the Costs of Medical Care, the authors concluded that there were very nearly enough physicians and more than enough nurses in the United States, if properly distributed,
to provide adequate service for the entire population, both in the prevention of disease and in the care of sickness when it had developed. They estimated that 220 nurses for every 100,000 population, of whom 44 would be public health or visiting nurses, would be necessary to render such service. The figures of the federal census of 1930 indicate that there were 240 graduate and student nurses for every 100,000 persons, besides a large number of "practical nurses" and hospital attendants. Of the 240 trained nurses, however, fewer than 16 were in public health and industrial nursing.

DISTRIBUTION OF NURSES

In 1900, according to census data, there were only 16 graduate and student nurses per 100,000 population in the United States. This figure seems very small in comparison with the 141 of 1920 and the 240 of 1930. In certain sections of the country the scarcity was much more marked than in others. The New England, Middle Atlantic, and Pacific states stood highest in 1900 in relative number of nurses, with 26, 31, and 33, respectively, per 100,000 population. The West South Central, East South Central, and West North Central states were lowest with 4, 6, and 9 nurses for every 100,000 persons. At each later census period the ratio of nurses to population showed a large increase in every geographical division and there was pro-


gressive reduction of the differences between the ratios of various sections. But even in 1930 in the East South Central and West South Central sections there were only 108 and 112 nurses per 100,000 persons, in comparison with the New England and Pacific states that had 390 and 374, respectively.

The inequality of distribution that still exists is largely the result of differences in concentration of population, wealth, and hospital facilities. As one of its subjects for investigation, the Committee on the Grading of Nursing Schools made a careful study of the distribution of nurses within the three states, New York, Louisiana, and California. For each state there was recorded, county by county, the number of registered graduate nurses. It is likely that in all three some graduate nurses were in practice who were not registered. If this were true, however, the actual figures would probably be only slightly higher than those that the study indicated. The outstanding feature in all three states was the way in which nurses clustered in the more urban counties and avoided those that were rural. In the borough of Manhattan in New York City one out of every 234 people was an active graduate nurse. In Albany County the figure was one out of every 394, but in Schoharie County, Albany's next door neighbor, there were only four registered nurses or one for every 5,391 people.

New York was not essentially different from the other two states that were examined. In California, in the

1 Committee on Grading of Nursing Schools: Nurses, Production, Education, Distribution and Pay, May 1, 1930, pp. 20-24.
wealthy county of Santa Barbara and in the large and wealthy cities of San Francisco and Los Angeles, nurses were so numerous that it was not surprising that those already there were requesting of nursing organizations that no more should be encouraged to come. Yet there were three counties in California without even one state registered nurse. In Louisiana the situation was worse. Although the population contains a large percentage of Negroes, almost all of the graduate nurses are white, and they were found to be concentrated in a few areas. In most of the state even the white population was practically without nurses. In 26 parishes with a total of nearly 244,000 white persons there was no record of a single active graduate nurse. But in Caddo Parish, where the city of Shreveport is located, there was one registered nurse for every 171 white people.

It is evident that nurses go to the thickly populated areas and stay away from the sparsely settled ones. They are likely to live where there are social and cultural advantages, and where there are ample hospital facilities. Counties that do not have good hospitals are particularly likely to report a genuine shortage of nurses. Nurses also tend to live where the concentration of wealth is greatest. Many localities are so poor that their inhabitants are unable to pay for nursing service. The situation in 1930 in Chester County, Tennessee, on which the Committee on the Costs of Medical Care made a special report, has its counterpart in thousands of other communities, small and large. It was found that the 10,600 residents of that county afforded eight physicians an average annual net income of less than $1,000 each. They paid the eight "practical" nurses a total of about $2,500, or an average of a little more than $300 per nurse. Graduate private-duty nurses called from Jackson, Tennessee, received a total of $275 for about six weeks of nursing service. This amount represents the entire sum spent for private-duty graduate nursing care in the county during the year. It is certain that graduate nurses cannot be expected to settle in such areas to practice private-duty nursing on an individual basis.

SALARIES

Salary is always an important consideration whatever the profession. Its level is one of the chief factors in determining who as well as how many will enter a particular group. There is a tendency for great numbers of persons to flock wherever earnings are large and working conditions are good. Unfortunately, salaries that are high at some given time do not always remain on that level. General economic conditions, the demand for the particular type of service, and the number of persons within the given occupation all determine what the remuneration will be. As soon as a profession begins to be over-crowded, competition among its members is so increased that some find themselves without enough work and have to sell their services for a lower fee. It is this situation that has arisen in the field of private-duty nursing.

1 Falk, Rorem, and Ring, The Costs of Medical Care. Publications of the Committee on the Costs of Medical Care, no. 47, University of Chicago Press, 1933, p. 252.
So great was the influx subsequent to 1917 that the nurse’s potential income has been very much reduced. In 1927, according to the Committee on the Grading of Nursing Schools, the typical private-duty nurse spent an aggregate of five months in twelve out of work.1 The Massachusetts State Nurses’ Association gave 33.8 weeks a year as the average working period for nurses in 1929. Other surveys, quoted in a report of the Committee on the Costs of Medical Care, indicate that the private-duty nurse in 1929 was employed not more than 30 weeks annually.2 Professor George M. Weir made a similar inference of a thirty-week year for nurses in Canada in 1929.3

In 1926 the median salary of the private-duty nurse was estimated to be only $1,297.4 (This was exclusive of the board that she received while nursing her patients.) Scattering statistics indicate that as a result of the depression the figure dropped in the early 1930’s to a much lower level for those who found enough employment to maintain themselves, while many were able to obtain no practice at all. The nurse in the smaller city appeared to be somewhat more successful in getting cases than did the one in the larger city. If this were true, it may have been due to the fact that the field was less over-crowded and the individual nurse was better known to physicians, registries, and patients. The unusually well-prepared and efficient nurse, and the one who had valuable contacts apparently obtained a fair amount of work wherever she found herself. With some increase of late in the public’s ability to purchase more health service, as has already been noted, the situation is probably better for the nurse at present than it has been during the last few years. Regardless of such possible gains, however, irregularity of employment and long intervals of enforced idleness constitute a serious economic condition for those who must rely entirely upon their professional practice for support.

Another fact besides irregularity of work that makes the situation discouraging, is that the private-duty nurse has no prospects of increasing her income appreciably from year to year except by working a greater number of weeks. Factors, such as ability, experience, and education, have almost no influence upon the amount that the nurse charges. They do play some part, however, in determining how much she may be employed.

Charges for private duty in the home or hospital vary somewhat from community to community, but they were rarely less than five dollars and seldom more than eight dollars a day before the depression began, and in the main they were uniform in a given locality and even within a state or section of the country. At present, in those hospitals where the eight-hour day has been introduced, the private-duty nurse generally receives either four or five dollars and no maintenance.

With respect to earnings, the private-duty nurse is at a

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1 Burgess, May Ayres, Nurses, Patients and Pocketbooks, pp. 289, 304-316.
2 Falk, Rorem, and Ring, The Costs of Medical Care, pp. 253-254.
4 Burgess, May Ayres, Nurses, Patients and Pocketbooks, pp. 304-309.
considerable disadvantage over the nurse who is on the staff of a hospital. In a survey conducted in San Joaquin, California, in 1929, this discrepancy appeared very clearly. Of 74 women in private duty, 30 per cent had annual cash incomes of less than $600, whereas 19 per cent of 69 staff nurses employed in hospitals received less than that amount. It must be remembered that institutional nurses are also given maintenance while private-duty nurses in hospitals are not. Approximately 50 per cent of the private-duty nurses had incomes of less than $1,000; among the institutional group only 29 per cent received as little as that amount. The maximum earnings from private duty were between $1,600 and $1,800 and only 5 per cent received as much as $1,600. Of the institutional nurses, 46 per cent were above the $1,600 level and 7 per cent earned $2,000 or more.1

The figures of the Committee on the Grading of Nursing Schools shown in Table 3 tell what happened to the salaries of nurses employed by hospitals between the summer of 1929 and that of 1932.2 The downward trend undoubtedly progressed still farther after that. The Committee reported that only one per cent of the nursing chiefs of 1929 received less than $1,000 and maintenance; in 1932 the proportion was 3 per cent. Eighteen per cent received $2,500 or more and maintenance in the former year, and 16 per cent in the latter. Among the ward heads and

1 Sinai, Nathan, A Survey of the Medical Facilities of San Joaquin County, California, 1929. Publications of the Committee on the Costs of Medical Care, no. 13, pp. 79-80.


Although institutional nursing offers steady employment and a living wage, the salary range is so small even in prosperous times that it does not furnish great incentive for diligence on the part of the young nurse in the hope that she will be promoted. Aside from increases given to the superintendent of the hospital and the superintendent of nurses, raises have always been very slight or non-existent. It has been recommended that there should be a broader salary scale with greater differences between different levels of responsibility, and greater opportunity for promotion.3

1 Committee on the Grading of Nursing Schools, The Second Grading of Nursing Schools, 1933, p. 30.
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If this plan could be put into effect the quality of hospital nursing service would probably benefit.

In public health nursing, salaries tended to increase until 1930, to hold their own for the next two years, and then to decline. Only about 20 per cent of the 349 public and private nursing agencies reporting to the National Organization for Public Health Nursing as of January 31, 1933, had made no cuts. The results of four successive salary studies by the Organization are summarized in Table 4, which indicates that median monthly salaries at the beginning of 1933 were very similar to those of 1925, except for salaries of directors. These were lower than in 1925.1

Table 5 gives the median annual salaries of public health nurses engaged wholly in school nursing, whether paid by boards of health or by boards of education. Although information is available only for 1928 and subsequent years, the trend is the same as in other public health nursing.2

Both size of city and number of nurses employed by a given agency appear to have an influence upon salaries in the public health field. Although Miss Tattershall's figures, presented in Table 6, for median salaries at the end of January, 1933, were based on a somewhat inadequate number of cases, they indicate that in general the large departments of health and large public health nursing associations paid better salaries than did the smaller ones.3 Salary variations were more marked, however, in the case of di-

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Table 4—Median Monthly Salaries of Public Health Nurses Employed by Health Departments and Public Health Nursing Associations, 1925, 1930, 1932, and 1933

<table>
<thead>
<tr>
<th>Year</th>
<th>Directors</th>
<th>Supervisors</th>
<th>Field nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health department nursing staffs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1925</td>
<td>$200</td>
<td>$145</td>
<td>$130</td>
</tr>
<tr>
<td>1930</td>
<td>190</td>
<td>190</td>
<td>165</td>
</tr>
<tr>
<td>1932</td>
<td>180</td>
<td>175</td>
<td>145</td>
</tr>
<tr>
<td>1933</td>
<td>165</td>
<td>135</td>
<td></td>
</tr>
<tr>
<td>Public health nursing associations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1925</td>
<td>$210</td>
<td>$150</td>
<td>$125</td>
</tr>
<tr>
<td>1930</td>
<td>250</td>
<td>165</td>
<td>135</td>
</tr>
<tr>
<td>1932</td>
<td>225</td>
<td>165</td>
<td>135</td>
</tr>
<tr>
<td>1933</td>
<td>200</td>
<td>150</td>
<td>120</td>
</tr>
<tr>
<td>All agencies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1925</td>
<td>$210</td>
<td>$150</td>
<td>$125</td>
</tr>
<tr>
<td>1930</td>
<td>225</td>
<td>170</td>
<td>140</td>
</tr>
<tr>
<td>1932</td>
<td>210</td>
<td>165</td>
<td>135</td>
</tr>
<tr>
<td>1933</td>
<td>190</td>
<td>150</td>
<td>125</td>
</tr>
</tbody>
</table>

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Table 5—Median Annual Salaries of Public Health Nurses Engaged in School Nursing, 1928, 1930, 1932, and 1933

<table>
<thead>
<tr>
<th>Year</th>
<th>Directors (Boards of education only)</th>
<th>Supervising or chief nurses (Boards of education and boards of health)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1928</td>
<td>$2,100</td>
</tr>
<tr>
<td></td>
<td>1930</td>
<td>$1,950</td>
</tr>
<tr>
<td></td>
<td>1932</td>
<td>$1,950</td>
</tr>
<tr>
<td></td>
<td>1933</td>
<td>$1,540</td>
</tr>
</tbody>
</table>

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2 Ibid.
3 Ibid.
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rectors than for supervisors and field nurses. This is what one would expect. In agencies employing large staffs, the director has more responsibility than in a smaller association. The amount of work and responsibility undertaken by the supervisor and the field nurse do not show such a marked difference and consequently their salaries are likely to be more uniform.

TABLE 6.—MEDIAN MONTHLY SALARIES OF PUBLIC HEALTH NURSING DIRECTORS, SUPERVISORS, AND FIELD NURSES, JANUARY, 1933, BY SIZE OF STAFF

<table>
<thead>
<tr>
<th>Number of nurses on staff</th>
<th>Directors</th>
<th>Supervisors</th>
<th>Field nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health department nursing staffs</td>
<td>Health department nursing associations</td>
<td>Health department nursing associations</td>
<td>Health department nursing associations</td>
</tr>
<tr>
<td>50 or more</td>
<td>$200</td>
<td>$165</td>
<td>$150</td>
</tr>
<tr>
<td>25 to 49</td>
<td>185</td>
<td>150</td>
<td>135</td>
</tr>
<tr>
<td>10 to 24</td>
<td>160</td>
<td>145</td>
<td>125</td>
</tr>
<tr>
<td>2 to 9</td>
<td>165</td>
<td>175</td>
<td>135</td>
</tr>
</tbody>
</table>

Although, except in private duty, the salary situation has not been critical for those who have had employment, nurses generally feel that they are inadequately paid for the service they render. Reasons for the low salary level are apparent from the preceding discussion. Some of the causes are coincident with problems of the general social order, and will be solved only if the entire economic and educa-

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tional system of America is improved. Some of them are the result of conditions within the profession itself. The fact has already been emphasized that lack of planning and of professional control have worked hardship both upon nursing and nurses.

PUBLIC HEALTH NURSING

Public health nursing made its appearance over fifty years ago and had some 3,000 nurses in its service before 1912. Only in the past twenty years, however, has it become a country-wide movement. Today there are more than 4,300 organizations giving public health nursing service, and nearly 20,000 nurses engaged in their various activities. It is now administered primarily by three types of agencies: departments of health and boards of education that are governmental agencies, and public health nursing associations that are non-governmental. It is also provided by a few industrial and insurance companies, tuberculosis associations, child clinics, and so forth.

This work originated through the interest of socially minded citizens in various communities, and developed through voluntary organizations supported from private funds. At first these organizations were concerned primarily with the sick poor, but gradually they extended their service to persons of moderate means. They also began to stress public health nursing as a means of preventing sickness and of teaching health. They carried on experiments and demonstrations in the prevention of tuberculosis and the care of infants, in the health supervision of school chil-
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dren, and in the operation of health centers. The public health nurse learned that health measures can be taught to groups of persons only to a limited extent; that the ultimate victory over ignorance can be best attained through personal contact with individual people in the home, the school, and the factory. Whatever her immediate duty may be, even if it is giving hourly nursing service, the goal set the nurse is the education of her patients in the prevention of disease and the knowledge of better living conditions. That many individual nurses and some public health associations have fallen short of achieving or even apprehending this objective has undoubtedly been true, but that prevention and education are constantly stressed as the aim of the movement as a whole is of great significance.

So conclusively has public health nursing proved its worth that the American people have gradually recognized that the government should assume some responsibility for creating official health agencies which would lessen the burden of the private agencies and extend the scope of service. In response to public opinion, more and more specialized agencies that emphasize the prevention of illness and the promotion of health have been turned over to or have been organized by departments of health. Service for school children has been fostered in some cities by boards of education and in others by boards of health. In 1924, when the first census of public health nursing was made by the N.O.P.H.N., there were already more agencies and nurses under governmental than under non-governmental auspices. Table 7, based on the approximately

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complete censuses of public health nursing in 1924 and 1931, indicates the extent to which the trend toward governmental operation of these services progressed during a period of seven years.\(^1\) It has probably continued since 1931.

**TABLE 7.—PUBLIC HEALTH NURSING ORGANIZATIONS AND NURSES IN THE UNITED STATES, 1924 AND 1931**

<table>
<thead>
<tr>
<th>Type of administration</th>
<th>Agencies</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Per cent</td>
<td>Number</td>
<td>Per cent</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1924</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governmental</td>
<td>1,695</td>
<td>51.8</td>
<td>6,398</td>
<td>57.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-governmental</td>
<td>1,574</td>
<td>48.2</td>
<td>4,773</td>
<td>42.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,269</td>
<td>100.0</td>
<td>11,171</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1931</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governmental(^a)</td>
<td>2,751</td>
<td>63.2</td>
<td>9,745</td>
<td>61.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-governmental</td>
<td>1,597</td>
<td>36.8</td>
<td>6,170</td>
<td>38.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,348</td>
<td>100.0</td>
<td>15,915</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Governmental includes joint governmental and non-governmental administration.

The amount of public health nursing varies widely from one section of the country to another. In 1931 the state of

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Connecticut, with 32 public health nurses to every 100,000 population, showed the highest ratio for the country, while Mississippi with two per 100,000 population showed the lowest. New England as a whole provided the largest proportion of service, and the West South Central states the smallest. Below the Mason and Dixon line no state had more than 10 per 100,000. In spite of the relatively rapid increase in public health activities that had been going on throughout the United States, 53 per cent of all counties lacked any such nursing service, and 12 per cent had service in only part of their areas. Although public health nursing is particularly necessary in rural localities on account of the frequently inadequate health services of all kinds, less than 20 per cent of the total number of nurses giving community service were available for the 44 per cent of the population that lived in areas of less than 2,500 persons. Fifty-two per cent of the nurses, on the other hand, served the 36 per cent of the population in cities of 100,000 or more.1

The National Organization for Public Health Nursing estimates that there should be, generally speaking, one public health nurse to every 2,000 or 2,500 persons, if a program of education and prevention of sickness were to be carried on effectively. This would necessitate some 62,000 nurses for the entire country, or 42,000 more than the present number. In only two of the 28 communities surveyed in 1931 and 1932 was the population per nurse under 3,000. One nurse to from 3,000 to 4,000 persons was found to be the most frequent ratio in these communities. Although it may be safely said that one public health nurse is needed for every 2,000 or 2,500 persons, it is obvious that the adequacy of a program for any particular community cannot be determined solely by means of this ratio. There are many factors besides population that must be considered: topography, type and concentration of population, social and health conditions, and other health and social resources. There are also factors within public health nursing associations themselves with which one must reckon: the type and scope of program, kind of administration, and degree of specialization of service.1

One of the chief reasons why expansion has not been more rapid is financial. Financing the movement has always been a serious problem and it became increasingly difficult, particularly for private agencies, after 1930. Nursing staffs were not decreased appreciably, however. The National Organization for Public Health Nursing has estimated that there were decreases in personnel of 4 per cent in 1932, 2 per cent in 1933, and one-half of one per cent in 1934, but that between December, 1934, and May, 1935, additions were made to the extent of one per cent.2 Support of the private associations is derived from payments by contracting insurance companies and industries, personal contributions, allotments from Community

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Chests, and to a very small amount by patients' fees and taxes. Public health nursing provided by departments of health and boards of education is almost entirely supported from public funds. As a rule it is given free of charge and is designed primarily for those classes who cannot afford to pay for it.

Realization of the inequality of amount of public health service now being rendered to different communities found expression in the Social Security Bill signed by President Roosevelt in August, 1935. Two of its sections are devoted to public health. One section, to be administered by the United States Children's Bureau, deals with maternity and child welfare and the care of crippled children. The other section makes provision for assistance to states, counties, health districts, and other political subdivisions of states in establishing and maintaining more adequate public health services, including the training of personnel for state and local health work. This portion of the bill aims to stimulate a comprehensive, nation-wide program of public health, financially and technically aided by the federal government, but administered and supported, in so far as possible, by states and local communities. The United States Public Health Service has responsibility for putting this section of the act into operation. Allotments are to be determined on the basis of population, special health needs, and financial requirements in the respective states. Grants-in-aid to state or local projects are designed to supplement state and local funds, and in no case are they to be used to replace existing appropriations to such projects. No state is eligible for aid, moreover, unless it is able to provide plans for certain essentials of health organization.

As the states take such steps as may be necessary for obtaining grants, the result should be a considerable extension of public health services particularly in rural and economically under-privileged communities. This program has broad implications for the future of public health nursing. It has equally broad implications for the relative importance of private versus public agencies. What the eventual alignment between non-governmental and governmental organizations will be is as yet unknown. If public agencies do take over a large part of the burden now being carried by private associations, the latter may have an opportunity for more experimentation than at present, for the developing of new methods, and the extension of public health nursing to still wider fields of service. The fruition of such an opportunity would result in the greater welfare of American society.

Whatever the final disposition of responsibility may be, the greatest need of public health nursing at present is for improvement in the preparation of its nursing personnel. The National Organization for Public Health Nursing has drawn up "standardizing qualifications," which it considers the minimum requirements that should be insisted upon by agencies when making new staff appointments. The first qualifications, applicable from 1925 to 1930, recommended completion of two years of high school work, graduation from a school of nursing approved by the
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Organization, and state registration. For the nurse working alone, it further suggested four months of instruction in a recognized public health nursing course, or one year’s experience on the staff of a public health agency that gave daily nursing supervision. These proposed requirements were raised for the period 1930–1935, and still later revisions applicable to the years 1935–1940 raised them further.

The N.O.P.H.N. now recommends that a new appointee should have completed high school and preferably should have had some work of college grade. The school of nursing from which she has been graduated should be accredited by a state board of nursing examiners and should be connected with a hospital having a daily average of at least 100 patients, or a minimum of 50 patients and affiliation with one or more hospitals for supplementary training. The school should offer not only basic preparation in the more customary services, but it should give instruction in tuberculosis, syphilis, gonorrhea, and the acute communicable diseases. Throughout the curriculum it should emphasize the mental aspects of nursing. If such training has not been available, the appointee should have secured preparation through affiliation with another school before graduation or through post-graduate work. It is also recommended that she should have had instruction and experience in out-patient clinics, psychiatric nursing, and family health work, and that she should maintain state registration and should have certain specified personal qualifications.

For the public health nurse working alone there are the additional recommendations of a year’s course in public health nursing that meets the requirements of the N.O.P. H.N., and at least one year of experience under qualified nursing supervision in a public health nursing service that emphasizes family health. For a supervisor, director, or educational director, the National Organization recommends a baccalaureate degree, special preparation in public health nursing, preparation in the theory and practice of supervision or in advanced work in education, experience in public health nursing ranging from two years for supervisors to several years for directors, and certain personal qualifications.

The qualifications recommended in 1925 as minimum requirements for staff appointments were very mild. They had been devised as an attempt to raise the level of preparation throughout the country to at least some degree of uniformity. Many of the individual public health agencies went far beyond these standards in their requirements. By a gradual process the qualifications have been moved upward, but even now the N.O.P.H.N. considers the standards it has set as only the minimum that should be demanded of new appointees.

Because the general training provided by most schools of nursing has not been adequate for the type of service that the public health nurse is expected to render, emphasis

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has been placed upon the necessity for further training, preferably in regular post-graduate courses. But in spite of the fact that advanced work is deemed essential, only one-third of 800 field nurses whose qualifications were recently analyzed had had any theoretical preparation through post-graduate courses, and only about 7 per cent had completed an accredited public health nursing course. Few executives and supervisors had had any special preparation or previous experience in administration or in supervision; the large majority had worked up from the ranks of the agencies that were then employing them.

On account of the small proportion of nurses who avail themselves as yet of courses on the post-graduate level, the N.O.P.H.N., insists that more responsibility for training must be borne by schools of nursing and by public health nursing agencies. It maintains that those schools that are really educational institutions and not "hospital utilities" should have little difficulty in giving basic training in the prevention as well as in the cure of illness, and that if more facilities for viewing nursing service from the angle of prevention were provided, all nursing, and particularly public health nursing, would profit greatly. The agencies, too, in the opinion of the Organization, should improve their present facilities for training. So long as the greater part of the specialized preparation for public health nursing is obtained while the nurse is actually in practice, the

INDUSTRIAL NURSING

Since 1895, when the first graduate nurse was engaged by the Vermont Marble Company, there has been a slow but steady rise in the number of nurses employed by industry. In 1930 the federal census reported a total of 3,318. Nearly two-thirds were in manufacturing and mechanical industries—generally in large establishments. More than two-thirds were found in ten states.

The original motive for employing nurses in industry was economy. The enactment of workmen's compensation laws made a few employers realize that a program of prevention was indirectly a saving to themselves. As time has gone on both labor and the public have exhibited more concern about working conditions, and many employers are coming to manifest an interest in their employes that may make possible the wide adoption of the preventive features of health service. Thus far, however, although industrial nursing is often spoken of as a branch of public health nursing, the industrial nurse herself has generally neither been given the opportunity nor had the preparation essential for building a broad program of prevention and education. She has been primarily engaged in dressing accident injuries, keeping the records of the medical department, and frequently supervising the sanitation of the plant. In a few progressive industries where greater emphasis is placed upon prevention, her field of service is

1 Survey of Public Health Nursing, Administration and Practice, pp. 18-20.
more extensive. She learns the cause of accidents and teaches caution. Sometimes she does follow-up work in the homes of the employes, and attempts to remedy health conditions that affect the workman's efficiency in the plant. It is evident that the possibilities of development in industrial nursing service are almost unlimited. If the nurse were only prepared for her task, she could prove an invaluable agent in the prevention of accidents and illness, in the development of habits of personal hygiene, in the adjustment of the worker to his job, and in the creating of personal and group morale. Unfortunately, these possibilities remain as yet largely unrealized. Employers often have no clear idea of the nurse's function, and she herself is frequently no better off. She has rarely been trained as an industrial nurse, or even as a public health nurse, and since she works alone, she lacks the invaluable help and guidance that come from being connected with a public health nursing unit.1

PRESENT STATUS OF THE PROFESSION OF NURSING

Every profession is faced by the problem of how it can render efficient service to society and maintain high standards for its members. Although nursing has made an extremely valuable contribution to our social life through the improvement of hospital conditions, the providing of a trained personnel to care for the sick, and a growing interest in the prevention of disease, the preceding pages have indicated that it still falls short, partly for reasons outside itself, of accomplishing much that society needs to have done, and that would give the nurse herself more in the way of a rich and successful life.

A large part of the public fails to obtain competent nursing service at the time and place necessary. The person who has the misfortune of finding himself sick in the more remote rural areas may be totally unable to procure a graduate nurse, or only after long delay. Even though he lives in a city whose nursing registries have long waiting lists, he may not succeed in securing one able to care for him efficiently in his home. Another difficulty that he encounters is his frequent inability to obtain a nurse trained in such specialties as psychiatry, neurology, and the communicable diseases. Nurses with only general training sometimes accept cases in these categories, while the patient who feels himself protected by engaging a registered nurse is unaware that she may never have seen a patient with scarlet fever or with a manic-depressive psychosis.

And finally the most insurmountable obstacle of all is that of the patient's obtaining service at a fee that he is able to pay. If he belongs to the small wealthy class, no problem exists. If he is a member of the low income group and is in need of dispensary service, hospitalization, or public health nursing, care will frequently be provided free of charge, but it may be inadequate both in quantity and in quality. If he is a member of the large middle class, his

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income has often been insufficient to permit him to set aside sums for unusual emergencies and he finds few plans for prepayment of service available to him. Consequently, if sickness befalls him suddenly, he is faced with the alternative of foregoing the nursing care that he needs, or of involving himself and his family in serious financial difficulties from which it may take months or even years to recover.

It is apparent that the whole question of nursing service presents many difficulties for the public. For each of these there is a possible solution, but some of the solutions are contingent upon alterations in our whole economic and social pattern, and it is a truism that change by evolution generally comes slowly. How soon health services can be provided for all those who live in remote rural areas is unpredictable. How and when the costs of illness can be more evenly distributed is also an uncertainty, although the question is now receiving earnest consideration.

Nursing also presents many problems, as we have seen, to its own personnel as well as to the public. Although there are many nurses who are able, competently trained, and forward-looking in attitude, there has been no method of guaranteeing that only such persons should enter the profession. Until recently, as much as a high-school education was not required by many schools of nursing. Even yet, little is being done to determine the applicant’s intelligence, adaptability, or aptitude for nursing. Hospitals have demanded long hours of hard work from the student nurse, in return for which many of their schools have given her only a rudimentary knowledge of the theory of nursing. Clinical experience has been offered the student, but generally without sufficient supervision or planning, and sometimes without enough diversity in types of service. The basic training course has acquainted her with the resources of the modern hospital, and it has prepared her to perform adeptly those techniques associated with the more customary forms of nursing. It has often not succeeded, however, in making her adaptable to new conditions when placed upon her own initiative or when obliged to improvise equipment. It has trained her primarily for general private-duty or institutional nursing, and has neglected to emphasize sufficiently prevention of disease, public health nursing, or other forms of care given on an organized group basis to the community.

Under circumstances such as these, it is not surprising that great numbers of nurses have found themselves with too few private-duty calls or no institutional position; without the preparation required for entering the field of public health; and without the background and the resources necessary for visualizing the public’s need for numerous new fields of nursing service and for organizing such service.

But forces have been at work which are altering some of the traditional concepts of the function of nursing and the form of training. Formerly, the nurse acted exclusively as a remedial agent engaged only in the task of attending the sick. As the science of medicine has advanced, it has become increasingly clear that any adequate program of health service for the modern community must provide a
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strongly organized, dynamic plan for the prevention of disease as well as for the diagnosis and treatment of sickness. Out of this realization has grown the public health nursing movement, described in an earlier section, which is today giving health education and nursing care to a considerable segment of the population that was formerly without such service. This movement is exercising a profound influence upon the profession of nursing. Because the public health nurse requires a different kind of education from that which has been offered the prospective private-duty nurse, nursing education is in the process of becoming more flexible and more capable of adjusting itself to the needs of a greatly enlarged function of nursing. Because it has provided its personnel with permanent positions and a higher income than that earned by the average nurse engaged in bedside care, it has offered an incentive to the competent and well-trained nurse. Through its insistence that its members must assume a large degree of responsibility for the prevention of disease and the education of the public, it has not only done much to develop initiative and resourcefulness in them, but it has added distinction and prestige and raised the professional tone of this phase of nursing.

There are other encouraging movements, besides that in public health, aimed to adjust nursing service more effectively to present conditions. The "job-analysis" of nursing, the growth of "not for profit" placement agencies, the recent interest of nursing registries in analyzing their work in relation to the demand for and the supply of nurses, the formation of nursing councils for co-ordinating and improving the nursing services of a particular locality, the increase in the proportion of graduate nurses on staffs of hospitals, the growth of the eight-hour plan for special-duty nurses—these, and a score of other developments, point to the fact that the profession is attempting to devise means whereby the public may be better served and nurses may be more profitably employed.

RECOMMENDATIONS OF TWO CURRENT STUDIES

The national associations have been of great usefulness in forwarding the evolution of nursing from the stage of a skilled craft to that of a profession. They have created group consciousness among nurses and have provided forms of organization through which that consciousness could express itself. Because of the degree of co-operation that exists among the three associations that have been long established, they have been able to sustain concerted efforts directed toward the raising of standards that would not otherwise have been possible. In spite of the discouraging situation of chaotic educational conditions in many schools of nursing, these national bodies have moved steadily forward with vigilance and purposefulness in an attempt to elevate nursing to a higher level.

They realize that such a level will be reached only when the great majority of persons who enter nursing are individually qualified to assume professional responsibilities.
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And nurses will not be thus qualified until there is a well-integrated system of nursing education capable of producing such persons. Hence, much of their emphasis has been placed upon devising plans whereby the educational process may be made more effective. A long list of publications has been prepared with this goal in mind. The National League of Nursing Education has just published one important study and is bringing to conclusion another in the hope that they will serve as guides for schools interested in promoting sound educational preparation. These studies will be briefly reviewed here, not only because of the value of the recommendations that appear in them, but because they indicate the nature of an emerging philosophy of nursing education and of the function of nursing that is likely to affect greatly the future of this branch of health service.

One of these studies on which several years of work have been expended is entitled, Essentials of a Good School of Nursing. The point of view that permeates the study has been summarized by Dean Effie Taylor of the Yale School of Nursing in the words, "The objective of all nursing, the better care of the sick patient as a human being and as a member of society, has been constantly kept in mind." Emphasis is centered upon the welfare of the public rather than upon that of the nurse. The Committee on Essentials of a Good School of Nursing, of which Nellie X. Hawkins of Chicago is chairman, asserts that it is for the patient's sake that the maintenance of a good school of nursing is of fundamental importance. Because of the function of nursing in restoring the sick to health and in preventing illness, the personal and educational qualifications of nurses must be given thoughtful consideration. This consideration, moreover, must be a joint responsibility, shared by the public as well as by the profession if nursing is to be of maximum service to the community.

Guided by these principles, the Committee has set down certain recommendations that it believes should be generally applicable to schools that have as their primary function the preparation of professional nurses. Some of the most important of these are presented in condensed form.¹

1. Schools should be governed by a responsible body whose membership is convinced of their importance to society as educational institutions. Inasmuch as the hospital is primarily a service institution, the Committee believes that in those instances where the hospital maintains a school, its board of trustees should delegate to a "school of nursing council" the necessary powers and functions for operating the school as an educational institution. The members of the council should represent the following groups: the trustees of the hospital, the community, the field of general education, the public health field, the profession of nursing (or alumnae), the profession of medicine (or medical staff), the superintendent of the hospital, and the principal of the school. In those schools of nursing connected with a university rather than a hospital, the plan of organization and control should conform to that of the other professional schools in the university.

2. A good school of nursing should have financial resources adequate to forward its educational program on a professional

¹ The following paragraphs summarize some of the recommendations that appear in Essentials of a Good School of Nursing, published by the League, June, 1936.
level. The state and private individuals should assist in maintaining professional nursing education as they do the education of teachers and other workers in the service of the public. Tuition and fees charged students and compensation by the hospital for such nursing service as students render, should contribute to the maintenance of the school. However, few, if any, good colleges and professional schools expect the student to contribute more than fifty per cent of the cost of his education. The trend toward the placement of greater financial responsibility upon students in schools of nursing through increase of tuition fees is sound, but the student must, in turn, be guaranteed satisfactory training. There should be a budget for educational work, distinct from the hospital's budget for nursing service.

3. A third recommendation deals with the teaching staff. "All members of the faculty holding the more responsible positions should be required to have a broad background of general education as well as specialized professional preparation, and as soon as possible this requirement should be extended to all members of the faculty." They should have had experience both in teaching and in executive work in schools of nursing and hospitals. Good schools should provide such conditions of service as will make possible a degree of economic security, and will inspire the staff to further study and personal growth.

Tuition was rarely required of students, except in a few outstanding schools, until fairly recently. In fact, students were generally paid small monthly allowances for service rendered the hospital. Of late, however, there has been a growing tendency for schools to charge tuition and to cease making payments. In 1935, according to Ella A. Taylor's article on Tuition in the American Journal of Nursing for September, 1936, about one-third of all schools charged tuition but some of those making such a charge still continued their monthly allowances. The tuition for the entire course, generally collected in one payment during the first year, varied from less than $25 to $325. One-fourth of the schools charged $50 or more, and one-fourth charged $100 or more. The most common sum was $50. Twenty-four per cent of the schools requiring tuition reported this amount.

Since the demand for adequately prepared nurses for faculty appointments far exceeds the supply, the salary scale should be flexible and a premium should be put on sound preparation and experience. No full-time instructor can be expected to do effective work if her teaching load exceeds eighteen hours a week, and a lighter program is deemed desirable.

4. Students should be selected on the basis of educational preparation, maturity, physical and mental fitness, character, and qualities of personality that are essential for success in nursing. As an aid in choosing such students, the following information should be secured: record of general education, report of physical and mental health and chronological age, record of personal qualifications, record of psychological tests, and report of personal interview.

5. Schools should provide the teaching facilities and conditions of work essential to the carrying out of a sound educational program. Classrooms, laboratories, offices, equipment, and library should be adequate. Schools should command clinical facilities both in the hospital and in the community satisfactory for preparing students for a broad type of nursing service. Hospitals most likely to afford good facilities are those approved by the American College of Surgeons, and the Council on Medical Education and Hospitals of the American Medical Association. Mental hospitals used for purposes of affiliation should be approved by the Advisory Board in Neuropsychiatry, the United States Public Health Service, and the American Psychiatric Association. Public health nursing agencies should meet the recommendations concerning a satisfactory educational program outlined by the National Organization for Public Health Nursing. Although the Committee approves of schools being affiliated with hospitals having an average of 150 patients daily, it maintains that the number is of less importance than the variety and character of the services maintained.
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6. The curriculum should be constructed to meet the needs of the individual school. It should also meet the legal requirements for the practice of nursing in the state, and should be in line with the best professional thinking and educational practices of the country. It should be developed on a collegiate level; should be of a professional rather than a strictly technical type; and should represent optimum rather than minimum standards in the field of nursing education. A better balance than exists at present between technical preparation and the scientific, cultural, and social aspects of professional education should be sought. Demonstrations, the use of laboratory, clinic and case study methods, discussions, conferences, and seminars are recommended as effective means of teaching based on sound educational principles.

The other study of significance which is nearing completion is the second extensive revision of a Curriculum for Schools of Nursing, first published by the National League of Nursing Education in 1917. The League, the other three national associations, several other nursing groups, and a number of members-at-large interested in the content of nursing education have participated in the task through representation in the Committee on Curriculum. Most of the detailed work of outlining the individual courses has been performed by 17 subcommittees each composed of from five to 20 persons. Copies of the outlines of courses in tentative form have been submitted to groups throughout the United States organized for the purpose of studying them. Criticisms and suggestions offered by these groups are now being considered in the final preparation of the manuscript. The scope of the undertaking, that has already extended over two years, is thus apparent.

Although even a summary of this study is impossible within the limits of this small volume, certain basic assumptions and trends in thought will indicate the nature of the concept of nursing education expressed by Isabel M. Stewart, chairman of the Committee on Curriculum, and by numerous other nursing educators.

As a preliminary step to reconsideration of the curriculum, recent literature on nursing education, general education, and preparation for other professions was reviewed. This was done in order that the Committee might be in better position to construct a course of study in conformity with the newer educational patterns. The next step was to agree upon a philosophy that would express the purposes of nursing education in terms of present situations and needs, and that would be acceptable to the majority of those directly concerned with the education of nurses. The Committee finally decided to think of nursing education as a process of aiding prospective nurses to adjust themselves to various social and professional situations. The concept of adjustment was stated largely as follows:

Nursing education, like all education, is for the purpose of helping individuals to adjust themselves to the world in which they live.

It has a specialized function, comparable to that of other forms of vocational education, of selecting students with marked aptitude for a particular profession, and of aiding them to adjust themselves to the requirements of that profes-
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sion in such a way that they may give their best service to society and may continue to grow through that service and also through participation in the general life of the group.

Since nursing is one of several professions responsible for health service, the education of the nurse should help her to carry out her share of that service on the highest level, and also help her to co-operate with other professional groups in making the common health program as effective as possible.¹

In planning a revision of the curriculum, the Committee has made no attempt to define minimum standards. It has centered attention upon choosing the highest standards that can be realized at this time. Like the Committee on Essentials of a Good School of Nursing, it states that its suggestions are not designed for schools of nursing that are really not educational institutions at all, but for those that are making a genuine effort to qualify as true professional schools. Although it realizes that the majority at present are not organized and administered in a way that permits them to undertake educational functions on a professional level, it is encouraged by the fact that in a substantial number of schools which began as service agencies education is becoming a primary instead of a secondary consideration. To such schools the ideas presented in the revised curriculum are offered as an aid in helping them to define their standards and objectives more clearly and to recognize the steps necessary to attain those objectives.

The Committee has not selected one type of organization for a school of nursing, but has attempted to formulate a program sufficiently flexible to be adapted to the hospital or the university school. Although it does not advocate uniform standards in all institutions, it believes that there are certain general principles toward which nursing education should be working. It maintains, for instance, that the time has come to plan for an admission requirement of two years of education beyond high school. (The Committee on Essentials of a Good School of Nursing makes the same suggestion.) It does not specify that these two years should necessarily be spent in a college, but conceives of them as a period during which the student will gain in maturity, emotional stability, and general educational experience. Courses for the new curriculum have been outlined on the supposition that some schools will make this two-year requirement at once and others will work toward it.

The Committee recommends that the basic course should extend over a period of from two and one-half to three years, and that the number of hours of classroom work and clinical practice should be from forty-four to forty-eight weekly. Since a three-year curriculum and a fifty-four hour week are still customary in most schools of nursing, this suggestion represents a radical departure from practice. The Committee justifies its position on the ground that the elimination of all non-educational duties would permit a shortening of the course, while fewer hours of work would result in less fatigue and consequently in more concentrated effort by the student.

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Like the Committee on Essentials of a Good School of Nursing, it assumes that the school should be able to command such financial, clinical, and other facilities as may be required to put the entire program on a definitely educational basis. This would necessitate employment by the hospital of enough graduate nurses and other personnel to release students from work not educationally profitable.

In planning the details of the curriculum, the two criteria of social values and learning values have been constantly kept in mind. The Committee believes that every course must be constructed in terms of its contribution to the welfare of society, and also in terms of the capacities and learning needs of the student. The suggestion is made that the preclinical period be extended to eight months in order that more basic elements may be presented on which to build the clinical experience of the two subsequent years. If this were done and more time were devoted to group conferences and individual instruction on the ward during the clinical years, the amount of theory would be raised from the present level to from 1,200 to 1,400 hours.

The Committee has achieved two aims in the course of study designed that are consistent with similar trends in other professional education: it has enriched the content of the curriculum by not only increasing the amount of time devoted to the biological and physical sciences but by adding a substantial amount of material from the social sciences; and it has arranged the subject material in fewer and larger divisions than formerly so that courses may be presented from the functional point of view. The first of the four main groups of subjects is that of the biological and physical sciences, which include anatomy and physiology, microbiology, and chemistry. To these the Committee recommends that 20 per cent of the total number of curriculum hours be devoted. In the second group, the social sciences, which are designed to occupy 15 per cent of the time, are listed psychology, sociology, history of nursing, professional adjustments of the graduate nurse, ethics of nursing, and seminars on social and on professional problems. The medical sciences, that constitute the third division, have been divided into the introduction to medical science, materia medica, and the medical content of the various clinical courses. Twenty-five per cent of the curriculum hours are allotted to them. Most of the work in these three divisions is planned for the first year.

Finally to the fourth group, named nursing and allied arts, 40 per cent of the time is given. This block of subjects is introduced by a course on nursing as health conservation, followed by a second introductory course on nursing the sick. These two courses, together with nutrition and cookery, diet therapy, and a course in general medical and surgical nursing, constitute that portion of the work of the fourth group which falls within the first year. The second and third years are devoted largely to clinical courses, including instruction and experience in medical and surgical specialties, obstetrical, pediatric, and psychiatric nursing. Toward the end of training, a course of eight weeks in nursing and health service in the family is
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recommended, as is a course in advanced medical and surgical nursing and certain electives. 1

Throughout the curriculum the Committee has made an attempt to relieve rigidity, for it is convinced that professional training must become more flexible if women are to be prepared for all types of nursing service and are to be qualified to view nursing in broad perspective as an integral part of constructive health service.

NEEDED MEANS FOR CONTROLLING STANDARDS

Many persons, both among nurses and laymen, believe that further steps must be initiated if nursing is to become a profession capable of taking its place by the side of other groups that have long worked for greater social welfare. When they consider the present status of a large proportion of the more than 1,400 schools of nursing, they are convinced that neither the public nor the nursing group will be protected from deleterious influences until some form of control is exerted over weak schools of nursing. They suggest, therefore, that there should be a national body whose tasks would be the formulation of standards that might be applied in accrediting schools, the preparation of an index of those institutions that could meet such standards, and the keeping of the index up to date. Society has seen the salutary effect of the closing of many inefficient medical schools and the immediate improvement of numerous others, once it was found that weak institutions were unable to win the approval of the American Medical Association and the support of state boards of examiners. Hence, many persons assume that a widely publicized and staunchly supported agency for accrediting schools of nursing would bring to an end, or else would greatly strengthen, those institutions that are not educationally effective. An index of approved schools would also be of great usefulness to prospective students, who at present have no official source of information upon which to depend other than the long lists of names of institutions that are registered by the various state boards of examiners.

Those interested in the future of nursing further suggest that more adequate legislation should be enacted and enforced, state by state, for regulating minimum requirements for admission to schools of nursing, and for conferring the diploma and the certificate of registration. Such legislation as exists at present is frequently fragmentary, outworn, and poorly executed. Licensing examinations are often so lax that they do little to test the applicant's ability and preparation for becoming a nurse. By more exigent state control the poorer schools would be obliged to keep above the lower margin or else close their doors; others would be made to function with greater efficiency; and society would be better protected from poorly educated and incompetent nurses.

Finally, many believe that if a national council of state boards of nursing examiners were established (under this or some similar name), it might prove as successful in
raising the general tone of nursing examinations for registration as the comparable associations in the professions of medicine, law, and engineering have been. Since the federal government is unable to exert much control over professional groups, voluntary bodies organized on a national basis seem to be the only medium for achieving some degree of uniformity among the various states. A national council of nursing examiners would provide opportunity for the working out of types of examinations carefully devised to test ability and preparation for the various forms of nursing service. It would permit exchange of ideas and the development of guiding principles for the constituent state boards. Most important of all, it might lead to the evolving of more uniform requirements of nursing education, and to the harmonizing of the laws and licensure regulations of the several states.