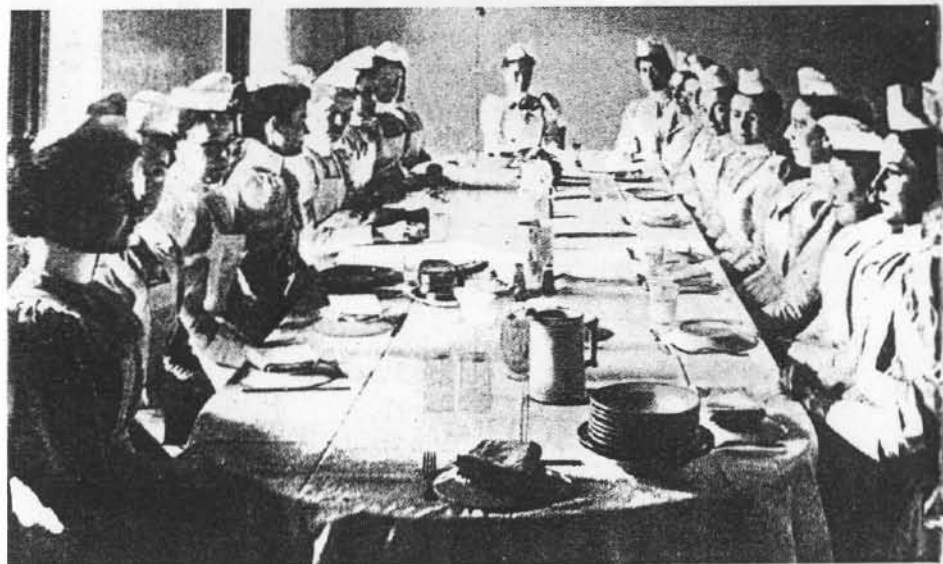
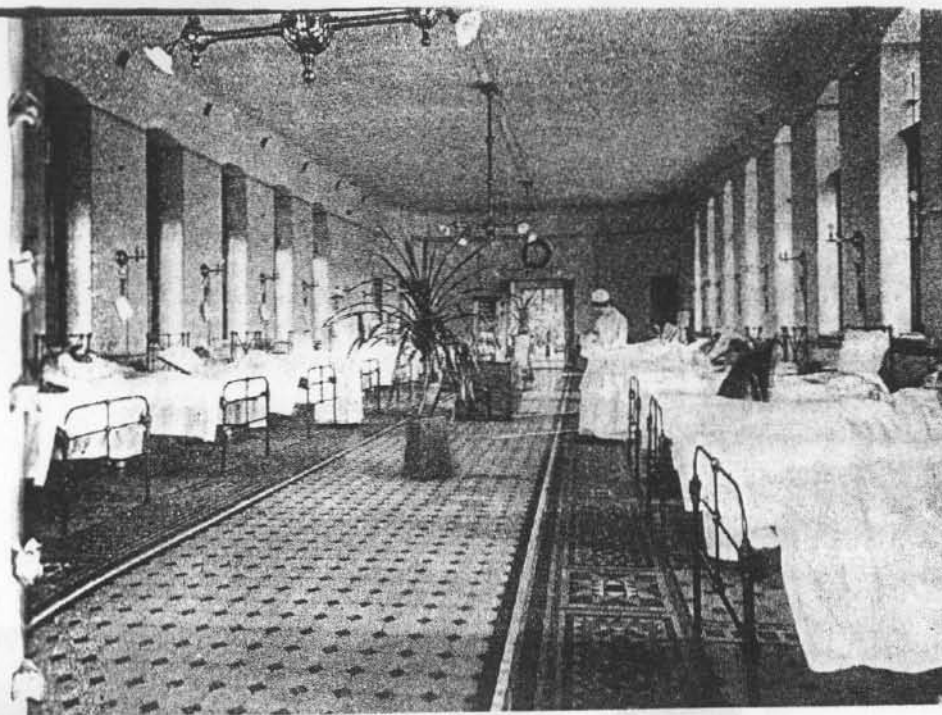


PROFESSIONAL nursing today is one of the largest professions in the United States, numbering some 850,000 active R.N.s in 1975. (American Nurses' Association, 1974) Nursing did not attain its present stature overnight. It grew slowly from small beginnings, dating from the earliest training schools in 1873. And back of these beginnings lies a history in the Old World, a history involving centuries of a checkered, unplanned process.

The Old World heritage was not so apparent in colonial times, when on this side of the Atlantic the amateur, personal, small-scale nursing and doctoring by well-meaning family and friends seem to have been superior to the practices in the great English municipal hospitals, where the poor, the insane, and the sick were brought together and where the manners and morals of the nurses were proverbially corrupt. In contrast, in Europe, the religious sisterhoods and deaconess



Slaves, Servants, or Saints?

(An Analysis of the System of
Nurse Training in the United States,
1873-1948)

By Beatrice J. and Philip A. Kalisch

societies trained their own people for service in their own institutions and turned this training to good account in time of war and in mission fields. However, the modern, systematic effort to train professional nurses dates no further back than the Crimean War, 1854-1855. The idea for such training took shape in the mind of Florence Nightingale. Defying all military restrictions and official obstructions, Miss Nightingale fought a good fight for wounded Englishmen in alien lands. She thus earned for herself the gratitude of the English nation, which found expression in the establishment of the great St. Thomas' Hospital School for Nurses, in London.

In 1861, at the outbreak of the Civil War, American women woke up to a knowledge of their responsibilities and opportunities. During the war years more than two thousand women were busy nursing the sick and wounded soldiers, organizing and superintending hospitals and, under the auspices of the Sanitary Commission, working in extemporized ambulance hospitals in the rear of armies. When the war was over, many of these women, who for four or five years had been forced to recognize the value of their own work and had developed genuine ability for organization, were not willing to fold their hands and let the old order re-establish itself. Out of this intelligent unrest grew the New York State Charities Aid Association, which, in 1873, opened the first nursing school under the modern, or "Nightingale" system in Bellevue Hospital in New York City, then a dirty, distracting place, with the nursing done by convicts detailed from Ward's Island. In the same year, nurse training schools were established in New Haven and Boston.

The rapid growth of hospitals following the Civil War was associated with increasing urbanism. From 1860 to 1920, towns and cities sprouted up all over the United States. The

city, with its concentrated population, new wealth, and numerous poor, offered churches, religious orders, and enterprising doctors a magnificent challenge to found general hospitals. And these groups looked for the sure thing, for opportunities to minimize costs and maximize service. The hospital administrator who could keep the books in the black and transfer a healthy surplus to the building fund became an important and powerful figure.

With this breed, backed by local trustees and physicians, came a train of evils which preoccupied the minds of perceptive nurses and humanitarians: the absolutely free use of the hospital by the physicians, the creation of so-called nurse training schools for staffing, sweat labor policies for the student nurses and other service workers, the frequent denial of care to those who could not pay, and a righteous disdain for tapping the public treasury. In short, a complete system of insensitive health care delivery perpetuated injustice to hospital workers while falling far short of providing essential services to the communities. Despite the faults of the system, across the nation the lamps of new nurses' homes were lighting up. (Hampton, 1893)

The Development of Nursing Schools

To prepare women to serve the ostensible and latent nursing needs of the population, there was developed in the United States in the latter part of the nineteenth century, and strengthened and intensified in the early twentieth, a very peculiar educational system. It involved the instruction and training of upper lower-class girls by hospital nurses in the mysteries of ministering to the sick and in the wisdom of dedication to the Nightingale calling through the hard labor of learning by doing during three years of diligent, dreary

practice and work on hospital wards. Also required was sexual and peer group segregation in an isolated "nurses' home," submission to strict regulations, conformity to a series of severe and not easily comprehended taboos, a regimen of physical exercise, a Spartan diet, severe routinized discipline, regular moral and often religious exhortation — all devised to produce qualities of "helping," caring," and "passivity." Upon graduation, the young woman was ready for marriage or private duty nursing, since the bulk of hospital labor was carried on by the students.

This singular process of training makes sense only if one recognizes it for what it was: a system to supply the nation's hospitals with three years of cheap labor. The student nurse paid no tuition and in most instances received a salary of from 10 to 12 dollars per month plus maintenance as compared with 96 dollars per month paid to a graduate nurse. (Burgess, 1928) For many years student nurses constituted, almost exclusively, the hospital bedside nursing force. Indeed, even in the late 1920s it was estimated that not a single graduate nurse was employed as a general staff, or general duty, nurse in 73 percent of hospitals with nursing schools.

To the planners of hospitals it was doubtful whether a successful small hospital could be developed without a training school for nurses. This was not simply because the training school had proved to be the most economical way of getting nursing done, but because it was supposedly impossible to create the desired atmosphere if a number of graduates of different schools were employed. Each graduate nurse would come with habits firmly fixed by her hospital traditions and ideas of service. Under these conditions, according to the experts, real harmony of spirit among nurses from different schools would be out of the question, and the

home atmosphere that was the chief attraction of the small hospital would become an impossibility. (Aikens, 1908) By 1904, of the 1,484 hospitals in the country, 867 maintained schools of nursing which had a total enrollment of 21,844 students.

Since most hospital nursing was done by the student nurses, there developed one of those vicious circles that so often occur in economic life. Physicians sent their patients to hospitals. The hospitals built new wings to accommodate the new patients and enlarged the entering classes of student nurses to provide nursing for the additional beds. Shortly thereafter the number of graduates from their schools increased phenomenally.

According to the 1901 U.S. Bureau of Education Annual Report, between 1888 and 1898 the percentage increase in several professions was: nursing, 706 percent; dentistry, 327 percent; law, 217 percent; medicine, 79 percent; pharmacy, 36 percent; theology, 28 percent and veterinary medicine, 1 percent. It was inevitable that the expanding number of graduate nurses found fewer and fewer patients available for private duty nursing care because the patients were increasingly going into the hospitals and being cared for by students. In short, a system was put into effect which no group could afford to take the responsibility to disrupt. (U.S. Bureau of Education, 1906)

THE STUDENT'S LIFE

During the three years of hospital work the student nurse was generally, by day and by night, on Sundays and on holidays, considered the property of the hospital. The hospital seemed to take special care to exact payment of tribute to the uttermost farthing. Should a student nurse fall ill of typhoid

fever contracted while nursing in the wards, she would be allowed to graduate with her class provided her illness was not too long, but afterward she would have to serve the hospital until she had paid up to the last moment for her absence from service. No other apprenticeship, in trade or in art, could compare in severity and bondage with that of the student nurse.

The systematic hospital socialization of student nurses may best be understood as a concern about authority, power, and control. Supervised by a trusted director of nurses and surrounded by a tight wall of security, the school was expected to provide a plentiful supply of female nurses — respectful, obedient, cheerful, submissive, hard-working, loyal, pacific, and religious. A student's potential for developing these traits was evaluated during a probationary period of several months. Any nurse probationer who showed a tendency to shirk distasteful tasks was unquestionably declared "unfit." Perhaps the most difficult problem came when a girl during her probation had proved herself as promising and "worthwhile" and then, after being accepted as a full-fledged student, unexpectedly developed qualities which made it desirable to get rid of her. It might be that she grumbled at the least extra duty, or questioned the rules, or developed a too familiar attitude when dealing with men, or that her records were untrustworthy, or she could not get along in any place she was assigned to, or she talked too much, or openly criticized the doctors and head nurses. After a word of warning, such a girl would quickly be dismissed as a "troublemaker." (Twitchell, 1903; Aikens, 1914)

Most hospitals compelled the student to serve a term of three years, and some required four years of servitude. In 1896, the hours a student spent on duty in the wards varied

from 8 to 15 per day. In the majority of hospitals the student nurses were on duty for 10½ hours daily for six and one-half days of every week; many hospitals exacted 13, 14, or 15 hours of service daily in addition to scheduling one or two classes a week, which were supposedly addressed to the theory of nursing. The explanation of the origin of the preposterously long hours of service was that provision had not been made for a sufficient number of student nurses. (Nutting, 1896) Such attempts at economy in hospital administration were, of course, injurious to the patients as well as to the students.

A woman who worked extremely hard physically over eight hours a day was in no mental condition to profit to any extent by class instruction or lectures, and it was very questionable if a woman working 10, 11, 12, or more hours a day for three years would be equal to really good work during the third year, even if her health apparently held out to the end of that time. Able-bodied laboring men, by the late 1890's were advocating a working day consisting of eight hours. If this was a reasonable demand, then hospitals were surely not justified in putting a harder task upon student nurses, who were not only on their feet during the greater part of their time, but were subjected to a constant tax upon their patience and temper, as well as being burdened with no little mental anxiety and responsibility. One student nurse testified:

I certainly cannot stand this much longer. I fainted last night for the first time in my life. Miss Gray said I must have eaten something that didn't agree with me, and seemed to feel very much injured by my thoughtless action. She was greatly relieved when she found that I soon recovered sufficiently to continue on duty. I could stand the loss of sleep at night all right if I did not have to work so extremely hard. I think it a shame to have so few nurses on duty at night,

when the work is the most trying. It oughtn't to be necessary to break down one's health in order to become a graduate nurse, but that is what it amounts to. ("Extracts from the Journal of a Pupil Nurse," 1908)

Since the hospital recognized that only healthy young women would be able to do the strenuous work required of them, at the time of entrance, the students were given health examinations; the unfit were eliminated, and only the physically fit were admitted to the school. Theoretically, the health training given the student, together with the technique for avoiding infection, should have placed the student in a good situation to avoid infection. However, administrators in schools of nursing knew that not only did the health of the average student fail to improve during the years spent in the hospital but, on the contrary, it actually tended to deteriorate (Titus, 1922) and the illness among student nurses greatly exceeded the illness of other young women who worked for their living. Said a graduate nurse of eight years' standing, "Doctor, there must be something wrong in the system which takes young women who are sound and healthy at the commencement of their training and graduates them three years later mostly wrecks." (McMillan, 1907)

It was a well-known fact that the majority of students who entered schools of nursing with negative results from tuberculin tests would, if the hospital admitted patients with tuberculosis, have positive tuberculin results when they finished their training. In the average general hospital with a tuberculosis service, approximately 80 percent of the student group graduated with positive tuberculin. Two investigators found that the frequency with which tuberculosis infections were contracted by student nurses in three general hospitals in Minnesota was five times as great as the frequency among

girls who were attending a college of education in the same communities. (Harrington et al., 1935)

In the October, 1913 *Ladies' Home Journal*, the editor published a scathing criticism about the scandalous way in which hospitals fed their student nurses. The editor noted that hospital superintendents were voicing complaints that not only was the number of applicants for training as professional nurses materially decreasing, but the personal standards of those who did apply were considerably lower than formerly. But how could hospitals expect "women of better education and finer feelings" to come to a place where they would be "asked to sit down to rations of a kind and quality only a remove better than what we might place before a beggar?" The way the nurses at the average hospital were fed, or rather underfed, "was nothing short of an outrage upon womanhood." And this outrageous fact applied to seven out of every ten hospitals. Indeed it was a common remark among resident doctors in hospitals that "they would not stand the stuff that is put before the nurses to eat." There was not "one scintilla of doubt that if those nurses were men the present order of things would soon change by compulsion," concluded the *Trained Nurse and Hospital Review* journal editor. ("Are Nurses in Hospitals Underfed?", 1913) Little complaint about food came from the student nurses, however, as such would be ground for expulsion.

All social intercourse with the resident medical staff was prohibited in most of the training schools, and the reasons given were many and amusing. Some said it was for "disciplinary reasons," others "professional," another "familiarity," yet another "morality" (whose, was not specified), and several naively stated, "The nurses would lose respect for the doctors." These answers ignored the fact that the student

nurses took over practically all care of male patients, with the exception of catheterization. (Kefauver, 1920)

THE "EDUCATION"

On the whole, educational standards did not conform even to those set for high schools, which is not surprising considering the fact that nursing schools were found to provide hospital service, not to educate for a profession. Much of the work required of the probationer was distinctly not nursing. Although she entered a hospital to be taught the intelligent care of the sick, in many hospitals she was instead set to do the work of a chamber or kitchen maid. She dusted, she scrubbed floors, she washed dishes. In short, she did all sorts of menial tasks for which hospitals that did not operate schools of nursing employed ward maids, attendants, and orderlies. Nor did this emphasis on housekeeping duties end with the probationary period. One student nurse secretly complained in her diary:

We are shown one certain way of performing each duty, and woe betide her who fails to adhere to the accepted method. To say that any tendency to experiment and find another, perhaps a better, way of doing things is distinctly discouraged is putting it mildly, very mildly, indeed. The elaborate procedure followed in the making of beds is a fair sample of the rigid attention to trifling details exacted in the performance of all hospital duties. The sheets must be placed just so, with their hemmed ends turned one certain way; the blankets likewise must be placed with great exactness, not a tenth of an inch further down on one side than the other; the white coverlet must be laid with geometrical precision, its end being turned and folded in a very special way, while the pillows are shaken up and beaten down and flattened out and smoothed until they resemble padded

boards. Finally one padded board is laid flat at the head of the bed and the other made to assume a bolt upright sentinel-like position on top of it. ("Excerpts from the Diary of a Pupil Nurse," 1909)

The private opinion of this student was that as long as the patients were clean and comfortable, it was not a matter of tremendous importance which hem, broad and narrow, happened to be tucked under the head of the mattress, or whether the end of a white coverlet was a sixteenth of an inch lower or a full quarter of an inch higher than the prescribed line.

Hospitals made few attempts to nurse patients scientifically, and little effort was made to teach nursing as a science. In most schools of nursing the "education" consisted of 95 percent service and less than 5 percent instruction in theory. Despite this mix, physicians of the early 1900s constantly complained that nurses were overtrained. For example, the New York Academy of Medicine, was well filled on the evening of March 29, 1906, with an audience of physicians and nurses. With one exception the speakers voiced the opinion that the trained nurses of the day were overtrained and that there was too much theory in their training and too little of practice. (Thompson, 1906; "The Training of the Nurse," 1906)

Much of the public seemed to agree with the physicians on the matter. For example, an editorial in the *New York Evening Sun* of March 3, 1906, maintained:

Nurses nowadays are instructed in a great variety of topics, and it is a question whether the smattering of knowledge they acquire is not often more mischievous than useful. Some of them are too apt to think that their position entitles them to censure the work of the doctor and to carry out his

orders or not as they see fit. Thus we have known of one who persuaded her patient that his surgeon was incompetent in having failed to remove some catgut sutures from a wound at the proper time; another, in a public hospital, who ignored the house physician's prescription of a narcotic in the case of a boy on the ground that "it was a shame to expose him to the danger of acquiring a drug habit."

What we want in nurses is less theory and more practice. The place of the nurse is an honorable one, and every candid physician is glad to acknowledge that the successful issue in many cases, such as pneumonia and so on, depends at least as much on her services as on his. But to stuff her head with scraps of knowledge about a number of subjects which do not concern her duties at all would surely be foolish. A thoroughly trained nurse is indispensable. An overtrained and "learned" nurse is apt to be a nuisance.

FIRST PROFESSIONAL ORGANIZATIONS

To protect the public and the educated nurse against the badly trained woman and to establish a uniform standard of education, individual superintendents could at first do little until unity among nurses as a body had been effected and the need for reform and improvement had been generally recognized. An opportunity was seized when among the many congresses held in Chicago during the World's Fair there was one held for trained nurses, working as a subsection of the hospital section of the Congress of the Associated Charities. This was the first time in the history of nursing in America that nurses had come together as members of the same profession. The most important result of this meeting was the organization of the American Society of Superintendents of Training Schools for Nurses. The object of this organization was to help lay a solid foundation in the schools upon which a good practical educational standard might be established, and

to further the best interests of the nursing profession by promoting fellowship among its members. (Davis, 1912)

Recognizing that any advance must come by the creation of an interest and enthusiasm in the work and in awakening an *esprit de corps* among graduates of the same school, the next step was the organization of school alumnae associations. At the end of two years more than thirty groups were organized and steps were taken to form a national association which held its first meeting as the Associated Alumnae of the United States and Canada in April, 1898. (Damer, 1904)

With the formation of this association, representing the nurses, and that of the Society of Superintendents, representing the teachers and leaders, nurses were prepared to do effective work. As the state and local associations developed and presented themselves for admission to the Associated Alumnae, it became evident that some other name must be adopted. The title, "The Nurses' Associated Alumnae of the United States," no longer adequately defined the organization. Thus in May, 1911, the name was changed to the American Nurses' Association. Similarly, when the American Society of Superintendents was organized, its active members had included superintendents and assistant superintendents only. With the development of state and local leagues, the membership was expanded. At the 1912 convention the desirability of changing the name of the society was discussed and the outcome was the adoption of the name, "National League of Nursing Education." These two organizations became a nucleus for reform from within nursing. (Colvert, 1922)

NURSE LICENSURE

Meanwhile, on another front, it was not until after the

English nurses realized the necessity of legal status that the Americans awoke to this need. Two nurses, Sophia F. Palmer of Rochester, New York, and Sylveen Nye of Buffalo, New York, took the first definite steps leading toward state registration. The first public step was probably Miss Palmer's paper read before the State Federation of Women's Clubs on November 9, 1899. As they were originally enacted, the laws of the different states, although far from being uniform, still had many points in common. All the laws provided for a period during which nurses with varying lengths of training might be registered, usually without examination, thus protecting suitable nurses who trained or practiced prior to the time of the legal enactments. (Aikens, 1910)

Two new provisions came into the nurse licensure laws later. One was a provision for the inspection and registration of training schools. Another provision was that of defining what was meant by "nurse" and "training-school," which was equivalent to restricting the use of the word "nurse" to the trained graduate, or professional woman, and gave the training school a place among educational institutions. All the laws gave the licensee the title of "Registered Nurse," with the right to use the abbreviation "R.N." The laws of state registration although faulty and not uniform, nevertheless raised the standard of the schools by weeding out the very worst and led to greater uniformity in curricula. (Perrin, 1915)

EARLY COLLEGIATE SCHOOLS

The early efforts to establish nurse training within institutions of higher education were disappointing. When the University of Texas in 1897 assumed control of the John Sealy Hospital of Galveston and established it as a university

hospital, the nursing school became one of the schools of the College of Medicine. With neither students nor faculty to meet university standards, it exerted so little leadership in nursing that credit for establishing the first university school of nursing is commonly given to the University of Minnesota. Indeed, the recognized birth of college nurse education came in March, 1909, when the University of Minnesota established a school of nursing, although it did not offer a degree program until 1919. (Beard, 1922)

Several additional schools were soon founded. Indiana University followed the Minnesota example and organized a school of nursing in 1914 as a part of its School of Medicine. It granted the B.S. degree and the diploma in nursing to students who had completed three years of preliminary education in the university and two years, four months in the School of Nursing. In 1916 two five-year programs leading to the Bachelor's degree were started, one in the University of Cincinnati in cooperation with the Cincinnati General Hospital, and one in the School of Household Arts of Teachers College, Columbia University, in cooperation with the Presbyterian Hospital School of Nursing. These five-year degree programs, which were elected by only a small number of the students, covered two years in general education which were followed by about twenty-eight months of specialized work in either teaching or public health nursing. (Pickering, 1925)

The three-year curriculums were usually offered side by side with the five-year curriculums because universities found it impossible to recruit enough five-year students to provide the affiliated hospitals with the required nursing service. What is more, for decades after, the great preponderance of students enrolled in the shorter course rather than

in the one leading to a baccalaureate degree. As a result, departments were forced to spend time and energy on instruction on the lower education level, and frequently taught students with varying amounts of preparation in the same courses.

THE CALIFORNIA EIGHT-HOUR LAW

One might have expected that the Progressive Party, which appeared on the American political scene in the early 1900s, would have adopted the reform of nursing education as one of its causes. However, although the Progressives attempted to minimize the most outrageous and indefensible exploitation of the working population, they largely bypassed the hospitals.

One notable exception to this indifference occurred in California. In 1911 the California Legislature passed the "Eight-Hour Law for Women" that limited the working hours of women employed in any mercantile, mechanical, or manufacturing establishment, laundry, hotel, or restaurant, or telegraph or telephone establishment or office, to eight hours a day for six days in the week. In 1912, a bill was proposed that would include student nurses in the eight-hour law.

Debate in the California Senate was heated as this bill was sandwiched in between layers of the "non-sale of duck bill" and impeded in its progress by every tactic known to the reactionary politicians. Senator Henry Lyon, who fathered and championed the bill, reviewed the situation in the hospitals in the state, pointing out the long hours of labor required of student nurses, the money earned by them for their institution, and the pittance, barely enough to cover the cost of uniforms and books, paid to them. He was supported by Senator Anthony Caminetti who read several letters

from prominent people, to the effect that if there was any class of young women engaged in any vocation who needed the protection of the eight-hour law it was the student nurses. He referred to the requirements of health, education, public safety, and humanitarianism, and wound up by asking if California, which was in the vanguard in humanitarian legislation, should deny student nurses the privileges it had accorded other women. (*San Francisco Chronicle*, 1914; *San Francisco Examiner*, 1914) Physicians, in general, were opposed to the bill. As Dr. Antonio D. Young wrote in "The Nurse's Duty to Herself": "The element of sacrifice is always present in true service. The service that costs no pang, no sacrifice, is without virtue, and usually without value." (Young, 1913)

Nurses were divided in their opinion. A reform nurse, Lavinia Dock, argued: "I think nurses should stand together solidly and resist the dictation of the medical profession in this as in all other things. Many M.D.'s have a purely commercial spirit toward nurses (have private hospitals of their own, etc.) and would readily overwork them." She added: "If necessary, do not hesitate to make alliance with the labor vote, for organized labor has quite as much of an 'ideal' as the M.D.'s have, if not more." (Dock, 1913) On the other hand, the idea of labor control in hospital training schools was repugnant to most graduate nurses. They saw a grave danger in the entrance of labor laws into nursing and hospital affairs, for when once the wedge was entered who could tell how far it would go. The demand might be for eight hours one year, but who could guarantee that it would not be six hours the next year, and something else the year after? (Edson, 1914; Jamme, 1919)

Neither fresh ideas nor nurses who had them were welcome

where elderly, respectable matrons fingered the levers of authority, harkening only to the wishes of hospital authority figures. For example, the superintendent of nurses in one California hospital argued that nursing was a profession that called for perseverance, determination, and self-sacrifice, but how could hospital schools instill these principles in the minds of their students when the first lesson they must teach was the self-centered, eight-hour law? How could they at the command of the law turn against the principle that the patient's comfort was first and the student nurse's second? Real nursing, self-sacrificing service, could not be timed by the clock; it never had been, it never would be. Soldiers going into battle were not called to retreat because time was passing; neither should those soldiers who were fighting disease and death be told to lay down their arms and steal away because a certain hour had arrived. Surely the legislature in passing a law which was such a handicap to the education of the nurse was not looking to the reputation of the state. How did it think it possible for women trained in California to compare favorably with nurses from other states where no such menace to education existed? (Williamson, 1914)

Apparently, these negative opinions prevailed in the California nursing "establishment." When, at the time the bill was introduced, the representatives of the State Nurses' Association were asked to give their opinion on it, the following resolution was passed: "Resolved, That the California State Nurses' Association do not endorse a bill including nurses under the Eight-Hour Law for Women." (Williamson, 1914)

Despite the opposition, the bill finally passed with a vote of thirty-two ayes and no noes. But arguments against such legislation continued as is illustrated by the following extract from the published letter of a superintendent of nurses:

The eight-hour law is still a heavy burden, really the most cruel thing they have ever done in the nursing profession; I don't know when it is going to end. Patients are complaining, head nurses work day and night doing the student nurses' work, while the latter are constantly grumbling and in a state of discontent at not getting all the experience they should have; that is, the conscientious ones, while the others are running round, attending picture shows, theatres, etc., tiring themselves out before they begin their work. One shift of nurses does not put in an appearance till 3:30 P.M. daily, so you can imagine how much experience they lose. They come on duty tired out with being out all day, and not fit for work. I am trying to arrange some rule whereby I can keep them all in for two hours of their time each day to study, but as they are all off at different hours it is almost impossible to arrange unless I give up my whole time, and I cannot devote that to looking after the nurse off duty, when those on duty require so much attention. I worked out a system of instruction — it worked beautifully, but the eight-hour law has smashed it all up, crippled us, for every time a head nurse wants to teach a student anything she is off duty, and I have to form classes at night to give instruction that should be learned in the wards. The patients also complain of the constant change of nurses — the doctors, also, as orders are frequently overlooked or not properly attended to. We cannot keep a nurse on half-an-hour longer today and make it up to her tomorrow, even if it is in the middle of an operation or obstetric case she must drop everything and go.

. . . The eight hours has compelled us to increase the number of nurses three-fold, which also means more head nurses, maids, cooks, waiters, etc., etc. ("The Eight-Hour Day for Nurses," 1914)

From the California hospital administrator's viewpoint there was little to be said in favor of the law. There was a larger payroll and a larger staff to house, and as more nurses

were required to supplement the work of the students, operating expenses increased. After passage of the law, these expenses were offset in the private institutions by an increase in the rates and in the endowed institutions by a decrease in the charitable work that was being done; in the public institution the increased expense fell on the taxpayer. (Pahl, 1915) A more limited training was the unfortunate lot of the student nurse. Some hospitals abolished their training schools, which perhaps was not such a calamity in several instances. Other hospital schools gave up their affiliations, on the grounds that they had only enough students to care for their own patients and therefore could not spare them for experience in other institutions. (Williamson, 1914) This abridgment of experience was a detriment to many training schools that really needed the special opportunities for learning impossible to obtain in most general hospitals. All in all, reports of the experience with the eight-hour law in California did little to encourage other states to follow suit.

THE ARMY SCHOOL OF NURSING

Despite the imperfections of the established nurse training systems, when the United States faced a shortage of nurses during World War I, the War Department opened an Army School of Nursing with branches at all major camps. There the students were put to work in camp hospitals and rendered notable service during the influenza epidemic of 1918-1919. Advances were made in the Army School of Nursing by an increase in the period of classroom instruction and a decrease in the amount of ward service. What is more, girls of a distinctly higher class were attracted to the school by its patriotic appeal. (Goodrich, 1919)

After the Armistice in November, 1918, the war-engen-

dered nurse situation changed. The leadership of the reform forces was no longer as dynamic as it had been, and again it was demonstrated that the responsibility of attempting change carried with it the necessity of making enemies among the physician and hospital administrator groups. Organized nursing was in a debilitated public position. Excess wartime enrollment in schools, particularly the weaker ones, had produced thousands of graduates who were glutting the market for private duty nursing.

THE GOLDMARK STUDY

In 1919, the Rockefeller Foundation appointed a Committee to Study Nursing Education with the view of developing a program for further study and a recommendation for future procedure. This committee placed the actual conduct of its investigation in the hands of Josephine Goldmark, who was assisted in the survey by both lay and nurse investigators. This group studied graduate nurses as they were functioning in the various fields — public health, private duty, and institutional — as well as the schools in which nurses were being prepared.

The Goldmark report, which was published in 1923, observed that the major services in most general hospitals — medical, surgical, obstetric, pediatric, and communicable — were staffed by students who too often had had no instruction about the diseases or conditions of patients committed to their care except that which was given by the practical instructor in teaching nursing procedures. The student nurses, after their preliminary period of four months, were usually assigned to either medical or surgical patients, so that it was obviously important that the medical and surgical lectures be given during this period. Yet in 75 percent of the small and

medium-sized hospitals the students received instruction in medical and surgical conditions in the second and third year. They were assigned to night duty after only six months. They cared for critically ill patients both in the daytime and at night without adequate teaching or supervision.

Too often the pressure of getting the work done removed any possibility of either good teaching or good supervision. It was also determined that in most schools:

- The sciences and the theory and the practice of nursing were frequently being taught by unprepared instructors in poorly equipped basement classrooms.
- Hospitals controlled the total teaching hours and, in so doing, reduced the ground covered to the barest outline or even omitted some subjects entirely.
- Lectures were often given to students at night after a day of hard work.
- The student's practical experience was usually limited to those services which were found in the hospital. The student learned to nurse only those patients for whom the hospital cared.
- The practical experience might be under the direction and guidance of graduate nurses who had neither preparation nor time to teach.

The report emphasized that the training of nurses was the only professional education that had not progressed to an ordered educational scheme but was a survival of the outworn method of medieval apprenticeship training. The Committee made many recommendations to schools of nursing, pointing out the obvious defects and urging them to improve standards and methods of teaching so that nurses might be given an adequate basic clinical training which would fit them

to grow progressively in their professional careers. (Goldmark, 1923) Despite the major criticisms, on the whole the Goldmark Report was based on a gradualistic approach to the problems of nursing.

THE COMMITTEE ON GRADING OF NURSING SCHOOLS

Close on the heels of the Goldmark study came the Committee on the Grading of Nursing Schools. This committee had its origin in two separate movements. One was an attempt by members of the medical profession to study the education and employment of nurses in order to arrive at methods for improving the nursing service available to them. The other movement, which apparently began even earlier and was initiated by the nursing profession itself, also contemplated the study of nursing education and specifically stressed the importance of grading the schools. These two rather different approaches to the nursing problem eventually led to an amalgamation of forces and to the formation of the Committee on the Grading of Nursing Schools. The Committee was organized with two representatives each from the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing, and one representative with one alternate each from the American Medical Association, the American College of Surgeons, the American Hospital Association, and the American Public Health Association. The work of the group was coordinated by May Ayres Burgess.

In the fall of 1926, the Committee adopted a five-year program, covering three types of study: an inquiry into the supply of and demand for graduate nurses, a job analysis of what nurses did and how they might be taught, and the grading of schools of nursing. The supply-and-demand study was

carried through practically as scheduled and resulted in the publication of the book, *Nurses, Patients, and Pocketbooks*. (Burgess, 1928) The study showed, among other things, that there was, numerically, an oversupply of graduate nurses, and this oversupply was increasing much faster than was the general population. What is more, since nurses congregated in cities, their geographic distribution was very uneven. Unemployment among graduate nurses was both serious and chronic. The annual earnings, especially for private duty nurses, were woefully inadequate. Educational standards were low. Nurses avoided taking, and were often unprepared to take, many different types of cases for which skill in nursing was needed. Although, in general, physicians and patients were pleased with their nurses and nurses were happy in their work, there remained a substantial proportion of nurses who were not rendering satisfactory service and an even larger proportion of nurses who were chronically unhappy because of the inadequacy of their training or the conditions under which they worked.

In a second report (Committee on the Grading of Nursing Schools, 1930) it was brought out that of 1,389 schools reporting to the Grading Committee, only 112 indicated that all their students were high school graduates. In half of the nursing schools in this country one out of every three students had been admitted to training without having finished high school, and in some schools every student was not a high school graduate. This report also included the finding that many schools were so small that they could not possibly hope to give adequate instruction. There were 60 schools in which the entire student body numbered 9 or less, and a little over 300 schools in which the entire student body was composed of 19 or fewer individuals. Not only were many of the schools

too small to make adequate instruction feasible, but all too frequently the hospitals themselves were too small to be adequate teaching centers. There were 73 schools conducted by hospitals which had a daily average of not more than 19 patients.

There were few adequately financed hospitals. First consideration was rarely given to the nursing school by either the hospital superintendent or the hospital board, which was usually ignorant concerning the needs or function of a school of nursing. When the hospital was compelled to budget for nursing education the inevitable happened: the school of nursing received a minimum allotment since the board of directors usually agreed to expenditures that showed in tangible assets, such as buildings and equipment.

A cost study undertaken by the Grading Committee sought to determine whether hospitals would gain money or lose money if the schools were given up. Of 208 participating hospitals, 37, or 18 percent, reported that they would save money if they gave up their schools; 171, or 82 percent, reported that they would lose money. As for amounts, two hospitals reported that they would gain respectively, \$306 and \$209 a year per patient by giving up their schools; two others claimed that they would lose, respectively, \$454 and \$525 per patient. The cause of these discrepancies was due apparently to the wide differences in replacement estimates. The cost study of the Grading Committee, as well as earlier studies, showed plainly that the hour-for-hour service value of the student nurse as compared with the graduate nurse was still to be determined, and that in practically all hospitals students were performing tasks of a non-nursing nature. For example, one hospital would substitute two graduate nurses and one maid for every ten students. This replacement sug-

gested that roughly two-thirds of the student's time was spent in nursing and one-third in maid's work. (Burgess, 1932)

In the early 1930s, Phoebe Gordon, of the University of Minnesota School of Nursing, made several interesting studies on comparative nursing service costs: (1) under the then-prevailing system, (2) under a system providing for payment to students according to the hourly rate, and (3) under a system of all-graduate nurse service. The results of these studies indicated that the then-current system was least expensive (hospital with 30 graduates and 130 students: cost, \$84,382); that with a system of hourly charge for student service the cost to the hospital increased \$15,000; that the substitution of graduate nurses for students almost doubled the cost of the nursing service (\$167,977). (Gordon, 1930; Thompson and Gordon, 1931)

Against these findings hospital administrators argued that schools of nursing and the nursing care of patients accounted for the high cost of hospitalization. According to Bert Caldwell, the executive director of the American Hospital Association, part of the cost of hospitalization was the result of expenses incurred by training a student nurse over a three-year period at a cost of \$2,000; the student returned only \$1,000 to the hospital in the work she performed. Student nurses gave approximately 7,000 hours of service to the hospital during their three-year course. If these hours of service were worth only \$1,000 to the hospital, then student nurses were indeed cheap labor, for the hospital credited their contribution at the rate of 14 cents an hour. (*St. Paul Dispatch*, 1937; Rorem, 1933)

The logical people to provide nursing care in a hospital were graduate nurses. A registered nurse could obviously do more skillful nursing than a student. She had better judgment

and was better prepared to adapt procedures to the individual patient according to his needs. Her training and her experience made her familiar with the various changing clinical pictures of diseases. A graduate nurse staff assured the patient of competent, safe nursing care. Hospitals might argue that a student group provided a service as good or nearly as good as a graduate nurse service, but if semi-trained students were as well qualified for general duty nursing as were graduate nurses, there was little value in the three-year course in nursing education. ("Graduate versus Students," 1933)

There has been nothing stranger in the entire history of American nursing than the attitudes which developed, both by the employer and the employee, towards the use of the general staff, or general duty, nurse. When the Grading Committee asked 500 directors of nurses: "If you had your choice, which would you rather have to take care of your patients — student nurses or graduate nurses?" 76 percent replied emphatically that they would prefer student nurses and only 24 percent voted for graduate nurses. That this preference was not theoretical was made evident in the disclosure that 73 percent of the reporting schools had no general staff, or general duty nurses, 5 percent had one general staff nurse, 4 percent had 2 general staff nurses, 3 percent had 3, and 15 percent 4 plus. However, in the upper 15 percent group, one school with 388 students employed 90 general staff nurses, and another with 230 students, 80 graduates. The chief reasons offered against the use of graduate nurses were difficulties of discipline, extravagance in the use of supplies, lack of familiarity with methods and routines of the particular hospital, the fact that they were "here today and gone tomorrow," their resentment of criticism, and the increased costs to the hospital. (National League of Nursing Education, 1933)

Perhaps the best approach to humanizing the situation described by the Grading Committee is to try to perceive something of the role of the student nurse in the social structure and functioning of hospitals. If you were a 19-year-old, first-year student nurse in a general hospital in 1932, you would be providing 7,095 hours of service over the next three years. In general you would not be paying any tuition, but in return for your labor, you would receive room and board and 631 class hours of instruction in nursing subject matter offered by the graduate nurses and physician lecturers. Unlike students in colleges and universities, you would not receive the basis for a real education. You would dislike much about the work. Your great complaint would be the constant fatigue accompanying your every move. You might privately complain about classes being held in the evenings after an exhausting day's work. You would be one cog in a vast, authoritarian labor system, made up of some 85,000 other students in 1,800 hospitals across the nation. (Committee on the Grading of Nursing Schools, 1933)

The findings of the Grading Committee added very little to what the nursing profession had long been pointing out, but it did furnish a factual basis which strengthened the arguments for reform. However, the Committee was not concerned with publicly exposing scandalous nursing conditions in the hospitals and therefore did not make public the grades it assigned to the schools. Bad training schools, in the Committee's opinion, would change their practices once a confidential appraisal based totally on a paper survey was communicated to them.

The Committee identified four tasks that needed to be accomplished to effect improvement.

- *To reduce and improve the supply of nurses.* To make an immediate reduction in the number of students admitted to schools of nursing in the United States, and to raise entrance requirements high enough so that only properly qualified women would be admitted to the profession.
- *To replace students with graduates.* To put the major part of hospital bedside nursing in the hands of graduate nurses and take it out of the hands of student nurses.
- *To help hospitals meet costs of graduate nurse service.* To assist hospitals in securing funds for the employment of graduate nurses, and to improve the quality of graduate nursing so that hospitals would desire to have it.
- *To get public support for nursing education.* To place schools of nursing under the direction of nurse educators instead of hospital administrators, and to awaken the public to the fact that if society wants good nursing it must pay the cost of educating nurses. Nursing education should be a public and not a private responsibility. (Burgess, 1928)

This last recommendation focused once again on the question that would continue to bedevil hospitals for the next half-century. It is in some ways the central problem of hospital care, for it is nothing less than the question of the meaning of true nursing. Is the good system of preparing nurses one which allows student exploitation to subsidize the cost of patient care? Or is it a system designed to maximize the preparation of quality nurses? Does "quality" mean the kind of quiet, submissive slave that the training schools produced in such large number, for so many years, or does it refer to a nurse who is prepared to give to each patient sensitive care based on a knowledge of his individual needs?

THE U.S. CADET NURSE CORPS

During the 1940s, American nurse training took a sharp and decisive turn. From the earliest days until World War II the federal government had ignored conditions in the training schools. A combination of circumstances was responsible for an abrupt shift.

The need for nurses rose sharply as a result of World War II. Between 1940 and 1945 the general hospitals were faced with a jump in the patient admissions rate from 74 per 1,000 population to more than 120 per 1,000, and the length of stay rose from an average of 13.7 days to 16.5 days. At the same time, the nursing schools supplied the vast majority of the 73,000 nurses in the federal services. (American Nurses' Association, 1945) Consequently, the federal government took action to increase the nurse supply through the appropriation of \$5,300,000 in 1942 and 1943 for scholarships to nursing students in basic and postgraduate programs and for nurses taking refresher courses. When this sum proved to be much too little in the face of even heavier demands, the Bolton Nurse Training Act was passed in June, 1943, under which \$161,300,000 was authorized for the development of the Cadet Nurse Corps. In addition, \$17,400,000 was made available under the National Defense Housing Act for student nurse dormitories and educational facilities. Thus, from 1942 to 1948, nursing education received federal aid in the amount of 184 million dollars. (Kalisch and Kalisch, 1974)

The Bolton Act was directed toward the recruitment of from fifty to sixty thousand student nurses annually and their preparation in an accelerated curriculum so that after nine months the value of their work with patients could be considered as two-thirds of that of a registered nurse. To achieve this goal the U.S. Public Health Service paid for the entire

education of nursing students—tuition, fees, books, uniforms, maintenance, and monthly stipends. To obtain the benefits of the U.S. Cadet Nurse Corps, a student was not required to prove actual need of funds. She did have to promise to engage in essential military or civilian nursing, however, so long as the war lasted. Candidates were to be between the ages of seventeen and thirty-five, and minimum admission requirements included good health and graduation from an accredited high school with a good scholastic record. Since during the war years almost all student nurses joined the Cadet Nurse Corps, the Act resulted in an almost complete federal subsidization of the huge classes admitted in 1943, 1944, and 1945.

The Bolton Act required that the period of nurse education be accelerated from the traditional thirty-six months to thirty months or less. In order to meet the requirements of the State Boards an additional six-month experience was thus needed. During this period, students undertook an important practice assignment either in their home school or in another civilian, military, or governmental institution. Seventy-three percent of the Senior Cadets remained in their home hospitals while the other 27 percent served in the Army, Navy, Veterans Administration, Public Health Service, Indian Service, or other civilian hospitals or public health agencies. (Kalisch and Kalisch, 1974)

To participate in the Cadet Nurse Corps program, a nursing school had to meet certain minimum requirements established by the Division of Nursing Education of the U.S. Public Health Service. Thus, another survey and evaluation of nursing education came into being. However, it differed from previous national studies in two respects.

First, although this federally sponsored program was vol-

untary in the sense that no nursing school was forced to participate in it, the school that wished to survive had a strong incentive to participate since prospective students sought admission to schools where they would have the benefit of Bolton Act funds. It was therefore not surprising that schools which in the past had refused to have anything to do with surveys of nursing education became involved in this one. In all 1,125, or 87 percent, of the 1,295 nursing schools in the country took part in this federally sponsored survey, in contrast to participation rates of 74 percent and 81 percent, respectively, in the two surveys conducted by the Committee on the Grading of Nursing Schools.

A second important difference was that whereas previous national surveys of nursing education had relied on paper reports for their data, in the Cadet Nurse Corps program each participating school was visited by a nurse consultant from the U.S. Public Health Service. This visitation from the representative of a national organization was an unprecedented experience for all but the comparatively few nursing schools that had applied for accreditation by one of the national professional nursing organizations.

The visits were made by twenty-five U.S. Public Health nurse consultants. Each visitor carefully observed at least one clinical department in the hospital, if possible with the clinical instructor or supervisor and the assistant clinical instructors or head nurses, and noted especially the appearance of the patients and the functional arrangement of patients' units, the general atmosphere in the department, the patients' records including the method of checking medications and treatments, the students' records including the method of assignment of experience, and provisions for teaching in the department. The inspection also included the

dietary unit, the teaching unit including classrooms, the laboratories, the director's supervisors', and instructors' offices, the library, the health service facilities, the residence, the dining room, and the recreational facilities. (Leone, 1972) The consultant always had a terminal conference with an appropriate official, such as the administrator of the hospital, the president of the university or college, or a member of the board of trustees. In this conference she discussed her findings, indicated in general the recommendations, and verified the data on which they were based. (Creasy, 1972)

In the worst cases, the Division of Nurse Education was forced to take aggressive action. For example, one weak school with 82 students, of which 71 were members of the Corps, was visited first in June, 1944 and again in December, and specific recommendations were made following each visit. All in all this school was characterized by inadequate nursing care of the patients, lack of cleanliness, insufficient equipment, inadequate faculty, and poor teaching facilities. On the day one consultant visited the nurses' residence, the janitors were in the process of exterminating bedbugs. (Berdan, 1973) At the second visit the consultant recommended that approval for participation in the Cadet Nurse Corps program not be extended beyond March 31, 1945, unless definite progress was made in complying with the recommendations made following the first visit. It was essential that steps be taken immediately to establish affiliation for medical and pediatric nursing for both white and black students and also for obstetric nursing experience for the black students. She recommended that no more students should be admitted until more adequate laboratories were provided for teaching the science courses, more adequately prepared clinical instructors were secured, more adequate bath and toilet facilities

were installed for the students, and a well-lighted, well-furnished library with at least a minimum number of reference books was established.

A third visit to the school in March, 1945, disclosed that nothing had been done toward making improvements. Supervision of student practice was woefully lacking. In spite of the fact that there were seventeen head nurses and supervisors on the payroll there were only two on duty on the day of the visit. In two units young students who had entered the school the previous September had complete responsibility and gave all medications and treatments. They had had no instruction in pharmacology, medical and surgical nursing, foods and nutrition, or diet therapy. The students reported concern about the lack of supervision. They said they were often alone on the wards and could find no one to relieve them when it was time for them to attend classes. They also complained about the classroom instruction. For instance, instruction in pediatrics and neurology was started in September, 1944, but because the doctors so often missed their classes they were still having these classes in March, 1945. The students said it was very difficult to keep up with the content of the course when it was taught so irregularly.

During the next four months the discontinuance of the school from the Cadet Nurse Corps received considerable publicity in the local press. Many changes were made in the administration of the hospital and the nursing school, and both the hospital and the residence were remodeled and re-decorated. In August, 1945, another visit was made by a consultant to determine whether the school had made sufficient progress to be re-approved for participation in the Cadet Nurse Corps program. In view of the progress made and the plans for the future, the school was re-approved for partici-

pation in the program. (Cadet Nurse Corps Files, RG235, 1945)

The experience of this school demonstrates one important facet of the Cadet Nurse Corps program: the strong incentive that the weak nursing schools had to improve to the point where they could qualify for participation in the program. Moreover, it illustrates the advantage of site visits over paper-and-pencil investigations in identifying the real causes of deficiencies and in providing face-to-face assistance in the correction of these deficiencies. Although the Cadet Nurse Corps program was established primarily to expand the quantity of nursing service personnel, it also became a force in improving both nursing education and nursing service throughout the country.

Frequently, the consultants drew attention to long-standing deficiencies that had gone uncorrected for years. For example, in one school an elderly lady with no advanced preparation for her position had been the director of nursing for fifteen years. She was very discouraged over conditions existing in the school, especially the excessive amount of time the students worked on the wards each week and the inadequacy of the teaching personnel as to both number and preparation. The hospital administrator had been in his position for three years. He was interested in the consultant's visit and accompanied her in her tour of the hospital. He was extremely critical of the USPHS Division of Nurse Education policy of directing all correspondence to the director of the school since, according to him, she was not concerned with fiscal affairs. He also commented on the amount of paper work required by the Corps. He stated that he wished the Cadet Nurse Corps had never been created and that the hospitals would have managed all right without it. He realized, though,

that with the Corps in operation in other schools, his hospital had to continue participating if it wished to attract students. He claimed that he wanted to cooperate in regard to the consultant's recommendations but continually stated, "I don't know how we can do it."

This was a poor school of nursing. The consultant felt that the director of nursing was aware of the deficiencies in the school and was honestly making an effort to improve them. However, she also felt that the administrator and the medical staff were far from sympathetic toward any plans to improve the education program, especially in the matter of reducing hours. In her view, if strong steps were taken by the Division of Nurse Education, something would be accomplished. It was finally recommended that further payment of federal funds be withheld from this school until hours for all junior and senior Cadet students were reduced to no more than forty-eight hours per week plus class, preferably forty-eight hours per week including class. (CNC Files, FRC, RG235)

The U.S. Public Health Service could not, as a government agency, do for nursing education what Abraham Flexner's report on *Medical Education in the United States and Canada* did for medical education between 1910 and 1930. It was not able to put before the public the conditions in nursing that were equal to or worse than those described by Flexner. The Public Health Service preferred to avoid open conflict, and perhaps it was best for the unity and stability of society that it did so. Thus, the only recourse was to quietly withdraw funds in the very worst cases. Nevertheless, federal aid to the nursing education program had an enormous impact on conditions in the hospital wards and in the classrooms. The administrators, faculties, students, and

patients, all experienced direct benefits. Additionally, the spillover effects upon future standards were immeasurable.

THE BROWN REPORT

The wartime federal nurse training program evolved from informal and heroic beginnings to a comprehensive program of professional self-examination which yielded considerable advancement during the three years following the armed conflict. The keystone of this postwar advancement was the study, *Nursing for the Future*, conducted by anthropologist Esther Lucile Brown, under a \$30,000 grant from the Carnegie Foundation. (Brown, 1948) *Nursing for the Future*, published in 1948, synthesized what some thoughtful observers had known for a considerable period, namely, that the current system of nursing education could not produce adequate numbers of nurses of the types needed. It constituted the third major study of American nursing. A fundamental principle of the Brown report that professional education in America is a responsibility of institutions of higher learning and that therefore professional nursing education must be centered in colleges and universities.

A number of factors created a situation in which a general change in nurse staffing in hospitals was necessary from the point of view of both educational and labor relations. Quite apart from the merits of the economic case for a decrease in student labor exploitation, the simple fact could not be denied that a greater amount of classwork and a lesser amount of service generally was essential, given the temper of the times and the facts of hospital organization. Only the question of the timing and extent of the change-over was uncertain.

The public was not unconcerned with the poor training

school conditions from 1873 to 1940, nor were some doctors and hospital trustees. But the public had no program of its own, and the management groups insisted that the prevailing system, despite its faults, was still the best that could be expected in the circumstances.

If one considers the curious way nurse training was financed before World War II, one is driven to conclude that, under existing conditions, the people were probably getting about the amount and type of nursing education that they wanted and were willing to pay for. However, the conclusion that the public was getting what it was willing to pay for, given access to the real facts concerning nurse training, is probably false: the problem of financing nursing education had never been put squarely, frankly, and forcefully before the American people. That the issue still remains unsolved is not, therefore, a matter of great surprise. There is no firm answer to the question of the extent of the resources that ought to be devoted to the education of nurses. The support that is appropriate depends on the type and amount of preparation the people of a free society want and choose to enforce, and on what means they can provide for this education. Be that as it may, both the student nurses and the patients that they serve deserve better treatment than that received under the bad conditions prevalent in most nurse training schools from 1873 to the early 1940's.

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