A study of the development of diploma and baccalaureate degree nursing education programs in Iowa from 1907-1978

Bonnie Ketchum Smola

Iowa State University

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A STUDY OF THE DEVELOPMENT OF DIPLOMA AND BACCALAUREATE
DEGREE NURSING EDUCATION PROGRAMS IN IOWA FROM 1907-1978

Iowa State University

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A study of the development of diploma and baccalaureate
degree nursing education programs in Iowa
from 1907-1978

by

Bonnie Ketchum Smola

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For the Graduate College

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1980

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Chapter One: Introduction

The nation's supply of nurses is marked by diversity in educational preparation. There are now three types of educational institutions for nurses; there are schools within universities, those attached to junior or community colleges, and hospital diploma schools. All three prepare students to write the State Board Test Pool Examination leading to licensure as registered nurses. A perusal of statistics of the past reveals a trend of slow growth in the number of university and community college nursing programs and a demise of the hospital diploma programs.

Even with the change, the diploma school seems to reflect the model of nursing still recognized. The power of the diploma school, in this respect, does not depend solely on the great majority of its graduates in the ranks of the practicing nurse nor on its success in the history of nursing education. The diploma education for nursing is pervasive throughout society at large; it is the reflection of what a nurse is, what a nurse does, and how one becomes a nurse (Strauss, 1966).

Justification for the Study

The history of the origin and development of an individual professional endeavor is ordinarily of no great importance except to the members of that profession. However, when the profession is the single largest division of one of the major industries in the United States and mandates from the professional association concerning the professions' educational practice cause significant changes among the practitioners, the past educational practices take on true historical
significance. Such is the case of the history of the nursing education practices in the State of Iowa.

In 1965, the American Nurses' Association issued a position paper that gave direction for orderly change in the system of education in which nursing personnel are prepared. The position paper stated: "Education for those who work in nursing should take place in institutions of learning within the general system of education" ("Educational Preparation for Nurses," ANA, 1965). The result was the closing of many hospital schools of nursing and the opening of many programs for nursing education in vocational schools. In 1974 the New York State Nurses' Association passed a resolution calling for the baccalaureate degree as the minimum preparation for entry into professional practice by 1985 (New York State Nurses' Association, 1974).

This resolution quickly became the focus of a national discussion and in 1976 the Council of Baccalaureate and Higher Degree Programs of the National League for Nursing passed a similar resolution. The idea gained support when a package of three entry-into-practice resolutions was passed by the American Nurses' Association in 1978 (ANA Convention, 1978, pp. 500-07). In 1978 the Iowa Nurses' Association supported the resolutions. In Iowa, three baccalaureate level programs have begun since 1976. All three of these programs are in small private colleges.

It would seem logical that a study of the past educational practices and trends in nursing in Iowa would be of value in planning for the future.
To a certain extent, knowledge of the past can have liberating as well as predictive value. Sol Cohen (1976), an educational historian, made this statement about the liberating function of history:

To Freud, neurosis is the failure to escape the past, the burden of one's history. What is repressed returns distorted and is eternally re-enacted. The psychotherapist's task is to help the patient reconstruct the past. In this respect the historian's goal resembles that of the therapists - to liberate us from the burden of the past by helping us to understand it (p. 298).

While new social, political, and economic conditions may arise that create fundamental changes in the conditions under which nursing education takes place, certain pitfalls of the past may be avoided by the nursing educator of today who is able to study the past from a detached perspective. Newton (1965), a noted expert in nursing history states, "Reflecting the present against the background of the past cultivates a perspective, tends to delay hasty conclusions, and often injects humility into those involved in current undertakings" (p. 20).

Because history must be seen in the light of the social, economic, educational, and political happenings of the time, this study of the history of nursing education in Iowa, specifically as it pertains to the early schools of nursing and the development of different levels of nursing education, must be viewed from many aspects, including the professional aspect of nursing (Christy, 1969).

The history of nursing education in Iowa, specifically as it pertains to the early schools of nursing and the development of different levels of nursing education is, for the most part, not recorded.
Accordingly, this study was directed toward recording, as accurately as possible, the past educational practices, laws, social forces, and role of the professional organization in the development of nursing education in the State of Iowa.

**Purpose of the Study**

The purpose of this study was threefold: (1) to provide contemporary nursing educators in Iowa a written account of the development of the early schools of nursing in Iowa, (2) to trace and record the growth and development of those schools that today provide diploma or baccalaureate level nursing education, and (3) to explore the relationships among selected social forces in relation to their impact on the development of professional nursing education. The specific social forces to be examined are: the Woman's Movement, religious influences, economic forces, and the medical domination of the health care field.

Specific questions to be addressed are: Has the Woman's Movement had an impact on the development of nursing education? Have nurses been supportive of the Woman's Movement? What role did religious factors play in the development of professional nursing education? Are religious factors significant today? How did economic factors influence the development of professional nursing education? Was the establishment of nursing education programs reactive or proactive? What has been the effect of medical domination on the development of professional nursing education?

This study reveals how nursing education has been provided in the
State of Iowa since the turn of the century. The study furnishes a background for understanding the strength and diversity of diploma or baccalaureate nursing education programs of today.

Assumptions of the Study

For the purpose of this study it was assumed that: (1) those hospitals or schools recognized at the time of their existence as training schools for nurses and graduating students as graduate nurses were, in fact, educational institutions for nurses, (2) that nursing education programs did not exist in isolation, but responded to social, economic, political, and professional forces, and (3) nursing education prepared practitioners at different levels.
Terminology of the Study

For the purpose of this study the following words are defined:

1. Schools of Nursing means an organized attempt by an individual or group of individuals to conduct a formal program to teach the practice of nursing.

2. Diploma level nursing education means that schooling intended to teach the practice of nursing provided by an institution whose primary function is care of the sick, not education.

3. Baccalaureate level nursing education means that schooling provided by an institution of higher learning to educate or train individuals to function in the position of nurse.

Design of the Study

The preparation of this dissertation involved a historical investigation of existing sources and data relevant to the development of diploma and baccalaureate nursing education programs in Iowa from 1900. As Hockett (1955) noted, the task of the historian "is to gather a body of ascertained facts which, properly presented, will clarify our understanding of the past and its significance for the present" (p. 64). By utilizing primarily the written records of past or current events, the historian attempted to test the truthfulness of the reports of observations made and reported by others. The historical method involved the collection, examination, criticism, and presentation of pertinent data. Brooks (1969) suggested the following approach for initiating a search for historical sources:
Resourcefulness and imagination are essential in the preliminary exploration as well as in the later actual study. One can suppose that certain kinds of sources would exist if he thinks carefully about his subject, the persons involved, the government, or institutions concerned, and the kinds of records that would naturally grow out of the events that he will be studying. He should ask himself who would have produced the useful documents in the transaction he is concerned with. What would be the expected flow of events? What kind of records would have been created? What would be the life history of the documents, from their creating through current use, filing, temporary storage, and eventual retention in a repository where he can consult them? What kinds of materials would one expect to be kept rather than discarded (pp. 19-20).

The final step is more than a mere listing of information, it is a presentation of facts, interpretations, and conclusions in readable form.

The critical examination of statements necessitated the two separate processes of external and internal criticism. External criticism established the validity of the document. All possible information regarding the document's origin or the authenticity of the source was examined. Once authenticity of the data was established, the historian's focus turned to internal criticism, which determined the reliability of the information contained within the document. An attempt was made to understand what the statements of the document said and meant and the truthfulness and reliability of the statements. Of greatest importance was the avoidance of reading into a statement a meaning other than that intended by the author. Hockett (1955) wrote, "There is a great temptation to make this mistake when one wishes or hopes to find a particular meaning in a statement, and great care is required to avoid this form of intellectual dishonesty. Taking words out of context is a common form of the transgression" (p. 41). The
researcher must be aware of his or her own biases in order to prevent allowing his theories or hypothesis to enter into an interpretation of the true intent of the statement. Hockett (1955) warns of this difficulty when he stated, "The quest must be for facts, even if they upset one's pet notions" (p. 41). The historian's task is a dual one: (1) to determine the facts; and (2) to attempt to present the truth through the facts at hand.

The compilation of the data necessitated reference to primary and secondary sources and utilization of the process of external and internal criticism. Most of the pertinent data were recorded on 8½ x 11 sheets. Where possible the materials were checked against one another for corroboration. In addition, and where appropriate and possible interviews were conducted to supplement and verify archival sources. Based on a series of unstructured questions, interviews were designed to gain additional details or confirm information regarding a particular incident, or phase of diploma or baccalaureate nursing education in Iowa with which the interviewee was most knowledgeable.

Preliminary research commenced in March, 1979, and culminated in May, 1979 with the presentation of a report on the administrative practices of existing nursing schools in Iowa. This work revealed the extent of information available, its location and a general overview of the proposed topic.

Intensive research began in June, 1979, after determining into what general periods the material should be divided. While basic chronological divisions served as a guide, the selection of periods for this
investigation was primarily thematic. The periods were divided as follows: The Preregistration Period, prior to 1907; the Early Professional Years, 1907-1918; The Era of Hospital Schools, 1918-1930; From Depression to World War II, 1930-1945; Postwar to a New Age, 1945-the late 1960s; and, the New Profession, Late 1960s-1978. Research proceeded, generally, on a period by period basis beginning within each period from a consideration of the national, political, social, professional, and nursing education scene and progressing to the emphasis on nursing education developments in Iowa, particularly as it related to diploma and baccalaureate level nursing education programs.

The most helpful secondary source materials for nursing education developments at the national level were: the M. Adelaide Nutting Collection at Teachers College, Columbia University in New York and the Florence Nightingale Collection at Columbia University-Presbyterian Hospital School of Nursing in New York. Additional helpful secondary source materials were located at the Sophia Palmer Historical Collection, and the Mary M. Roberts Collection, deposited by the American Journal of Nursing Company at the Mugar Memorial Library at Boston University in Massachusetts. In addition, the American Journal of Nursing Publishing Company in New York maintains a collection of archival materials that relate to early nursing schools which provided much helpful information.

This investigation continued with a review of primary and secondary sources dealing with the nursing education developments in Iowa. Most useful of these sources of information were: Minutes of the Iowa State Association of Registered Nurses, located at the Headquarters of the
Iowa Nurses' Association in Des Moines, Minutes of the Iowa Board of Nursing also in Des Moines. Additionally, minutes of individual schools of nursing faculty meetings, hospital trustee's minutes, publications of individual hospitals, materials located in the Archives of the University of Iowa, and at the School of Nursing of the University of Iowa, Iowa City were useful.

Interviews were conducted throughout the study. Among the interviewees were retired directors of nursing programs living in Iowa, former students of nursing programs, retired housemothers living in Iowa and neighboring states, and former hospital administrators and trustees. The interviews were designed to elicit two types of information, details or corroborating data about a program or programs of nursing education with which the interviewee had first hand information.

A chronological approach was used throughout the study with single chapters devoted to specific time periods. The introductory chapter discusses the rational for the study which includes summary discussions of selected national concerns related to nursing practice and nursing education and the general trend of nursing education. Included in the introductory chapter are the justification for the study, the purpose of the study, assumptions of the study, terminology, and the design of the study.
Chapter Two: The Preregistration Period, Prior to 1907

Professions exist because of a mandate from society to perform certain functions. A key attribute of a profession is its autonomy (Stewart & Cantor, 1974), or its power to control the terms, conditions, and contents of its work (Friedson, 1977). For nursing this power was seen as coming from legislative action as it had for the profession of medicine. By 1895 all the states had passed registration laws for physicians (Derbyshire, 1969). Because of the close association of medicine to nursing, medicine undoubtedly furnished the major model to nurses in search of their professional status.

This chapter traces the emergence of organized nursing practice in the United States with special reference to Iowa in order to set the background for understanding the need for registration. The Iowa nurses' struggle to gain control of their profession through the legislative process is examined in detail.

The early schools of nursing are examined in relation to the questions of the study. The traditional pattern of nursing education clearly demonstrates the role of women in society and the effect of that role on the development of professional nursing education. This study demonstrates the economic advantage to hospitals in conducting schools of nursing.

Women's education is discussed to illustrate the limited opportunities existing for women. Women were expected to find satisfaction in the role of homemaker. The social structure kept women in occupations that were felt to have feminine characteristics. Women's
education was designed to keep women in their proper place.

The social status of women and the professional status of nursing are closely related. Because women were viewed as needing the protection of a paternalistic system, the hospital school of nursing served as an ideal education system. The hospital school of nursing provided direction and control of social activities for women. Under this rigid system of education, the free experimentation and intellectual stimulation characteristic of a liberal education could not flourish.

The hospital schools of nursing increased at an astonishing rate. The reason for the increase was probably an economic one. Hospital schools of nursing provided free labor to the hospital. Nursing service needs of the hospital were met through the schools. The lack of control over the schools of nursing, coupled with the lack of control over who practiced nursing, concerned the early nursing leaders. The nursing leaders looked to registration of nurses to answer the problems of the profession.

Gaining registration acts for nurses was a struggle. The key point of disagreement centered around the composition of the board of control of the practice of nursing. The final results were that nurses gained very little. While all individuals practicing nursing were required to register, the practice of nursing was placed legally under the control of physicians. Nurses were permitted to practice nursing under the supervision of physicians. Certainly, this constraint must have seemed as much of a myth in 1907 as it does now. Nurses simply do not practice nursing in the presence of physicians.
The final discussion of the chapter centers about the activity of nurses in Iowa. Iowa was not different from the rest of the nation. The exploitation of students existed in Iowa. Some Iowa hospital schools of nursing were attempting to provide education for the nursing students.

The development of the concern for health for the citizens of Iowa is examined. This examination reveals the conception of themselves held by Iowans at the turn of the century. The establishment of the State Board of Health demonstrated the progress of the State of Iowa. Quotations from various publications of the State Board of Health help to set the stage for understanding the development of professional nursing education in the State of Iowa.

**Early Schools of Nursing: The Traditional Pattern**

The hospital or diploma school is frequently referred to as the "Nightingale" school. According to Whittaker and Olesen (1964), for a long period of time anything even remotely associated with the Nightingale ideology seemed to be infused with a magical quality which insured its success.

The year 1873 is generally thought of as the beginning of the modern era in American nursing because three "Nightingale" schools were opened that year; Bellevue in New York, Connecticut Training School in
New Haven, and the Boston Training School which became Massachusetts General Hospital School.

The three early schools, and many that followed, enjoyed success partly because of the favorable publicity that had been given the English nursing school started by Florence Nightingale and partly because of a growing conviction that the establishment of apprenticeship education for nurses led not only to improved patient care but also to significant savings in the cost of operating a hospital (Bullough & Bullough, 1969). The movement to establish nurses' training schools in hospitals rapidly gained momentum in the United States. In the year 1880 there were 15 schools; in 1890 there were 35; in 1900 there were 432; and in 1910 the number reached 1,023 (Dock, 1912). To put these figures into perspective, it is important to know that in 1978 there were only 1,207 schools preparing registered nurses ("Demand Down," 1979).

The phenomenal growth of hospital sponsored schools was encouraged by hospitals, as the schools represented an answer to the problem of staffing. To ensure an adequate supply of the students who provided the bulk of nursing care, hospitals established their own schools of nursing, paid the students stipends and the instructors salaries, and settled into contented self-maintenance. The increase in number of schools was paced by the growth in numbers of hospitals themselves. The very rapid development was stimulated by innovations in science and by the newly emerged philosophy that hospitalization was the most efficient and sensible method of dealing with illness (Stewart, 1947, chap. 3 & 4).
Women's Education

The establishment of the apprenticeship, or in-service, pattern of education was perhaps unavoidable at the stage of social evolution the United States had reached in the last quarter of the nineteenth century. Society as a whole then felt comparatively little responsibility for women's education or for vocational education of any type.

According to Kendall (1976), American males had a full range of educational institutions available to them long before the Revolution. American girls had "only their mother's knee" (p. 9). As the country became more affluent, schools that were independent commercial enterprises, called "adventure schools," offered an educational possibility between the dame school and marriage. The Adventure schools offered an organized opportunity for travel and a mild exposure to art, music and language. The dame schools were really no more than small businesses, managed by "improverished women who looked after neighborhood children and saw to it that idle little hands did not make work for the devil" (pp. 15, 16). The next schools developed for women were the female seminaries where domestic work was included in the curriculum in part for the sake of economy and in part so that the women would not forget their "ultimate destiny" (p. 25). Woody (1929) states that "it was on the foundation of a seminary education that women built the superstructure of a higher education and prepared for . . . various professions" (p. 470). Teaching was the major "profession" for women which required some "higher education." Nursing was not yet taught on a collegiate level.
From an educational point of view, the apprentice system served to provide a cheap educational arrangement for numbers of women, many of whom were far too poorly qualified financially or otherwise to enter occupations which required preparation at a higher level. The function of formal apprenticeship has been apparent in American society since colonial times and therefore was not a creation of the culture of the early twentieth century. It would seem that apprenticeship has always been a popular method of educating the poor, various minority members of the society, and women (Woody, 1929).

Social Status of Women

Most women of the mid-nineteenth century, when the nursing profession began to emerge, led a sheltered existence. They were removed from the world of work outside of the home and had to depend upon their male relatives for any contact they might have with their social and political environment. Therefore, it was expected that they would enter into the occupational world through a system of schooling that would impose the rigid moral and physical sanctions necessary to continue to separate them from the world (Whittaker & Olesen, 1967).

The hospital school which was the answer for many of them, was frequently seen as bearing a close resemblance to a convent. Both were comparatively closed systems wherein the student nurse and the novice nun could be socialized in an environment removed from their previous existence. The isolated and contained environment presumably provided the quickest and most effective change in personal value systems and even in personality attributes. The secluded company and isolation
inevitably gave rise to the ideals considered so much a part of both occupations; dedication of one's life to a "calling," the sanctity of one's trust, commitment to a purpose, and sisterhood (Ross, 1961, pp. 12, 99).

Professional Status of Nursing

The purposes and functions of higher education have long been questioned. Even as early as the fourth century B.C., Aristotle, in his Politics, expressed the prevailing differences of opinion about the purposes of education when he said that "the existing practice [of education] is perplexing; no one knows on what principle it should proceed—should the useful in life, or should virtue, or should higher knowledge, be the aim of our training; all three opinions have been entertained. Again, about the means there is no agreement" (Aristotle, 1943, p. 321). Ever since those ancient days, proponents of professional and technical education on the one hand and liberal studies on the other, have been concerned with the relationship which existed between them.

Those who advocated an intensification of education in the professional and vocational fields had the responsibility of describing how preparations for the other broad activities of life were to be adequately provided. Those, on the contrary, who stressed the social and personal values of liberal education had to realistically face the increasing need in the changing world for persons with advanced training in an occupational field.

Wolfle (1954) reported that in 1901, of all of the first degrees granted, the aggregate of those in business, agriculture, education, and
engineering was only 4.1 percent of the total awarded by all types of institutions (p. 294). Universities of the last decade of the nineteenth century and first of the twentieth were still close adherents of the philosophy of learning for its own sake and were just beginning to feel that service to the community was a duty they should undertake. Therefore, it can be understood why nursing and the university community had few areas in common. M. Adalide Nutting, Lavinia Dock and Annie Goodrich were early leaders of American nursing who apparently felt the desire for and realized the inevitability of having nursing education available through universities. They were keenly aware of the elements within their profession that separated nursing and the university community. These elements were the general atheoretical nature of nursing knowledge, the heavy dependence upon technical skills, and the lack of a strongly intellectual and liberated ideology.

While the nature of the association desired with the university probably differed from nursing leader to nursing leader, it is evident from a review of the editorials in the American Journal of Nursing at the turn of the century that the rank and file of nurse practitioners were being indoctrinated to recognize the necessity for such as association. As early as 1901, the American Journal of Nursing, then in its second year of publication, carried an article by Ethel Gordon Bedford Fenwick, president of the International Council of Nurses, entitled "A Plea for the Higher Education of Trained Nurses." Fenwick gave advance notice of the movement for higher education. Although the article appeared to be primarily concerned with preparation for top-level positions, it contained a distinct hint of an expanded frame of reference in
regard to nursing activities. Fenwick proposed four reasons for the higher education of nurses: the advanced level of many of the activities they perform; the development of intelligence and vitality necessary for keeping abreast of advances in science and in hospital economics; the cultivation of the individual personality; and finally, the evolution of a strong sense of civic responsibility (pp. 4-8). The hospital economics postgraduate course offered in 1899 at Teachers College, Columbia University was a beginning. Dean James E. Russell of Teachers College reflected nursing leaders' sentiments when he pointed out in an address to the Superintendents' Society in 1900 that truly professional status could never be reached under the hospital training school system. He stressed the belief that educational progress was dependent on free experimentation with emphasis on increasing knowledge and intellectual stimulation (Bridgman, 1953, p. 42).

The Hospital School

Both the hospitals and the nursing profession have been caught in a dilemma traceable to the historical circumstances that made the rapid advances in medicine and the consequent demand for nurses coincide with the beginnings of nursing education.

It is significant to note that the first school for nurses established by Nightingale was established to educate nurses, not to furnish nursing service for the hospital. Nightingale did not want education compromised by the needs of the hospital for service. The school at St. Thomas's Hospital received an endowment from Nightingale.
She devoted the national gift presented her after the Crimean war to the establishment of the St. Thomas's Hospital School for Nurses. Therefore, the nursing school had a separate economic foundation, distinct from the hospital. Lectures, class work and practical work under supervision were provided for the students. The nursing care given to the sick in hospitals was scandalous prior to the employment of student nurses. Hospitalization was only for those who could not afford care in their own home. To the nurse, hospital work meant dealing with riffraff and the scum of creation. Most nurses hoped to nurse more respectable persons. But even if she were lucky enough to care for the ill in their home, the nurse was considered the most menial of servants. The entrance of refined, educated, and specially trained women to care for the sick in the hospital was nothing less than a revolution. These student nurses proved so useful to the hospital that before long other hospitals began to adopt the new idea of training schools and to establish them, not as separate educational enterprises but as working departments under their own management with students as a sort of apprentices.

The rapid growth of hospital training programs for nurses, especially in the period between 1890 and 1910, created many problems for the new graduates. Because hospitals were staffed primarily by the students, the majority of the graduating nurses were forced to seek employment as private duty nurses working in the homes of their patients. To obtain employment, it was necessary for the graduate nurse to compete with untrained nurses, correspondence school graduates, or former classmates who had either failed or decided not to complete the two-year
course of study. In addition, but not highly publicized because of its identification with hospital graft and mismanagement, the practice of sending students into homes to perform private duty nursing was a relatively common means of increasing revenue in some American hospitals. In other words, student services were sold to nonhospitalized persons with remuneration being made to the hospitals. Graduates were competing with students for jobs both within and without the confines of the hospital.

Some physicians joined with nurses in speaking out openly against this use of student labor. R. L. Larsen, a Chicago physician, wrote the editor of the *New York Medical Journal* deploring the fact that hospitals solicited business for student nurses by public advertisement, so that a fee for the student's services could be added to the institution's coffers. He said the practice should be condemned. Larsen declared that such "nefarious intrigues" on the part of hospitals was a hidden fact kept from "medical men of honor" who were associated with agencies engaging in deleterious methods of making money (Larsen, 1904, p. 235).

Another physician, Charles W. Kollock of Charleston, South Carolina also spoke out against those who sold student services for their own gain. He felt such a practice interfered with the teaching of nurses and urged his physician colleagues to expose and publicly denounce those working toward the furtherance of this type of hospital graft (Kollock, 1904, p. 235).

Isabel McIssaac, a nurse Director of a school of nursing, summed up the reasons given by hospital managers in justification of their
The arguments set forth by boards of managers in favor of the pupils being sent out to private duty are two, the increase of the school revenue and the value of such training. I see no way of answering the argument regarding the finances. If it is necessary for the school to earn a livelihood in that way, a constant effort must be made to reduce its disadvantages to a minimum (Proceedings of the American Society of Superintendents of Training Schools, 1896, 1897, p. 65).

Although nursing leaders passed resolutions against this type of activity, they were without power to control it. Further, they were convinced that nothing short of protective legislation would put an end to it. The public would have to realize that it was being deceived as much as were the student nurses from this particular use of the apprentice's time (Proceedings, 1896, 1897, p. 66).

The public needed protection against unqualified practitioners. In addition, within the ranks of trained nurses, and particularly among nursing educators, there was a growing sense of self-identity. A few leaders were ready to take the beginning steps toward the professionalization of nursing. The leaders talked of registration and better standards. These goals could be achieved through better education. As an indication of what the leadership was contemplating, one could read the 1895 report given by Isabel Hampton Robb to the American Society of Superintendents of Training Schools for Nurses. Here she talked of a "really liberal education" and of encouraging a system whereby students would not be paid. This she felt would "place the schools, at once, on a scholastic basis, and be another means of attracting to them as students refined and intelligent women" (Robb, 1895, pp. 33-40). The
precursor to the National League for Nursing, at first called the Society for Superintendents of Training Schools in the United States and Canada, was founded in 1894. In 1896 the organization that was to become the American Nurses' Association, originally the Nurses' Associated Alumnae of United States and Canada, was established. Primary objectives in the formation of both these nursing organizations was to gain control over the profession of nursing and to stop the uncontrolled growth of substandard nursing schools (Roberts, 1961, pp. 20-30).

Legislative Action

Once the initial work of organizing was completed, the members of both nursing groups turned their attention to seeking state licensure as a mechanism for accomplishing their goals. Sophia Palmer, one of the founders of both organizations and the first editor of the American Journal of Nursing, made what was probably the first public statement supporting licensure in a paper read before the New York State Federation of Women's Clubs in 1899. She stated that nursing's greatest need was for a law that would control the schools of nursing. She requested that the schools be placed under the supervision of the Regents of the University of the State of New York, the established pattern for other types of professionals licensed in that state. The Regents would then be responsible for appointing a board to examine and register nurses (Dock, 1912). Lavinia Dock, a Superintendent of nurses, who was the main driving force behind the establishment of the Nurses' Associated Alumnae (Marshall, 1972), wrote an article for the first issue of the
American Journal of Nursing which favored licensure. The article honestly pointed out that licensure could not solve all of the problems of the profession (Dock, 1900, pp. 8-12).

An editorial in the second issue of the American Journal of Nursing clearly pointed out to the membership the benefits of better standards and of registration. It spoke directly to the nurses' desire to provide quality patient care, as well as to their interest in their own respectability, when it reminded registered nurses that there were individuals who were free, under the present state of affairs, to "masquerade in nurse's uniform." These pretenders were said to be such unsavory characters as "rejected probationers" and "laundresses" ("Editorial," 1900, pp. 166-167). In her presidential address before the third annual meeting of the Nurses' Associated Alumnae, Isabel Hampton Robb outlined the two priorities of nursing as the support of the growth of the professional organizations and the campaign for registration for nurses in each of the states (Robb, 1900, pp. 97-104).

The slow process of professionalization was beginning among nurses in other countries also, but there were no governmental registration programs in existence. Most European countries did not institute nursing licensure until about 1920 (Seymer, 1933). The first nurse registration act was enacted in New Zealand in 1901. This act encouraged American nurses to push forward with their efforts toward the goal of registration (Roberts, 1961).

It is of interest to note that England did not furnish a model for nurse registration even though the English experience was used as a
model for nursing education in this country. This was because England was dominated by the strong figure of Florence Nightingale, who did not approve of individual licensure for nurses. In 1886 a committee of the British Hospitals' Association made a proposal to form a body of examiners for the purpose of testing nurses and keeping a list of those who qualified. The examiners were to be independent of the training schools and have as their objective the creation of a standard of excellence in nursing which would protect the hospitals and public against employing incompetent nurses. Nightingale was against this proposal because she felt that technical competence should be secondary to good character. Although she agreed that training programs should include instructions in how to carry out nursing procedures, in her estimation the primary goal of training was to build character. She felt she had "raised nursing from the sink" by emphasizing culture and moral standards, and that the new focus on competence rather than character would destroy her life's work (Woodham-Smith, 1951, p. 352). Nightingale felt that the then current model was a better one for protecting the public. The model kept the former student closely tied to the training school with the matron giving ongoing surveillance of both technical skills and character.

In 1888 the British nurses organized an association and attempted several times to obtain a royal charter that would allow them to test and register nurses. They were defeated because of Nightingale's influence, however, and nurse registration did not become a reality in England until 1919 (Seymer, 1933, p. 251).
American nurses were aware of the controversy that was taking place over the issue of licensure in England. Florence Nightingale was revered and her influence could not be denied. However, Ethel Gordon Bedford Fenwick, one of the leaders of the proregistration forces in England, was more influential on the issue of organization and registration in the United States. Fenwick visited this country in 1892 to prepare an exhibit for the International Congress of Nurses at the Chicago World's Fair. While in America she visited with Isabel Hampton Robb and other American nurses to encourage them to organize and to seek registration (Dock, 1912, pp. 125, 142). Her arguments apparently appealed to American nurses. There is little evidence in any of the literature that the nurses were particularly concerned over negative consequences that might follow from a shift in curriculum emphasis from character to technical competence, therefore the objections of Florence Nightingale and her followers were of little influence.

In looking for a model for the type of registration they wanted, nurses turned to other professions. Dock (1900) in the American Journal of Nursing, cited the example of medicine, although she also noted that dentistry had been able to control educational standards through the efforts of the schools rather than the state (pp. 8-12). Palmer mentioned physicians, pharmacists, dentists, and teachers as possible role models for licensure (Dock, 1912, p. 144). Because of the close association of medicine to nursing, medicine undoubtedly furnished the major model to nurses in their search for professional status. State medical practice acts had been enacted in all of the states by 1895. A Supreme
Court decision in 1889 held that occupational licensing laws were a valid exercise of the police powers of the states, so the way was open for nurses to proceed (Derbyshire, 1969, pp. 1-9).

The 1889 decision also pointed to the fact that licensure in the United States could not be conceived on a national basis, as it was and is in most countries. The federal government has only those powers listed in the constitution and these powers do not include the right to regulate occupational groups. Therefore, the push for registration had to be carried out in each one of the states. To facilitate this effort, the Nurses' Associated Alumnae moved to set up constituent state organizations so that the local membership could do the necessary work for lobbying for the registration acts (West, 1933, pp. 41-59).

Although the state governments had the constitutional right to pass these acts, it was necessary for the nurses to contact friendly legislatures for their assistance. Programs of local, state, and national nurses' associations often featured "how to" seminars to help nurses with the lobbying process ("Biennial," AJN, June, 1934, pp. 603-627). This pattern is not unusual. Even though the professionals often speak of public control by means of state licensure, the professionals themselves have participated and continue to participate significantly in the licensing process (Derbyshire, 1969).

What opposition there was to the early nursing licensure tended to come from hospital administrators, people who operated correspondence courses to prepare nurses, mental hospitals, and occasionally charitable organizations that sponsored home nursing programs. Physician opposition
came from doctors who administered hospitals and nursing homes rather than from active practitioners (West, 1939). Such opposition was sufficient to cause nurses to lower their sights, from their original goal of protection of the term "nurse" to the term "registered nurse." The opposition was not sufficient to stop the movement in any state. Many times nurses could marshall enough lobbying power to pass a nurse registration act in a single session of the legislature; but if that was not possible they tried again and again until the bill passed. At times the nurses settled for a weak bill and planned their strategy for revision. A common compromise that had to be made by many of the state association of nurses was to settle for a board of examiners that included one or more physicians.

North Carolina nurses were the first to succeed in gaining registration (Robinson, 1946, pp. 282-283). A nurse registration act was passed there in March 1903. The Editorial Comments of the April 1903 American Journal of Nursing offered the following congratulations to North Carolina:

We offer our congratulations to the North Carolina State Nurses' Association in being the first to secure the passage of a bill for registration. The bill is printed in another department, and is a poor substitute, we are told, for the original bill. All of the bills, as originally drawn, differ on so many points, and are being so torn to pieces in the hands of the legislators, that we reserve all comment as to their comparative merits until the battle is over. Each State has met the same kind of opposition, that of the commercial interests of private hospitals or quack nursing schools, as in the case of New Jersey, or, like New York, has been caught in the toils of medical politics, but even if the results are in a measure humiliating, the public knows much more about nurses and their standards than it did two months ago (p. 590).
Three other registration acts were passed that same year in New Jersey, New York, and Virginia. One by one the other states followed suit; by 1910 twenty-seven states had passed nurse registration acts, and by 1923 all the states then in the Union, plus the District of Columbia and Hawaii, had licensure laws for nurses. The Alaskan and Puerto Rican laws came later (Lesnik & Anderson, 1947, pp. 306-307).

The Preregistration Period in Iowa

As in all frontier and pioneer communities, Iowa was without hospitals. Sick and injured persons were cared for in their own homes. The demand for hospitals began as a need for care of unfortunates suffering from cholera, smallpox and other contagious diseases arose. Often these individuals were cared for in abandoned buildings by Catholic sisters who had volunteered their services as charitable undertakings (Brigham, 1916).

The first record of an organized hospital in Iowa is found in connection with the beginning of the college of Physicians and Surgeons, the Medical Department of Iowa State University at Keokuk, in September 1850 (One Hundred Years of Iowa Medicine, 1950, p. 372). There is no mention of nurses training or education in connection with the Iowa State University Hospitals until 1898 (Wilson, 1931).

Education

In 1830, three years before the Iowa country was officially opened for settlement, the first school was established at Galland in Lee County. The school was established by a physician for his own and the
neighborhood children. The Iowa pioneers were determined that their children should be educated and when the Constitution of 1846 was adopted a Superintendent of Public Instruction was included among the officers of the State. In 1849 the Iowa school law added a provision authorizing the establishment of high schools (Petersen, 1952).

The idea of a State University came into being when the U.S. Congress gave the Territory two townships of land, some 46,000 acres, to be sold to establish funds for the creation of a State University as soon as Iowa became a State. The State University of Iowa was approved on February 25, 1847 by the First General Assembly. The University opened in 1855 with three teachers in a building formerly occupied by an academy.

Denominational and private colleges opened and in the beginning offered the traditional pattern of Greek, Latin, and mathematics, with some courses in classic literature. After the Civil War, the development of science and the several technologies caused the curricula of most colleges to change. During the 1890s, there was no question that a more liberal attitude toward education was developing. The success of Drake with its Liberal Arts College, College of the Bible, Music Conservatory, Art School, School of Oratory, Commercial School, Academy, and affiliated Medical and Law colleges, was a sign that times were changing (Petersen, 1952, chap. 29, 30).

According to Cole (1921), the most significant forward movement in both education and agriculture was made at Ames when in 1887 congress provided additional funds and agricultural experiment stations were
established. The farmers of the state demanded that the leadership of the college be given to an individual who would help the college grow in prestige and influence (pp. 494,495). The outcome of this movement was the election of William M. Beardshear as president and James "Tama Jim" Wilson as professor of agriculture, with two agricultural scientists, C. F. Curtiss and David Kent as his assistants. "President Beardshear . . . opened the doors of the college to many who had before shunned it" (p. 494).

Iowa Health Status: Early Developments

If one agrees with Pellegrino (1963) that:

Medicine is an exquisitely sensitive indicator of the dominant cultural characteristics of any era, for man's behavior before the threats and realities of illness is necessarily rooted in the conception he has constructed of himself and his universe (p. 10).

then to examine the behavior of Iowans, in relation to health practices, reveals their conception of themselves and the world around them.

Care of the mental patients was an early concern of Iowans. Those felt to be insane were confined in jails, if violent, or cared for in their homes. During Governor Grimes term of office the General Assembly was induced to make an appropriation for the first hospital for the insane. Governor Grimes "personally supervised the construction of that institution" (Cole, 1940, p. 240). In 1861, fifteen years after Iowa had become a state, the doors of its first state hospital for mental patients opened.

Fairchild (1927) recorded the inception of the Iowa Institution for Feebleminded Children at Glenwood as "emanated from the broad and
liberal mind of a member of our State Medical Society" (p. 326). Dr. W. S. Robertson of Muscatine, in 1874, estimated that there were in Iowa "at least 1200 idiots and imbeciles" (p. 326). The School for the Feebleminded was started in 1876, under the superintendence of O. W. Archibald, M.D. (p. 327).

John H. Gear was inaugurated governor of Iowa January 17, 1878. In his inaugural message he suggested "the necessity of establishing a State Board of Health, whose duty it should be to pass upon the qualifications of practicing physicians" (Harlan, 1931, p. 104). Interestingly enough, the physicians had been encouraging the establishment of a State Board of Health for at least two and one-half years. The records show that the twenty-fifth session of the Iowa State Medical Society held in Des Moines, June 26, 1875 adopted the following resolution:

That a committee of three be appointed to draft and present for consideration at the next meeting, a bill creating a State Board of Health in Iowa (One Hundred Years, 1950, p. 39).

At the next meeting, the twenty-sixth session of the Iowa State Medical Society held in Des Moines, January 26, 1876, further action was taken. A resolution was adopted reaffirming the action of the Society, the previous year, that a State Board of Health be established (One Hundred Years, 1950, p. 40).

The committee for the establishment of a State Board of Health of the Iowa State Medical Society, reported at the twenty-ninth session held at Davenport in June of 1879 that the last legislature had failed to approve the Bill but the committee had hopes that it might succeed the next time (One Hundred Years, 1950, p. 42). Their hopes were well
founded as the Eighteenth General Assembly enacted Chapter 151, "an act to establish a State Board of Health in the State of Iowa, to provide for collecting vital statistics, and to assign certain duties to local boards of health, and to punish neglect of duties" (First Biennial Report, 1881, 1882, p. xi).

Section 12 of the act provided a sum of $5,000 per annum to pay the salary of the Secretary and meet the expenses of the office of the Secretary and the Board. The appropriated sum was to meet all costs of printing and contingent expenses. The salary for the Secretary was not to exceed $1,200 per annum plus actual expenses incurred in the "performance of official duties (First Biennial Report, 1881, 1882, p. xii).

Section 14 of the act defined the composition of local boards of health as follows:

Every local board of health shall appoint a competent physician to the board, who shall be the health officer within its jurisdiction, and shall hold his office during the pleasure of the board. The clerks of the townships and the clerks and recorders of cities and towns shall be clerks of the local boards. The local boards shall also regulate all fees and charges of persons employed by them in the execution of the health laws and of their own regulations (First Biennial Report of 1881, 1882, p. xii).

The first meeting of the Board was held at the State House, Des Moines, on May 5, 1880. Dr. William S. Robertson of Muscatine was elected President, and Mr. L. F. Andrews, Secretary. The election of Dr. Robertson as the first president was a recognition of his efforts as State Senator in securing the passage of the Act creating the State Board of Health. At the time he was also Professor of Theory and Practice of Medicine in the Medical Department, State University of Iowa,
Iowa City (Bierring, 1960).

For the year 1880, the clerks of 388 townships and 29 cities and towns, and 117 health physicians made a report to the State Board of Health. At the time there were 1,528 townships and 283 incorporated cities and towns in Iowa, so that reports were received from less than one third of the State (First Biennial Report of 1881, 1882, p. 56).

"It was not expected that perfection would be reached by this first effort" the Secretary stated in his first report (First Biennial Report of 1881, 1882, p. 56), and he was not surprised. The forms provided by the State Board of Health for reporting births, deaths, and contagious diseases were not used by all who reported. Many simply did not know what to do. Letters shared by the Secretary in the Report of the Iowa State Board of Health, 1881, published 1882, contained the following statements:

Sergent's Bluff, Woodbury County, "I do not exactly understand what kind of report should come from me" J. A. Taft, Clerk (p. 57).

Richland Township, Cherokee County, "The local board met but did nothing, as they thought there was nothing to do" F. D. Bailey, Clerk (p. 57).

Washington, Buena Vista County, "I am at a loss to know what is my duty" Thomas J. McClung, Clerk (p. 57).

Lincoln Township, Poweshiek County, "We are all ignorant as to our duties under this law. There has been nothing contagious in this township, except a few cases of diphtheria; one death" J. C. Morgan, Clerk (p. 58).

Highland Township, Guthrie Center seemed to wash their hands of the whole matter when D. C. Garnes, Clerk, reported
After receiving your blanks and circulars, I notified the township trustees, and requested them to take some action, but they ignored the whole matter, and said they would have nothing to do with it, that we had no physician in the township, and did not need any (p. 58).

The Secretary of the Board of Health reported that "if the reports received from clerks and health physicians in an indication, there are but comparatively few organized local boards of health" (p. 65). All was not completely negative in the first report, the Secretary praised some areas of the State when he pointed out that "in several counties exists active and model Boards of Health, and the result of their labor is seen in the large decrease of mortality rate, and exemption from epidemic diseases" (p. 65).

Mr. Andrews, Secretary, in the same publication reported, "practical experience has demonstrated that Chapter 151, laws of 1880, is very defective, and requires an important amendment to accomplish the intent of the framers of the law, and the object of the State Board" (p. 142), he urge reform.

The following year the law was changed to require the Secretary to by a physician. Mr. L. F. Andrews who had been serving as secretary was then elected Assistant Secretary and served as such for 18 years (Bierring, 1960).

Dr. Robert J. Farquharson of Davenport was elected the first medical Secretary of the State Board of Health at the meeting on May 5, 1881. During the first five years the activities of the State Board of Health were limited to reporting outbreaks of contagious diseases throughout the State and the recording of birth and deaths as they were reported by the physicians practicing in the State.
Eight years after Governor Gear's inaugural message suggesting that a State Board of Health pass upon the qualifications of practicing physicians, the first Medical Practice Act in Iowa was a reality. The Twenty-First General Assembly created an Act to authorize the formation of the State Board of Medical Examiners comprised of five physicians and the Secretary of the State Board of Health. The Act, effective July 1, 1886, authorized the State Board of Medical Examiners to grant three forms of certificates to physicians wishing to practice in Iowa: 1) to those who were graduates of medical colleges recognized by the Board as of good standing; 2) to those who had been, at the time of passing of the Act, not less than five years in continuous practice in one locality; and 3) to those who, not having these qualifications, passed a satisfactory examination before the Board (One Hundred Years, 1950, p. 444).

At the first session of the Board held under the new law on July 9, 1886, it was reported that 3,200 applications had been received. Certificates to practice based on possession of a diploma were issued to 2,568; for term of practice 490; to midwives 8; and for successful examination, 16. On January 1, 1887, the special period for physicians to qualify under the Act closed, and the penalties of the law went into effect (One Hundred Years, 1950, p. 444).

The Act was amended in 1897 requiring that after January 1, 1899, all persons beginning the practice of medicine in Iowa must submit to an examination and all persons receiving their diploma subsequent to January 1, 1899, must present evidence of having attended four full
courses of study of not less than twenty-six weeks each, "no two of which to have been given in any one year" (One Hundred Years, 1950, p. 445).

During 1902 the State Board of Medical Examiners gained some experience in the regulation of other health professionals. The June, 1902a Iowa Health Bulletin states

The Twenty-ninth General Assembly passed an act repealing the former illy-conceived and prematurely born osteopathic law—Chapter 69, Twenty-seventh General Assembly. Under the present law no one can practice osteopathy without a certificate duly recorded . . . No one is entitled to a certificate unless upon successful examination . . . except graduates of osteopathic colleges recognized . . . as being in good standing and who are engaged in the practice of osteopathy in Iowa at the time of the passage of the act . . . no one can be admitted to the examination except the graduates of colleges as above named (p. 6).

Some of the osteopaths of the time were well aware of the law, a knowledge which caused the Secretary to report in September 1902, "if enterprise is any prophecy of success these osteopaths will certainly succeed" (p. 56). Because of the wording of the law, the Board was compelled to direct the Secretary to issue 285 certificates to osteopaths without examination. The "enterprising" osteopaths graduated in Kirksville, Missouri and Des Moines on June 25, 1902 and alleged that they began practice in Iowa the same day or the day following. One explanation for the large number of osteopaths practicing in Iowa is that a few days later, July 4, 1902, they would have been required to take the examination (Iowa Health Bulletin, September 1902b, p. 56).

There had been so many cases of smallpox in the State at the turn of the century, the State Board of Health stated in the publication of
the Board that "we hope this year to devote more space to hygienic questions" (Iowa Health Bulletin, June, 1902a, p. 20). Some of the hygienic advice was in regard to the care of hair. Girls were advised not to cut the hair as "it will not afterward grow to the length it would have done if not cut," and during illness the hair "should never be cut except upon the advice of the physician, as serious results may result therefrom" (p. 22). Sage advice; "the best protection against rabies is the amputation of all dog's tails just back of the ears, before they have contracted the disease" (p. 9), and "Waterloo has been having a terrible scourge of typhoid fever. If this growing city would for a while bury the hatchet and suspend its . . . strife and turn its . . . efforts to improving its sanitary condition . . . it would be better for its people . . . the contamination does not come from Cedar Falls" (p. 155), and humor

Mary had a little watch,  
And swallowed it one day,  
The doctor gave her laxatives  
To pass the "time" away.  
   Our Revision (p. 49)

were published by the Iowa State Board of Health on a monthly basis.

It was in this era that the nurses in Iowa began their struggle for professional status and legislation controlling the practice of nursing.

Legislative Action

An article in the January, 1933, Journal of Iowa State Medical Society on the "History of the Nursing Profession in Iowa Since 1904," recorded the activities of the Iowa nurses at the turn of the century
as follows:

It was about this time, however, that a sentiment had developed in every section of the state to the effect that the practice of nursing should be protected by an act of the legislature requiring the registration of all graduate nurses. Up to this time no accurate record had been kept as to the number of graduate nurses in Iowa but it is certain that there must have been several hundred and their services were available to all parts of the state. This does not take into account the great number of untrained women who were caring for the sick as a means of livelihood and the graduate nurses were desirous of having some distinction made between their services and those of this group. The apparent need for such distinction and for a more united program in nursing activities was discussed in informal gatherings, alumnae meetings and county organizations. It was finally agreed that the best way to get the desired result was to form a state organization, thus bringing together the smaller groups. This would act as a clearing house for information and instruction regarding progress.

As a result of correspondence between officers of local nursing organizations, a nurses' convention was held in Des Moines, January 4, 1904, at which the following officers were elected: R. Estella Campbell, president; Clara Craine, first vice president; Dora Metcalf, second vice president; Mary Redlingshafer, secretary; Jane Garrod, treasurer, and Mary C. James, auditor ("History of the Nursing," 1933, pp. 51-53).

The hand written minutes of the first meetings of the Iowa State Association of Graduate Nurses held January 4, 5, and 6, 1904, in Des Moines state that the Association be formed for the purpose of "furthering state registration" (p. 2). During the first meeting the constitution and by-laws of the organization were formulated and accepted. In addition, "The registration bill was then read by the secretary, after which a motion that the bill be read and discussed section by section was carried" (pp. 6, 7). And finally, in the interest of time, "the motion that . . . the committee on legislation be
given authority to make such changes as were deemed necessary to put
the bill in proper form for the legislature, was carried" (p. 7).

The nurses were not without political awareness, as the minutes of
the first meeting also state, "a motion that a vote of thanks be
extended Judge Charles A. Bishop for favors received in the past and
what we expect in the future, was carried" (p. 8). Judge Bishop had
been consulted as to legal features of the bill (Wilson, 1931, p. 11).
Plans were made to print the new constitution, by-laws, minutes of
meeting, and the registration bill and distribute them to nurses over
the state. The state was to be canvassed for graduate nurses to invite
them to the annual meeting to be held in June of that year. A motion
to send a delegate to the National Convention of the Nurses' Associated
Alumnae of the United States was not carried.

The president, R. Estella Campbell attended the National Associated
Alumnae Convention on her own and brought back "interest and enthusiasm
in national nursing affairs" (Wilson, 1931, p. 13). In June, 1906, Iowa
sent a delegate to the Ninth Annual Convention of the Nurses' Associated
Alumnae of the United States which was held in Detroit, Michigan. Min­
utes of the convention include a report from Grace E. Baker of Cedar
Rapids, Iowa as follows:

The Iowa State Association was organized three years ago.
Thus far we have had annual meetings and we have a membership at present of 205. Most of the work of the association thus far has been along legislative lines. At our annual meeting last year in June, in Cedar Rapids, considerable time was spent on the framing of a bill which came before the legislature in the spring. The fate of this bill is as follows: It came before the legislature in January; work was done upon it constantly until February, and it was brought before the Public Health
Committee of the Senate. The legislative committee appeared before this body and after much discussion it was decided that the bill should be recommended to the Senate providing for an examining board of three nurses. The examining board was the stumbling-block through the whole time. On March 9th the bill passed the Senate, but was amended on the floor in such a way that the examining board was to be the Board of Health. On March 16th the legislative committee went before the House Committee on Public Health and requested that the bill be killed in committee unless they felt that it could be amended and be brought before the Senate again with the provision that nurses could constitute the examining board. So the bill was killed, but we are not discouraged, and we are going to work again on the bill as soon as we have had our annual meeting in Des Moines next week ("Nurses' Associated Alumnae," 1906, p. 794).

The membership of the examining board was a "stumbling-block" for more than just the Iowa nurses. Nurses across the nation agreed with the editorial comment of the *American Journal of Nursing*, May, 1903b.

Nurses are the best judges of the qualification of nurses. The difficulties of nurses are best understood by nurses, and there can be none more capable of dealing justly and fairly with all of the problems that registration will bring than nurses themselves, with the Board of Regents, with its three medical men, as the final court of appeal. That the New York State Nurses' Association should nominate from its members names from whom the Regents shall select the Examining Board is simply in line with the treatment accorded the other professions (p. 592).

In February of 1906 *The Iowa Medical Journal*, Editorial section commented about the legislation pending for nurses and opticians.

These bills both demand separate boards for examination and control. Both were considered before the committee of Public Health of the House February six. No action was taken by the committee. The concensus of opinion seemed that everything medical or having to do with the public health should be under the control of the State Board of Health.

If anything is done it appears now that amendments will be offered looking to this method of giving relief.
Those practicing optometry should be examined as to their qualifications and should be graduates of some recognized school and should pay a license. Nurses spending three or four years in preparation to secure their diploma should have recognition over those who pass as nurses without such preliminary training. The plan is not to prohibit any one from nursing, but to protect the physicians and patients from being imposed upon by nurses who have not had proper training (p. 95).

It was not until March 12, 1907, by a law made effective July 4, 1907, and found in the laws of the Thirty-Second General Assembly, Chapter 139, that the Iowa Nurses were successful in securing the first attempt to regulate or affect the practice of nursing in the State of Iowa. The Act served to regulate persons professing to be registered nurses. The examining committee was made up of two physicians, the Secretary of the State Board of Health and two nurses. The law provided for the revocation of certificates and included a penalty for its violations.

The history of the nurse practice act was summed up by the Historical Committee in the Journal of Iowa State Medical Society when they compiled a "History of the Nursing Profession in Iowa from 1904" in January of 1933.

The story of how the Nurse Practice Act was won is a story of partial success, at least, since by its provisions, all graduate nurses expecting to practice their profession must register. Other features of the legislative enactment which the nurses desired were rejected, but these were mainly matters of administration, which under the present law are, with time and patience, proving quite effective (p. 53).

The "other features of the legislative enactment which the nurses desired" considered "mainly matters of administration" by the committee
of physicians were very significant to the nurses. The physicians clearly were reluctant to give up control of nurses' education and service. The concept of "handmaiden" to the physician is one in which the nurse is part servant and part alter ego. In this capacity the nurse acts in approved ways in the physician's stead. This picture of the nurse is clearly a dependent one and serves the purpose of the physician. The dependent role is reinforced in that physicians are generally male, and nurses female. Sex role socialization in American society emphasizes the male's assertive and leadership skills, while women are expected to be passive and withdrawing, lest they be considered unladylike or domineering. This situation reinforces the traditional physician-nurse relationship and contributes to the problem of the traditional role of nurses being subservient to physicians.

There are nurses who work for the rewards of the "handmaiden nurse", the rewards being the gratitude of patients and the respect of physicians and others for dedication. There are other nurses who seek the rewards of a professional practice. These rewards are recognition for the quality of work in the form of prestige, financial rewards, and opportunities for continuing professional development. The rewards for professional practice are in strong contrast to the view that the service to others is its own reward. This view stems from the close affiliation nursing has had historically with Catholic monasteries and later with nuns and Protestant nursing sisters.

The early nurse leaders were rejecting the "handmaiden" role for nurses. In addition, the nursing leaders were entering into political
activity. Politics by definition is concerned with the interaction of power relationships, and involvement with power is somehow a masculine attribute. The political role for nurses would have been uncertain and not in the usual line of women's activities.

When the efforts of these early nurses are evaluated, it is significant to remember that the first round of nurse registration acts was won by nurses at a time when women did not yet have the vote.

The Preregistration Period: A Summary

Has the Woman's Movement had an impact on the development of nursing education? Have nurses been supportive of the Woman's Movement? For the most part, early nurses did not question the authority and superior position of men in society. The customary social attitude toward women was almost as old as Christendom. In fact, the attitude had been dictated by the church, not by Christ, especially as influenced by Paul. It was generally believed that woman's place was in the home.

As is true today, the issue of woman's rights was confused with all types of rationalizations. Today the Equal Rights Amendment is confused with the abortion issue. In earlier times, the rights of women was confused with alcohol use.

The passing of laws, or the exercise of previously unused constitutional privileges, does not accomplish much as long as these efforts are not in accord with the emotional attitude of the dominant citizenry. Nurses, predominantly women, were not anxious to cause deliberate discord in their environment. This relative inertia of emotional attitudes, together with the social structure, is still effective in maintaining
certain social handicaps for women long after they have legally and politically been given the rights practically equal to those of men.

Nurses worked behind the political scene to obtain registration. The primary method of obtaining registration was probably through the use of manipulation. Most women were quite skilled in gaining their needs through manipulation. Open communication with men was usually judged as "unlady" like behavior.

Nursing leaders looked for reform through the process of registration of nurses. The medical profession had registered physicians for several years. Dentists and lawyers appeared to have control of their profession through registration. The nursing leaders desired protection for both the nurse and the patient and felt this protection could be obtained through registration of nurses who had completed a recognized course of study and passed an examination.

Legislation for registration was usually preceded by an effort of the nurses to organize. The nurses organized into state nurses' associations. A few of the nursing leaders warned that the registration laws would not solve the problems of the profession. However, the nurses were hopeful about the results of the registration acts.

The first state to enact a nurse registration law was North Carolina in 1903. In 1907 Iowa nurses were successful in obtaining registration. The registration acts did not solve the problems for the new profession. Exploitation of student labor continued. Nurse educators wanted to improve the educational status of the profession. In addition, shorter hours were needed to protect the health of the student.
How did economic factors influence the development of professional nursing education? Clearly, the evidence indicates that hospitals were interested in schools of nursing because the school provided cheap labor for the hospital. There was very little evidence that the hospitals were interested in the development of an educational endeavor. The hospitals needed nurses to care for hospitalized patients. Student nurse labor could be obtained through the establishment of a school of nursing. The establishment of nursing education programs was reactive to the needs of the hospital. When the hospital grew in size the school of nursing increased the number of students to meet the needs of the hospital.

At first, hospital schools of nursing in the United States were influenced by the successful results of the "Nightingale" system of training nurses. Before the advent of the "trained nurse", hospitals were not noted for their cure rate. Nightingale was responsible, to a large degree, for the elimination of filth from hospitals. After the Crimean War, Nightingale promoted a system of apprentice training for nurses to improve patient care. The apprenticeship system was an accepted route to all professions of the time. The Nightingale plan for educating nurses followed the traditional lines for education of professionals. The training schools were to be independent in administration, even though they were a part of the hospital. The instruction plans provided for lessons in scientific principles and practical experience for the mastery of skills. A contractual agreement between
the school administration and hospital management ensured the use of the clinical teaching facilities for the student nurses.

The hospital training schools established in the United States differed from the Nightingale schools in one very important respect. The schools were not endowed and had no independent financial backing. The schools, from the time of their inception, faced financial problems of major significance. An agreement by the school to give nursing service for the hospitals providing clinical experience was the major method of providing for the financial needs of the school. This type of apprenticeship arrangement was the factor encouraging hospitals to establish schools of nursing. Having a school of nursing became accepted as the most popular and least expensive method of providing nursing care to hospitalized patients. The hospital was the master and the student nurse the apprentice. The student gave free labor in exchange for informal training. The schools were dependent upon the hospital for their financial support.

The private enterprise system in the health care field provided ideal circumstances for the creation of oppressive conditions for women. The rapid growth in the number of hospitals in the early part of the century, and the emphasis on the economic functioning of the hospitals, was destined to include commercial activity harmful to progress in nursing education. The trend toward establishing apprenticeship programs as a source of labor, not as an independent educational enterprise, is clearly illustrated by the parallel growth of hospitals and nurses' training programs.
The question of the medical domination on the development of professional nursing education is closely related to the relation of men to women. At first, nurses were thought to function best if they merely did what they were told to do. Soon it became evident that the nurse's role in the structure of health care was filled much better if the nurse understood the reason for nursing actions.

As nursing has evolved, a continued struggle has existed against the attitude of "overtraining" nurses. Many hospital administrators, physicians, and nurses felt that education elevated the nurse beyond her essential task. The additional education was viewed as a waste of time and money. This attitude among members of the medical profession and society has been an obstacle to the development of professional nursing education.

In the beginning, nurses attended lectures for medical students; later, lectures were prepared especially for the nurses. However, the physicians were often in charge of the lectures and presented only what they felt the nurse needed to know.

By 1900, hospital administrators and physicians equated nursing schools with good business practice. The first three decades of "professional" nursing, from 1873 to about 1900, had demonstrated the usefulness of trained nurses. The nurses' skills were widely respected and they could insist on some degree of independence. The surgeons would no longer consider surgery without the aid of a trained nurse. Physicians depended upon the quality of care given by nurses and were reluctant to entrust their reputation to ignorant and untrained nurses.
Realizing how dependent they were upon quality nursing care, both hospital administrators and physicians felt they had to begin controlling their nursing staff and the training program for nurses. Hospital schools of nursing became closely associated with the management of labor in hospitals, rather than with professional activity. Hospital administrators recognized the value of training programs to the economy of the hospital. Schools of nursing, from 1900 on, were established for the hospitals of which they were a part. This refusal to allow the schools to remain outside of the control of hospital administrators was destined to prevent the development of the schools as independent educational enterprises.

It did not serve the purpose of the majority of hospital administrators or physicians to allow nurses to control nursing education. Therefore the history of nursing in America is interwoven with the growth and development of hospitals. Most of the schools of nursing were created and conducted by hospitals to serve their needs. The education of nurses became a by-product of service to the hospital. Physicians need not fear that nurses would gain knowledge superior to the knowledge of the physician so long as the physicians controlled nursing education.

What role did religious factors play in the development of professional nursing education? There is little evidence that any organized group of women nurses existed before the Christian era. The ideals of service, charity, brotherhood, and self-sacrifice were preached in the early Christian church. Nursing the sick, as a function
of the church, related the ascetic ideals to the acts of nursing. The old ascetic idea prevailed until well after the development of nursing as a secular activity. The concept of nursing as a scientific activity was slow to develop.

The fact that so many schools of nursing were begun by religious organizations maintained the concept of nursing as a "call". Nurses were expected to be self-sacrificing. Self-sacrificing nurses did not ask for an increase in wages. Nurses with the ideal of service did not complain about long hours of work. Both the religious and the maternal aspects of the role of the nurse dominated the practice of the early nurses.
Chapter Three: Early Professional Period, 1907-1918

This chapter discusses some of the problems of the emerging profession of nursing, nationally and within the State of Iowa. Specifically, the discussion centers on the nurses' efforts to improve nursing education.

The original registration acts are discussed in light of the questions of the research. The Women's Movement had little effect upon the registration of nurses. This was because the majority of the early nursing leaders saw registration as a professional and educational issue. Physician domination of the nursing profession was allowed through physician control of boards of nursing. The original registration acts permitted physician domination of the nursing profession by assuring a majority of physicians on the controlling boards of nursing.

The apprenticeship and preclinical period are discussed to clarify the subservient position of the apprentice. Nurse educators desired some type of education for the apprentice, prior to her being made responsible for the care of the ill. The preclinical period was not considered to be a profitable one to the hospital. The apprentice was not yet skilled in giving nursing care. Therefore, the initiation of the preclinical period was not as difficult to implement as was the affiliation to increase clinical experiences.

Some hospital administrators opposed the idea of affiliations between hospitals. The basis of the opposition was fear of disloyalty to the home institution. However, the training process of the apprentice did not foster independent power and control over the work.
The eight hour day is discussed to illustrate the importance of the economic influence on the development of professional nursing education. The opposition to the eight hour day, by the nurses themselves, is difficult to understand. However, the nurses' desire to be considered as professionals, and the fear of being thought disloyal to the hospitals kept the nurses from being pleased with the shorter work day. The religious influences in nursing also served to keep nurses from accepting the shorter work day. The long hours of work were considered essential to show self-sacrifice.

Conditions in the State of Iowa are discussed to set the stage for the discussion of the early professional period in Iowa. Iowa was progressive in some areas of health care. Of concern were matters of communicable diseases. Iowa nurses were able to make some progress in gaining control of the nursing education system in the State. However, the nurses were without funding, and the nurses' organization found it necessary to reimburse nurse members of the Board of Nurse Examiners. This personal funding to carry out the mandate of the legislature is an example of the concern for the profession. The personal funding is also an example of the nurse's naivety.

The early professional period in Iowa schools of nursing is presented in detail. The discussion reflects the service ideology of education for nurses. The task orientation met the needs of the hospital, but not the needs of future practitioners or their patients.

The large list of training schools is a clear indication that nursing schools were initiated in an effort to meet the needs of the
hospital. There is no indication of state wide planning. The schools were formed in reaction to a local need. There is no evidence that the hospitals considered where the graduates of their programs would be employed.

Iowa schools implemented an eight hour day very slowly. Iowa Methodist Hospital School of Nursing, Des Moines, granted the eight-hour day in 1939. Split shifts were initiated to gain the most service from an eight hour period.

Affiliation with general hospitals was a requirement for some schools of nursing in January, 1908. The schools of nursing connected to the State Hospitals for the Insane were required to affiliate.

The preliminary course in Iowa is discussed to present the content of the training schools. Additionally, the religious influence is reflected in the "Nurse's Confession of Faith," a dedication to the Iowa nurses. Among other resolves the "Confession" called for the nurse to pledge "an instant, constant and faithful service" to the "kind-hearted and helpful physicians." The "Confession" also asked the nurse to remember that to "serve with them (physicians) is pleasanter than to command alone." There can be no question of the intent of the physician who wrote this "Confession." The medical domination in the health care field would be difficult to deny.

During the early professional period, legislative activity was directed toward gaining greater control of the educational practices in Iowa schools of nursing. Nurses apparently recognized that strategies to gain greater autonomy succeed or fail on the basis of relative power
and control over the social field in which the attempt is made. To gain control over the education of nurses appeared to be the key to gaining greater autonomy for the profession. The nurses apparently were not ready to attempt nursing education in the university setting. The status of the university might have provided upward occupational mobility for the nurses.

**Original Registration Acts**

None of the original registration acts included a definition of nursing in terms of the scope of practice of the profession. The early acts were in fact registration acts rather than nurse practice acts. The term registered nurse was defined as an individual who had attended and graduated from an acceptable nursing program and had passed a state board examination, rather than an individual who engaged in a specific type of practice. Therefore, it was the educational process which was emphasized and the early efforts to reform tended to focus on improving the education or training.

The nurses of the time were aware of the effect the registration laws had on the educational process of nurses, an editorial in the March, 1913 b, American Journal of Nursing reports:
State registration has wonderfully strengthened the links of all of our organization life. Ineffective and inadequate as most of the laws have been, the results during these ten years, considered as a whole, will stand out conspicuously in the educational development of nursing, and will be more appreciated in a period of years ("Editorial," 1913b, pp. 410-411).

In most states nurses organized to strengthen the laws almost immediately after they were passed. A word of caution was issued in an editorial comment in the December, 1912b, American Journal of Nursing:

We wish to emphasize what we said sometime ago, that in agitating for compulsory registration we do not think it wise to attempt to raise the standards of an existing law, but to apply for such simple amendments as will make the voluntary laws mandatory, that is, that such standards as have been accepted and complied with voluntarily by the majority of the hospitals and nurses in a state should now be made to apply to all of the hospitals maintaining training schools and to all nurses who care for the sick for money ("Editorial," 1912b, p. 167).

In addition to working through the legislative process to improve the educational standards, nurses were urged to become active in evaluating and improving their own training schools by active participation in the local alumnae associations. The editorial comments of the October, 1912a, American Journal of Nursing stated:

If a nurse finds to her sorrow that she is not as well prepared for her work as are the graduates of some other institution, she owes it to her successors in that school to try to help remedy conditions. She may do this through her alumnae association in a direct appeal to the managers, or . . . the more round about way of state registration . . . the requirements of the state board will bring her school into line with the other acceptable ones ("Editorial," 1912a, p. 3).

Annie W. Goodrich, a nursing leader during the early professional period in nursing history, described the practicing nurses and their
education in an editorial comment published in the February, 1913, American Journal of Nursing:

Those who are practicing in this field . . . occupational statistics of the United States show that one hundred thousand women are practicing nursing, one out of ten, only, being hospital trained . . . . One Correspondence school . . . reported three thousand in its last graduating class, while the total number of pupils reported in 123 registered schools in New York State in 1912 was 3,623, the number graduating being only 1,184 (Goodrich, 1913, pp. 335-336).

Goodrich further examined the preparation of the ten percent of nurses who were trained in hospitals, her findings were reported in the same article:

The training may have been obtained in general or special hospitals or sanatoria, having a daily average of from six patients to four thousand, and cared for in houses more or less remodelled for the purpose, or in the most perfectly-constructed and completely equipped hospitals . . . . The minimum length of the course . . . is a year, the maximum four, the average length being three years. The experience may include all branches or may be limited to one, regardless of the length of the course . . . . The age of admission is from 17 to 40 or over. The tendency is . . . toward the admission of the younger pupils . . . the youngest and most limited educationally . . . are found in the institutions for the mental diseases and for infants and children . . . and in the general hospitals that offer the fewest advantages . . . clinical material . . . number of supervisors and instructors, with inadequately-equipped departments, whose schools are without libraries or class-rooms, and whose pupils are lodged in overcrowded dormitories.

The curricula from the standpoint of the subjects are fairly uniform. The number of hours devoted to theory, however, presents great variations, ranging from 74 to 822 for the entire course, the weekly average being from two to three hours, while the weekly average in practical experience is 67 hours . . . except in hospitals for the insane, where it averages 77, and at night the average is almost universally 84 . . . . From this incomplete and fragmentary . . . preparation of the nurse . . . it is
not difficult to conceive that there should be dissatisfaction . . . on the part of the public, the doctor, and the profession, with the existing conditions in nursing (pp. 336-338).

There was apparently some misunderstanding among educators other than nurses concerning the admission requirements for nursing students. For example, Annie Goodrich reported in the same article, that the First Assistant Commissioner of Education, in an address read before the New York State Nurses' Association stated, "I submit that when the law placed the age at twenty-one years, it assumed that the candidates for admission to these training schools should have at least a high school education" (p. 339).

The low educational requirements to enter a school of nursing were considered a detriment to nursing. Miss Goodrich further stated in the article, "There are few trades . . . that have the elements of a profession that do not require at least two years of high school . . . at least the full high school should be required for admission into schools of nursing . . . this was not the requirement" (p. 339).

The difficulty with the weak licensure laws and educational process could probably be summed up in the words of Annie Goodrich when in concluding the article she stated, "When the family had engaged the nurse it knows that it has not engaged a doctor; it does not know, however, that it has not engaged an untrained attendant" (p. 342).

Having received their own training in hospital schools, the heads of the schools acted with the same accord in regard to respect for rules and obedience to authorities as they had learned as students. Lavinia Dock, a nursing leader, and an active feminist best describes
why the nursing profession had not openly confronted the male dominant
health care system or attempt to change the social order when she
stated in 1903,

Nursing has not made itself a moral force; is not a public
conscience; takes no position in large public questions;
is not feared by those of low standards; allows all manner
of new conditions and developments in nursing affairs to
arise, flourish, succeed, or fail (Dock, 1904, p. 77).

Nursing leaders were attempting to speak to the nation with one
voice. An editorial in the February, 1913a, American Journal of
Nursing cautioned the nurses,

As time goes on and various problems arise threatening
the whole educational structure of nursing progress,
we are more and more convinced that the only enemies
we have to fear are those within our own ranks. Dif­
fferences of opinions must be present to maintain
interest and to promote thought and effort, but on the
fundamental questions it ought to be possible to pre­
sent a united front to the world ("Editorial," 1913a, p. 330).

Nursing leaders were concerned about the ability of the profession
to attract young women into the field. Another editorial in the
February, 1913a, American Journal of Nursing stated:

We hardly need to repeat what is already well known,
that there are so many attractive fields of occupation
open to the educated young women of to-day that they
will not enter that of nursing until it has been
established on a better educational and professional

In spite of the difficulties inherent in the system of training
nurses, some improvements were brought about by the unflagging efforts
of the nurses themselves. One such improvement was the introduction of
a preclinical period in which students were given courses in basic
scientific and nursing principles and preparation in elementary nursing
techniques before being assigned the actual care of patients. Another
improvement was the provision of at least a minimum variety of experi­
ences in the basic nursing services. This goal was accomplished by
affiliation with other hospitals or health care agencies. The third
improvement was the implementation of the eight hour day.

Apprenticeship and the Preclinical Period

The relationship between apprentice and hospital was a contractual
one. Frequently the pupils signed written agreements with the hospital.
Usually the contract specified the length of service to be given by the
pupil in exchange for instruction. The hospital generally promised to
provide room, board, and an allowance of money. The applicant promised
to abide by the rules of the hospital and the discipline of the school.
The hospital claimed the right to discharge a nurse at any time for any
reason deemed sufficient, such as "inefficiency" or "misconduct"
(Aikens, 1911, pp. 438-440).

Announcements from schools were similar in intent and language.
According to the discussion of the Superintendent of Training Schools
at their Fifteenth Annual Convention (Proceedings, 1910, pp. 186-197),
the bulletin from the Evangelical Deconess Home and Hospital at Marshal-
town, Iowa, is typical of the time. The Marshalltown bulletin states:

Should a nurse prove herself unworthy of her calling, by
gross sins, and give offense by her unbecoming conduct,
which we hope that God may graciously prevent, the board
of directors has a right to dismiss her immediately. In
all other cases a notice of three months beforehand shall
be given if either the home or a probationer wishes to
dissolve their relation with each other (Handbook
Evangelical, 1915).
Most bulletins stated that the money allowance, when given, was not to be viewed as a wage, "their education being considered their pay" (Handbook Evangelical, 1915, p. 1). Specific stipulations in contracts varied from hospital to hospital and periodic changes were made as the terms of wage, service, and other features were modified.

The initial stage of the apprenticeship was a probationary or trial period lasting from one to three months. The majority of hospital schools required a probationary period prior to having the pupil sign a contract (Aikens, 1911, p. 439). During this period the probationers were observed in order "to test their physical strength, mental fitness, consecrated purpose, and general adaptability for the work (Handbook Evangelical, 1915, p. 2).

The statutes and numerous official reports of various states show that the probationary period was observed as the initial phase of training. As education became the focus of training, the probationary period became more than a trial period; it provided an opportunity to give preparatory courses. In 1913 the Committee of Examiners of Registered Nurses in the State of Wisconsin recommended that the probationary period be used not only to prove fitness for work, but also to provide instruction for the pupils before actual care of the sick began. Courses suggested were bacteriology, hygiene, nursing ethics, anatomy, physiology, and "rules governing the school and the hospital" ("Committee of Examiners," 1913, p. 9). Ohio, Connecticut, California, Iowa, and other states urged hospitals to provide a definite course of study during the probationary period once legislative aid in regulation of
those who practiced as registered nurses was secured (Statues of Ohio, 1915, p. 17; Requirements, California, 1923; pp. 5, 7; "Survey," Connecticut, 1916, pp. 4-5; Iowa Health Bulletin, 1915, pp. 6-8).

The preparatory courses of the probationary period may have been an attempt by nurse educators to emulate the preparatory course offered in 1901 by Mary Adelaide Nutting, a nursing leader, at the Johns Hopkins Hospital, School of Nursing. Nutting (1903), director of the nursing program at the Johns Hopkins Hospital, stated that the purpose of the course was to overcome "the . . . universal custom prevalent in training-schools of mixing theory and practice indiscriminantly together with little regard to methods, standards, or logical sequence of subjects and with a totally inadequate provision of time for study" (pp. 30-33).

In general, the superintendents of training schools believed that using a more academic approach in teaching basic sciences would raise the standard of nursing education. They were in favor of establishing relationships with high schools, normal schools, technical institutes, colleges and universities. Clearly variety, diversity, and experimentation in an effort to improve the educational preparation of nurses was welcomed. Throughout the period between 1900 and 1920 many attempts were made to bring about the supplementation of apprentice training through the development of formal relations between hospital programs and educational institutions (Proceedings of the American Society of Superintendents of Training Schools, 1912, 1913, pp. 126-133).

Early attempts to supplement the apprenticeship training through preparatory courses were less than successful. Courses established at
Drexel in Pennsylvania and Pratt Institute in New York in 1903, closed shortly after opening. The courses at Kansas State Agricultural College in Topeka, Kansas, and at the University of North Dakota also were not successful.

Isabel M. Stewart (1918), an authority in nursing education, explained the failures of the preparatory courses:

The success of such courses has not been very promising... the time proved, as a rule, too short to get any great advantage from the college connection, the courses gave the student no definite academic standing. Hospitals offered very little, if any, inducements to students taking such work... the additional training was usually optional, and taken at the students own expense, it is not perhaps surprising that so few took advantage of the opportunities involved (pp. 4-5).

It might seem as though those schools of nursing connected with medical schools might fare better in having the sciences taught at the medical school. However, the majority of training schools did not profit from the proximity of a university setting. Instead it would appear that increased service demands in medical teaching hospitals increased the numbers of nursing students required without increasing educational opportunities for those students (Coplin, 1911).

The initiation of the preclinical period of instruction was probably the most important single change in the apprenticeship training of nurses. The preclinical period benefited both patient and student. The patient was protected from hazards that resulted from unreadiness of the student for critical responsibilities and she, in turn, was "saved its traumatic effects" (Bridgman, 1953, p. 44). However, the preclinical
period was so limited by the pressure to begin student service that the attempt to include all the necessary knowledge defeated its purpose.

In the preclinical period the student faced not only the ordinary problems of adjustment to what was usually a first experience away from home, but also the complex and often emotionally disturbing hospital situation. In addition, the philosophy of what was to be accomplished remained as reported in the Goldmark (1923) Report:

During this time they are to prove their fitness, in health and calibre, for their future work. This is and should be a period of genuine probation, testing the metal of the prospective student through hard and often distasteful manual work, initiating her into the ways of an institution where discipline is demanded by the ever-present issues of life and death (p. 228).

Thus, the preclinical period must be viewed as a mixed blessing. While it served to move the apprenticeship system toward education by allowing time for classroom instruction, when the new apprentice was of least value to the hospital, it was not without problems of its own.

Affiliations to Increase Clinical Experiences

Increasing the quality of educational offerings while at the same time meeting the service needs of the hospital without cost increase was the problem facing nursing leaders of the day. The phenomenal period of growth in the number of hospitals between 1900 and 1910 increased the problems. In one decade alone, 1900 to 1910, 1,651 new hospitals were established (Journal of the American Medical Association, 1924, p. 188). This was an era of unprecedented growth both for institutions caring for the sick and the apprentice programs for women associated with the institutions.
Many of the hospitals were small, private hospitals which were owned by a single physician or a group of physicians. Some were speciality hospitals caring for a specific condition or individual, for example, tuberculosis hospitals, children's hospitals, and mental hospitals. Statistics for the year 1905 show that at least half of these proprietary hospitals had training schools for nurses (Transactions Association of Hospital Superintendents, 1905, 1906, pp. 56-58). Providing an adequate education for nurses in small speciality hospitals was not easy.

The variety of educational experiences was supplemented by affiliation between general hospitals and the small or special institutions. However, many hospital managers were opposed to the idea of affiliations between hospitals. One of the major reasons for opposition seemed to be fear of disloyalty to the home institution. One physician, a member of the American Hospital Association expressed this view:

Affiliation with other hospitals is a matter of serious import. It may engender dissatisfaction and discontent because the pupils are meeting with different conditions, different and often conflicting rules and regulations, and the peculiarities of different supervising nurses. The feeling of loyalty to the interest of any one institution is hard to create. We send our nurses out for obstetrical experience and usually they are anxious to return home, but there are grave difficulties in the plan (Transactions, 1908, 1909, p. 207).

In spite of the opposition of hospital managers, the leaders in nursing steadily moved toward establishing affiliations as a standard requirement in those programs not providing experience in areas of general nursing practice. A strong argument in support of affiliation was presented by Ella Phillips Crandall, a member of the Committee on
Education of the National League of Nursing Education, to the American Hospital Association in 1916. Crandall stated,

The . . . mandatory nurse practice acts . . . grading and registration of hospitals and schools of nursing and the ever increasing demand for better qualified nurses will exert a constant and effective influence toward affiliation of hospitals for the purpose of providing adequate education . . . such affiliation can be established without injustice to the hospitals or the communities which they serve. While such prejudice against such affiliation still exists, it is unquestionably the only solution of the economic need of student service and a standardized educational requirement (Crandall, 1916, p. 47).

The hospital managers need not have feared disloyalty from the apprentice nurse. Apprentice type education does not foster disloyalty. According to Ashley (1976), a nurse author:

Apprentice nurses were taught to be loyal to the hospital, to be obedient and docile, and to accept the poor conditions of work and the stringent discipline. Repressive educational practices instilled in them respect for authority and a spirit of unquestioning loyalty to "master" institutions and to physicians. Nurses were not educated in a manner that might have led them to question the moral or social implications of a system that impeded their professional development. By design, apprenticeship education does not provide a liberal and general education. It most often stifles intellectual growth and prepares workers only too willing to conform to prevailing customs, traditions, and efforts to maintain the status quo (pp. 32-33).

The Eight Hour Day

The long hours of service given by the student to the hospital plagued nursing leaders for decades. Isabel Robb, the first principal of the training school in the Johns Hopkins Hospital, addressed this subject in 1986. Robb (1896), an authority on nursing education, speaking at a meeting of superintendents of training schools, especially
pointed out the dangers of adopting the three years' course unless with it came shorter hours. Her address pointed out the following:

I am sure that many of you have had some qualms of conscience at the way in which we are sometimes forced . . . to drive one pupil nurses through a two years' course. I assure you that I have had myself many anxious moments for the future of certain of my pupils as regards their health. It is well known that a combination of physical and mental labor is more exhausting than simple manual or simple mental occupation. It is true that for a time such a strain can be borne without producing any permanent injurious effects, and it is possible in most cases for women, to stand the strain imposed upon them for two years, although I am afraid that not all of them come out of the trial unscathed. If, however, this high pressure is to be kept up for three years, I am sure that the health of the nurses will suffer. A woman who works physically over eight hour a day is in no mental condition to profit to any extent by class instruction or lectures. I maintain therefore, that the three years' course must not be considered at all unless the hours of practical work are shortened, but if the two changes can be made together, than the preservation of the health of the nurse and the extension of her education and training will be insured. This again will result in an increase in her competency and consequently will be productive of greater benefits to the patients who come under her care during her training, and after she has graduated (p. 36).

Mary Adelade Nutting (1912) was among the first nurse leaders who condemned openly the practice of long hours of duty. She wrote "these long hours have always formed a persistent and at times an apparently immovable obstacle in efforts to improve the education of nurses and to establish a rational adjustment of practice to theory" (p. 29). Nutting (1897) further reported a brief study of the hours of work in 111 hospital training schools made in 1896 to the Superintendents of Training Schools:
A brief study . . . showed that the time in very nearly two-thirds of these training schools throughout the country student nurses were on duty for 10 hours and over daily. The hours of night duty were found to be 12 hours in 75 per cent of the schools, and in the remainder they exceeded that number and ranged from 13 to 13½. In no instance were these hours found to be under 12 (pp. 31-39).

The almost obvious conclusions reached in the early study of working hours of students were that they were universally excessive. At the time few industries were requiring their employees to work more than 10 hours daily and the wage-earner generally had Sundays free. Nutting (1912) pointed out that "it must be remembered that these statistics refer only to practical work in the ward, clinic, operating room, or other hospital department, and not to any portion of theoretical work; that the 10 hours . . . are . . . irrespective of lectures, class, or study" (p. 30).

The first break from the 10 to 12 hour day came for student nurses from the labor movement in California. The California legislators had passed a law limiting the hours of labor for women in that state. The "Editorial" comments of the May, 1913c, American Journal of Nursing, report the new law and its effects:

The bill introduced into the California legislature early in the season, limiting the hours of labor for women in that state to eight in a day, or forty-eight in a week, and which has given rise to much controversy, has become a law. It applies to women employed in manufacturing and mercantile establishments, and includes pupil nurses in hospitals, but excludes graduate nurses.

We understand that this bill has been very vigorously opposed by hospital authorities, and that superintendents of training schools are greatly concerned. To secure pupils enough for three complete shifts, and to so arrange for hours in a week, means an added burden and expense, and will increase the difficulties of administration. It
remains to be seen what the effect of this law will be, whether private institutions maintaining training schools will have to go out of business, or whether they will employ graduates whose hours of duty are not restricted, whether the limiting the hours of duty to forty-eight a week will increase the number of applicants to training schools. Evidently in California, patients are not expected to be sick on Sunday.

It is quite impossible at this distance to judge all of the conditions that have given rise to this law, which seems a drastic one. We believe, however, that the time has come when some limitation should be placed upon those hospitals who use their pupils for commercial gain without making systematic and adequate return in the way of nursing education ("Editorial," 1913c, p. 661-662).

The opposition, by nurses themselves, to the labor legislation was one of the difficulties encountered by nursing leaders stressing change. California graduate nurses had understandable grounds on which to object to the law. The law implied that nurses' training was labor rather than professional education. The California hospitals did not offer graduate nurses additional opportunities for full employment, rather they increased the number of women admitted to apprenticeship programs. This served to increase the number of unemployed nurses as the hospitals graduated more and more nurses.

In spite of the fact that many nurses resented the long hours of work required of them during their training period, they seldom questioned the reason for it. The subservient attitude of nurses trained in the apprenticeship system apparently kept them from questioning any one considered their supervisor. When an occupation has little or no status of its own, as has been the case with nursing for most of its history, the members of the occupation assume the status of the institution for which they work. Many of the nurses identified with the hospitals and viewed the labor movement as threatening to the nurses own sense of worth.
Isabel Stewart (1919), in the *American Journal of Nursing*, presented some of the reasons why nurses apparently resented the labor movement and had not themselves improved the conditions in training schools. Stewart noted that nurses did not want to be thought disloyal to hospitals and they did not want to "arouse public antagonism" toward the sponsors of nurses training. Stewart stated that the majority of nurses working with training schools identified with hospital management because they wanted to help maintain both the "efficiency" and the "good name" of their employers (pp. 439-440).

Hospital management, on the other hand, did not seem concerned about efficiency or the quality of service provided by its labor force. There was no distinction made between the work of students and that performed by fully trained, graduate nurses.

It is doubtful that securing a shorter working day alone would change the apprenticeship system or end the other methods by which training schools exploited students in the name of education. Apprentices were admitted in numbers large enough to meet the immediate needs of the hospital for nursing service. There were few qualifications for applicants and no set time for admissions. Students were frequently accepted at any time in the year that a vacancy occurred (*Handbook of Evangelical, 1915*). Student hours were arranged to "cover" the heavy work hours in the hospitals, for example working 7-11 a.m. and 3-7 p.m. assures student help during the busiest hours. Clearly, an eight-hour system in the hospitals did not alter the fact that the student nurses provided the majority of the nursing care and related workload.
Probably the greatest effect of the labor movement on nursing, was the realization by nursing leaders that something must be done to move toward education and away from apprenticeship. However, progress was slow and the immediate reaction to the eight hour day law in California was opposition.

Hospital administrators opposed the bill. Some nurses objected to it because it placed them in the labor class. An incidental provision of the law made it illegal for hospitals to charge for the services of student nurses working on private cases in the hospital or in the patient's home. This meant the loss of a considerable amount of revenue for the hospital. A published account of the testimony given by a San Francisco Labor Council Representative discloses just how much income was involved:

Investigations have shown that they are both underpaid and overworked. Undergraduate nurses received from $15 to $12.50 a month while the patients are charged $25 a week for their services and $7 to $10 for their board, giving the hospitals a profit of some $125 a month for each girl (Sacramento Enquirer, March 25, 1915).

The controversy continued for a number of years. The law was upheld by the United States Supreme Court. Being classified as labor did not please the nurses. The Court decision did nothing to help in the acquisition of professional status. Annie W. Goodrich (1916) summed up the nurses feelings in a statement to her colleagues in the National League of Nursing Education in 1915:

If our schools were really schools it would not be possible for them to be under any labor law . . . . The greatest indictment against hospitals and training schools was made when the labor organizations were obliged to put that eight-
hour law into effect. I do not believe it would have gone into effect if the labor organizations had not put it into effect (pp. 184-185, 188).

The existence of the eight hour law in California, supported by a United States Supreme Court decision that upheld the law did not quiet the discussion. When in 1917, the Illinois Legislature offered a similar bill the Chicago hospital executives organized an association to work for the exclusion of hospitals from the provisions of the law. A circular sent out by the Chicago association and published in the Modern Hospital, April, 1917, read in part as follows:

1. Nursing is a profession. It stands in the same relation to the sick of the world as the medical profession. The work of nurses can no more be regulated by hard-and-fast law than the work of the doctors or mothers. The sick and children are here and they must be cared for. The nurses all over the world will protest at being classed as wage-earners.

2. Nurses in training are not employees in the sense that they are wage-earners. They are a part of the hospital family, and are cared for as a father cares for his children. The money given them is only given as pin-money to take care of books, carfare, etc., not as wages. Their whole so-called working time is devoted to the study of the theory and practice of nursing.

3. There exists an erroneous idea that nurses in training are abused and overworked, a broken-down, sickly lot, while in reality nurses are the healthiest young women in the world, because they live regular hours, eat regularly, sleep regularly and enough, and are taught and made to practice the rules of hygiene that spell health. The health and well-being of the nurses are of such paramount importance to a hospital that there is no necessity for out-side legislation to regulate this. The hospital, to exist, must see that its nurses are mentally, morally and physically right.

4. If the time of the nurses in training is to be reduced, it will be necessary to increase the length of the course in the training schools. There is no more time than is necessary now, to teach them what they must know.
Furthermore, it will require at least a third more nurses in training than we now have, and this will greatly increase the expense of conducting the hospitals that it will be necessary to raise the rates in all hospitals and reduce the amount of charity done. Hospitals are not money-making institutions. They exist for the benefit of the sick of all classes, and it is all that a hospital can do now to get money enough to keep its doors open.

The hospital cannot be put in the same category as offices, factories, stores, etc. Hospitals must be kept open night and day, seven days in the week.

It is apparent that no proper investigation of hospital conditions has been made by any person or persons competent to judge the needs of nurses or employees of this bill.

We object to supervision of hospitals at the hands of factory inspectors. Investigation and regulation of hospitals in the state is heartily approved, but should be directed by the State Board of Health ("Chicago," 1917, p.269).

The nurse educators realized that they were nearly powerless to improve the conditions in hospital training schools. With hospital management in control of the schools, change was difficult. Although nursing as a branch of the health care scene continued to become more and more complex, some nurses, many physicians, and the majority of hospital managers held to the position that the apprenticeship system was the best way to educate a nurse. Nurse educators suffered from an almost total lack of influence over their own affairs.

The apprenticeship system, under which nurses trained, does not foster creativity and experimentation. Instead, it is the system of education must suitable for instilling a strong faith in superiors, a willingness to cooperate, and a tendency to deny oneself for the interest of others. It was probably very reasonable for some nurses to think that to work long and difficult hours was their responsibility and necessary for the good of the patients and hospitals.
Given the social position of women, the role of the nurse, the fact that many of the nurses were themselves trained in a hospital school, and the educational requirements to put nursing on an academic level, it is a wonder there was any progress in nursing education. The lack of reform in the apprenticeship system perpetuated educational preparation for nurses that was uniformly poor in quality and unsuited to meeting societal demands.

If modern nursing is believed to have begun with Florence Nightingale, then modern nursing was born in a Victorian era. Greatly influenced by Victorian ideas about women, nursing leaders and physicians of the day seemed intent on preserving the idea that nurses must remain "ladies." That they "accepted many of the Victorian notions of subservience is reflected in their writings and shown by their actions" (Ashley, 1976, p. 122). Nurses were often openly criticized for their lack of manners and womanly virtues. Many of the criticisms came from physicians. The American Journal of Nursing printed the comments of John Boyd, M.D. in April, 1913, as follows:

The nurse ought to be a woman first, last and always; everything good that the word stands for; educated, refined, gentle, firm, broad minded, mentality above the average, human, earnest, healthy, dignified, truthful, and possessing a good knowledge, first, of the healthy individual and then the disease to which he or she is subject (p. 505).

The same nursing journal printed an article by Dr. Walter Sands Mills entitled "Some Nurses' Vagaries" in February, 1913. It was the nurses' manners that were most annoying to this physician. He reported that one nurse would "blow on every spoonful of any hot liquid that she
fed to her patient to cool it before putting it in the patient's mouth."
The doctor names one of his own vagaries as he goes on to say "Now that
nurse was young and pretty, and if asculation (sic) [osculation] had been
in my line I should not have hesitated a moment to perform it, but I
could not possibly have her feed me in any such way as that; it would
have nauseated me." Little wonder he concluded his article by saying
"A thoroughly good woman can always be good, but a thoroughly good woman
who is a nurse probably has more temptations than those who take up
other kinds of work. It is to their honour that so few slip" (pp. 354-357).

Prior to Florence Nightingale, and existing along with her concepts
of nursing was the influence of the religious communities. The essential
character trait necessary to the religious community was that of obedi-
ence. The character of obedience was evidenced by an acceptance of the
will of God through total submission to one's superiors. The good
hospital nun or the good student nurse humbly did as she was told with
unquestioning belief, demonstrating complete faith in the wisdom of those
more exalted in rank than she, the priest and the physician. Training
stressed docility, passivity, humility, and a total disregard for
personal thoughts and needs. According to Sellew and Nuesse (1946),
"The self-sacrifice of these early Christians prompts modern nurses to
wonder how they explained to themselves the intensity of their love for
the poor and afflicted . . . they were seeking their perfection by
serving Christ in their fellowmen" (pp. 70-80). Asceticism is closely
identified with Christianity and the philosophy of asceticism was
typical of early nursing and nursing education. It was in the Victorian era under the influence of asceticism that the early nursing leaders attempted to define the role of nurse.

The nursing role had to be defined in terms of the physician even more so than the roles of the dentists and pharmacists, who were earlier on the health care scene. This was because licensure in nursing was about a generation behind that in medicine and the primary position in the health field had been taken by the physician (Bullough & Bullough, 1978, pp. 98-111, 136-138). Role definition of nursing was hampered because nursing, probably more than any occupation except house­wifery, reflected the sterotyped role of women. From the beginning, the nursing role has been defined as more limiting than it really was because nursing was considered a women's profession while medicine generally was restricted to men. Because the role of women was very narrowly and strictly defined, the role of nurses was also very narrowly and strictly defined. However, the definition of nursing and the practice of nursing differed because female nurses pretended to leave most of the decisions to male physicians while in effect making decisions of their own or manipulating the physicians to make the desired decisions (Stein, 1967).

Although nurses probably knew the male-female game which tends to go along with subordination prior to entering nursing, the precedent for this behavior pattern in nursing was set by Florence Nightingale (Smith, 1958). Nightingale was undoubtedly accepting the norms of her day when in Scutari she refused to allow the nurses under her command to give any care to the wounded men until the surgeons "ordered" them to do so
(Woodham-Smith, 1951, pp. 98-110). While this mechanism gained the support of the army doctors for the nurses, it also established the surgeon as a superior power over the nurse. For many years nursing students have been taught to be ladylike, subservient, and manipulative.

According to Strauss, Schatzman, Erlick, Bucher, and Sabshin (1965), the shortage of men in the profession of nursing, and the quota system in medicine which operated for many years to limit the number of women admitted to medical schools has greatly increased the sex segregation between medicine and nursing. This segregation has contributed to a stylized communication pattern between medicine and nursing. Communication is further distorted by the fact that the nurses in hospitals and other health care agencies are hired by, paid by, and under the control of an administrator, usually male, while they take direction from a physician and serve yet another. Nurses have been forced to learn to negotiate, and gamesmanship has become a part of their lives (Strauss et al., 1965, pp. 147-169).

Early American nursing educators did not agree on the character of the relationship between the nurse and the physician. Robb (1901) advocated dedication to nursing, a selfless denial of personal comfort, and an unquestioning loyalty to physicians. M. Adelaid Nutting fought for increased educational opportunities for nurses that would enable them to make intelligent judgments. Lavinia L. Dock (1907) referred to the nursing sisters of the old religious orders as being closely confined in shackles of mental subjugation and stated that "if now, having secured the freedom which was denied to the sister of the religious orders, we shirk its responsibilities and ignore its duties, then we
deliberately clothe ourselves again in her narrowmindedness but without her holy zeal and self-consecration" (p. 895).

The previously quoted words of Annie W. Goodrich, "if our schools were really schools it would not be possible for them to be under any labor law," summed up the problem and at the same time gave direction to future goals for the nurses. A speaker at the National League of Nursing Education in 1915 outlined the action to be taken with these words:

As far as I am aware only one state - California - includes hospitals and training schools, and controls the hours of duty for nurses as it does for women in factories. With this in view are we not in great danger of having the privilege of legislating for ourselves removed? Some other body seeing the ill effect of long hours of work for nurses may force us in other states by labor laws to conform to a standard which we should have ourselves recognized and established.

One question for us to consider is - How can we place ourselves above and beyond the control of labor laws? As a nursing body we must recognize that shorter hours are demanded, and, could we not place in our state bills [nurse practice acts] a clause to that effect, thus putting our registered training schools above criticism and reproach? Then, as speedily as possible, should we not make our training schools comply with the educational requirements of colleges and universities, thus placing nursing on a professional basis. The term "professional" can be applied in law only to a calling associated with a college or university, or to one where the degree of diploma is awarded through a college or university, or a chartered educational institution of that rank (Goodrich, 1915, pp. 184-185).

Goldmark (1923) reports that the first step towards university recognition of the nurses' training was taken in 1899 when Teachers College admitted properly qualified graduate nurses to the junior class, thus giving approximately two years of college credit to three years of hospital work.
Many history of nursing textbooks and the Goldmark report give credit to the University of Minnesota for the establishment of the first collegiate school of nursing in 1909. However, Gray's (1960) history of that school states that baccalaureate degrees were not awarded until approximately 1920 (p. 53). Baccalaureate degree or "special professional degree", nursing leaders were generally grateful for some association with a university.

According to Goldmark (1923):

We have to consider the ... status and value of the university ... on the side of physical facilities ... the standard plant and equipment for laboratory work in the sciences which the individual training school finds it so difficult if not impossible to command; supplies and materials of all sorts are abundant ... extensive libraries and convenient reading rooms ... On the side of instruction, the training school, unendowed as it is, can rarely afford the best teaching; the college or university connection guarantees teaching by men and women who are not only specialists in their subjects but trained teachers as well.

Thus the ... influence of the university ... can scarcely be overemphasized. Hardly less valuable is the effect of the university atmosphere and surroundings on the student morale ... She feels, too, a new sense of dignity and of the importance of her work through her recognition as a member of an educational institution.

But the university with its large endowment and liberal educational standards is important not only for physical facilities, level of instruction, and stimulation of morale; it is important for the essential character of the training school itself ... The long struggle, the devoted labor on the part of nursing instructors to make the student's professional training the first objective of the school is doomed to defeat by a system which depends on the training school for an unpaid nursing staff, and in any conflict between education and practical service must always put education last. In strong contrast is the position of the school of nursing which, as an integral part of a university, exists primarily as an educational undertaking (pp. 483-486).
The response following recognition of the need for baccalaureate curricula for nursing was not always accompanied by thorough study of the nature of the responsibility assumed and of the appropriate educational and social objectives. As a consequence, the programs established had a wide variety in effectiveness. Many collegiate institutions having nursing programs failed to maintain for students in nursing the same policies and standards as for those in other professional curricula leading to a baccalaureate degree. In spite of the greater resources of institutions of higher education, the preparation for nursing in some degree programs was inferior to that in some hospital schools (Bridgman, 1953).

The first steps toward baccalaureate level nursing was the establishment of a relationship with a university. According to Nutting (1912):

Some of the training schools which have succeeded in establishing such a relationship in a greater or less degree are those connected with the hospitals here named, the institutions with which they are related being given also:

- Children's Hospital, Boston, Mass., with Simmons College
- The Presbyterian Hospital, Chicago, Ill., with Rush Medical College.
- The Mercy Hospital, Chicago, Ill., with Northwestern University Medical School.
- Wesley Hospital, Chicago, Ill., with Northwestern University Medical School.
- Evanston Hospital, Chicago, Ill., with Northwestern University Medical School.
- Provident Hospital, Chicago, Ill., with Northwestern University Medical School.
- Lane Hospital, San Francisco, Cal., with Cooper Medical College, Leland, Stanford.
- Iowa Methodist Hospital, Des Moines, Iowa, with Drake Medical College, Drake University.
- Madison General Hospital, Madison, Wis., with University of Wisconsin, for some class and laboratory work (p. 46).
Nutting (1912) noted that the most promising effort being made at the time to establish nursing on a satisfactory educational basis was that effort of the University of Minnesota. Both the University of Minnesota College of Medicine and Surgery, and the University of Texas medical department had control of the nursing programs connected with their universities. A different and "less close relationship with the university" was held by those schools of nursing "forming an integral part of the university and other hospitals." These institutions were listed by Nutting as:

University of Michigan, Ann Arbor, Mich.;
George Washington University, Washington, D.C.;
University of Virginia, Charlottesville, Va.;
University of Colorado, Boulder, Colo.;
Washington University, St. Louis, Mo.; and the
University of Missouri, Columbia, Mo. (p. 47).

Nutting (1912) encouraged nurse educators to move toward higher education, but she sounded a warning note when she stated:

An interesting opportunity exists here for strengthening and developing training schools and improving the education of nurses which should be fully utilized. All of the resources of the university, and not alone those of the medical department, should be freely available to student nurses, since nursing draws from many sources beyond the strictly medical and sanitary for its perfection. Valuable, however, as are these connections with university, college, or technical school, they will not alone solve the problem of education in nursing. If the connection is through the hospital of which the training school is a part, there may be certain opportunities available, certain privileges granted to the student nurses, but there is no certainty that the university hospital will differ materially from other hospitals in its relation to the training schools. There are several schools belonging to university hospitals reaping no obvious benefit from such relationships. If, on the other hand, the training school is a department of the medical school, there may be some further advantages secured to it, but there is no guarantee that
the medical school will be willing to incur any appreciable expense for the training school or accord it any real freedom for growth . . . . It is the opinion of some of those who have for many years been engaged in hospital and training school work, who have given careful study to the peculiar relationship which has been established between them, and have met in every form the difficulties due to that relationship, that the first step toward developing proper schools of nursing lies in separating them from the hospital and its control and placing them upon an independent basis. Under the present system the school has no life of its own. It is in essence simply a part of the hospital service, and it is unquestionably governed in all its important functions, not by a body concerned with their fulfillment, but by everyday hospital conditions and necessities. That a number of important hospitals are interested in their schools and kindly disposed toward their students does not greatly affect the situation. It does not insure the maintenance of any stable educational policy; it does not prevent sweeping changes in the school as the result of a change in the administrative staff of the hospital, and members of that staff who may be hostile to the education of nurses will have power to do such destructive work in the training school as may set it back for years, upon so insecure a foundation does it now stand (pp. 48-49).

Nutting (1912) did not devalue the hospital experience, rather she encouraged a "sounder scientific foundation and a fuller knowledge of the principles and the general theory underlying and relative to the art of nursing" (p. 53). She stated that no one with any real knowledge of the hospital situation could underestimate the value of the opportunity for learning afforded in the hospital. However, "these magnificent opportunities should only be given to students thoroughly prepared to take the fullest possible advantage of them" (p. 53).
Iowa 1907-1918

According to Cole (1940), the eight years from 1908 to 1916 were years of reasonable prosperity in Iowa. The Iowa people lived in general contentment. The farmers were improving their homes and barns. Silos were being built to store animal food. In the towns and cities corresponding developments were under way. Many cities had new industries or were making efforts to attract new industries (pp. 442-443).

It was not until 1914 that an ominous cloud appeared on the European side of the Atlantic. On June 28 the Archduke Francis Ferdinand, the heir to the throne of Austria-Hungary, and his wife were shot and killed in Bosnia. The government of Austria-Hungary sent an ultimatum to the government of Serbia, which it accused of complicity in the crime. Serbia refused to agree to the terms of the ultimatum. To enforce its demands, Austria-Hungary then prepared to invade Serbia. It was the beginning of what became World War I.

For a while the war in Europe added greatly to the prosperity of the people of Iowa, especially the farmers. Food products had become important commodities, and Iowa had an abundance of such products (Cole, 1940, p. 443).

In January, 1913, Governor Carroll turned his office over to George W. Clarke of Adel. According to Cole, (1940) Clark was "almost a Progressive" whose first requests of the General Assembly included a request for the improvement of the grounds around the State Capital. For nearly thirty years the State Capital had "held up its gilded dome in a squalid patch of weeds" (p. 441).
In 1915 Senator Eli C. Perkins sponsored a bill creating a Children's Hospital at Iowa City in connection with the Medical School of the State University. Cole (1940) reports:

According to the Perkins Bill, free medical and surgical treatment was provided in this hospital for all sick or crippled children whose parents could not provide such treatment for them. In a single year as many as a thousand unfortunate children have been restored to near normal status. This Children's Hospital may be called one of Iowa's noblest institutions. In 1919 treatment of indigent persons at State expense was extended to adults, but the number so cared for is limited by the State appropriations (p. 442).

President Wilson issued a proclamation calling upon all Americans to remain neutral in thought, word and deed. American ships sailed to the fighting nations of Europe loaded with food products and the munitions of war.

Wilson was reelected President of the United States in 1916, and William L. Harding of Sioux City was elected Governor of Iowa. A series of incidents eventually led President Wilson to present a statement of grievances before Congress on April 2, 1917. The result was a declaration of war, first against Germany on April sixth and later against Austria-Hungary.

Cole (1940) states that the declaration of war was popular in America, and in fact so popular that "few members of Congress dared to vote against it. One . . . vote in the negative was Harry E. Hull, who then represented the Second Iowa District in Congress . . . he was roundly denounced in early all the Iowa newspapers" (pp. 446-447).
While the years from 1908 to 1916 were defined as years of reasonable prosperity in Iowa, the health conditions in Iowa during the same time period were another story. The Iowa Health Bulletins of 1910b carried news of Iowa's health and sanitary conditions. An article in the third quarter edition indicated the number of cases of scarlet fever and diphtheria reported in 1909 were less than the number reported in 1908; however, the deaths due to the two diseases had increased. The number of smallpox cases had declined from 2,820 in 1908 to 846 in 1909. However, there were no deaths due to smallpox in 1908, and four deaths attributed to the disease in 1909. There were half as many cases of measles in 1909 with twice as many deaths when compared to the 1908 report (p. 38). According to the first quarter edition, poliomyelitis occurred for the first time in epidemic form in 1910a with 186 cases and 29 deaths being reported (p. 11). The use of the common drinking cup was condemned (pp. 21-22). The sanitary distribution of bakers' goods was encouraged with the words:

How many drivers of bakery wagons deliver bread like kindling wood? The hands that hold the reins, adjust the harness and pat the horse are used to pile loaves like firewood, on shelves and against coats that could be used for cultural purposes by a bacteriologist. The uncovered loaves are subsequently pawed over by grocery clerks and delivery boys, none of whom are especially addicted to cleanliness (p. 25).

Cedar Falls, Des Moines, and Oskaloosa all suffered outbreaks of typhoid fever during 1911 and 1912 (Sixteenth Biennial Report, 1912, 1913, pp. 212-270). Dr. E. E. Munger, Spencer, Iowa, in a paper presented to the American Medical Association in June, 1912, and reproduced in the Sixteenth Biennial Report, stated that "Stamping out of typhoid
fever is one of the great tasks before the profession of this country" (p. 227). Dr. Munger went on to encourage hospital treatment for care and cure of diseases and safe delivery of children. He praised the Thirty-Third General Assembly of Iowa because of the law "this legislature deliberately enacted making possible the ultimate establishment of an adequate supply of hospitals with equal rights to all and special privileges to none" (p. 282). In a footnote entitled "Some Fundamental Truths" Dr. Munger States, "while trained nursing is an essential part of the treatment, the cost of such nursing is so high that it is next to impossible for any but the very well to do to avail themselves of its great benefits" (p. 282). Dr. Munger expressed the sentiment of the time when he stated that, "A necessary and most important adjunct will be a training school for nurses" (p. 283). He was speaking of the establishment of county hospitals, and noted that the "first hospitals built under the Iowa Law were located in counties bearing the names of Washington and Jefferson" (p. 283).

Nursing became increasingly important to the health of Iowa citizens. Public Health Nursing, in the form of Visiting Nursing under private boards, first made its appearance in Iowa at Davenport in 1902. School nursing had its start in Des Moines in 1906. Nurses had organized and succeeded in obtaining the first registration act in 1907 (Wilson, 1932, pp. 122-128).

The first registration act was considered weak by many nurses. It did not have provision for an inspector of training schools. Its examiner board included physicians, members of the Iowa State Board of
Health, and the Secretary of the Iowa State Board of Health. Most important, all decisions of the Iowa State Board of Health regarding nursing matters were final. Nonetheless, the nurses worked within the law and there was progress in the areas of registration of nurses working for money, minimum standards for schools of nursing, and strengthening the legislation controlling nursing in the State of Iowa.

Registration of Nurses in Iowa, 1907-1918

A report of the nurse examining board was given June 4, 1908 at the annual convention of the Iowa State Association of Graduate Nurses (ISARN) in Sioux City by Clara L. Craine. Craine announced that the first examination for Iowa Nurses was scheduled September 23rd and 24th of 1907. But as it turned out "most of the applications up to that time were from those who would be granted certificates by the law without examination. Only seven had applied who were not thus entitled and they had notified the Board that they would not appear at this time, hence no meeting was held" (ISARN, Minutes, 1908, p. 61).

The first examination administered by the State Board of Examiners for Nurses was reported by Craine at the 1908 convention as follows:

January 4th, 1980, I was notified that the approaching examinations would be divided between Drs. Powers, Eiker, and Thomas, Sister Mechtildes, and myself, each examiner to prepare ten questions, which schedule was to be submitted to the Board in advance of the meeting.

The following subjects were assigned to me:
Elementary Hygiene, Dietetics, Food Values, Domestic Service, Obstetrical Nursing.

January 29th and 30th, this meeting was held. Seven nurses were examined, an oral examination with practical demonstration occupying the full day of the 30th at Mercy Hospital, conducted by Sister Mechtildes.
and myself. The scope of this examination was planned in conjunction with Dr. Thomas who was assigned this work with us. The papers of the written examination were forwarded to us later, each examiner marking the papers of their own division.

Each paper had a confidential number instead of the name of the applicant, so the examiner was entirely without knowledge as to whose paper was being passed upon. The grading was upon the scale of 100, a percent of 75 being required. Later we were informed that all who had taken the examination had passed . . . .

The total number of nurses registered to date is 715. Of these 532 are graduates from Iowa Training Schools, and 83 from outside schools as follows: Illinois, Ohio, New York, California, Massachusetts, Michigan, Missouri, Minnesota, Nebraska, Connecticut, Colorado, Wyoming, New Hampshire, Wisconsin, Pennsylvania, District of Columbia, Canada, London and Berlin (pp. 61-64).

According to the Iowa Health Bulletin, Special, 1915, printed by the Iowa State Board of Health, Certificate Number One was issued to Della Weeks, a graduate of Cottage Hospital, Des Moines, Iowa by exemption before the law was in force. Certificate Number Two was issued to Alice Edith Isaacson, a graduate of St. Luke's Hospital, Cedar Rapids, Iowa, by exemption. Certificate Number Three was issued to Rachel Estelle Campbell, a graduate of Illinois Training School, Chicago, Illinois by exemption. The first certificate obtained upon examination was Certificate Number 696, issued to Christina Colling, a graduate of St. Joseph's Mercy Hospital, Sioux City, Iowa (pp. 108-162).

The requirements for the candidates for examination for nurses registration were given in the Iowa Health Bulletin, 1909A, as follows:

Candidates for examination must not be less than 23 years of age and of good moral character. They must be graduates of training schools recognized as in good standing by the Iowa Board of Health, and shall have received two years instruction in a general hospital. Applicants are required to file an application upon forms provided by the Board,
together with the examination fee of $5.00, at least two weeks prior to the date of the examination (p. 98).

The number of nurses registering in Iowa continued to increase. From the 715 reported in 1908 to the end of the biennial period in 1910 an additional 254 nurses were registered. A report of the Nurses' Department printed in the Iowa State Department of Health publication stated:

At the end of the biennial period, June 30, 1910, there were 969 nurses registered in Iowa. Of this number 254 were granted certificates during the last biennial period. Of this number 66 were registered without examination, as provided for in Section 2, Chapter 139, Acts of the Thirty Second General Assembly; 10 were registered without examination, as provided for in Section 2575-a-29, Supplement to the Code, and 178 were registered after having passed a satisfactory examination before this board (Fifteenth Biennial, 1910, 1911, p. 75).

The 1915 Special Bulletin of the State Health Department indicates there were in excess of 2000 nurses registered by June of 1915 (p. 162).

The examination fee of $5.00 paid by the nurses was not retained by the Nurses' Department, but was turned back to the State. Funds were very limited for the Nurses' Department, and for the Board of Health.

In May, 1909 Secretary of the Board of Health, Louis A. Thomas wrote:

Owing to the lack of funds, the State Board of Health has reluctantly decided that it will be necessary to discontinue the Bulletin as a Monthly Publication. The proposed change will take effect upon the close of the present fiscal year, June 30, 1909. After July 1st the Bulletin will be published quarterly . . . The Board receives an annual appropriation of $5,000, exactly the same amount it received when first organized in 1880. This appropriation is expected to cover all expenses of the department . . . salary . . . supplies and other contingent expenses.

Recognizing the urgent needs of the department, the Senate of the Thirty-third General Assembly voted to increase the annual appropriation to $9,000 but the House
of Representatives refused to concur . . . no department can render the most efficient services unless provided with ample facilities (Iowa Health Bulletin, May, 1909b, p. 162).

The Iowa State Association of Registered (changed from Graduate) Nurses was also attempting to increase funds for the Nurses' Department. The Association had a special interest in an increase in the fee for examination because "on account of insufficient funds accruing from low fees for examination, it was necessary to reimburse nurse members of the Board of Nurse Examiners out of the treasury of the state association" (Wilson, 1932, p. 19).

The committee on legislation reported the Iowa State Association of Registered Nurses efforts to increase the revenue for the purpose of registration at the annual meeting held June 4, 1909, in Dubuque:

Report of the committee on legislation was given by Miss Estella Campbell of Des Moines, in the absence of Mrs. J. W. Tyrrell of Des Moines . . . In January, 1909, Dr. Sams, who was a member of the Nurses' Examining Board and also a member of the State Board of Health, wrote to the legislative committee requesting that a copy of the proposed amendments to the registration law be sent to him. This was done at once, the following amendments being proposed:

Section II, "registration fee of five dollars ($5.00)" be stricken out and made to read "registration fee of ten ($10.00)."

Section III, clause reading "each applicant shall pay the secretary of the State Board of Health five dollars ($5.00)," shall read, "each applicant shall pay the secretary of the State Board of Health ten dollars ($10.00)," and the clause reading, "the fee for such certificate shall be twenty dollars ($20.00)." The reason for the proposed amendments was that the present income from the nurses seeking registration is not sufficient to cover expenses incurred in carrying on the work and the state will not assume any indebtedness.
A later letter written to Dr. Sams asking what had been done in regard to this matter was answered with the information that same had been turned over to Dr. L. A. Thomas, Secretary of the State Board of Health. Dr. Thomas, upon being consulted, stated that there was no hurry about this matter and it would be looked after later.

The legislative committee interviewed several members of the legislature both in senate and house endeavoring to interest them in these amendments, also in trying to secure for the Nurses Examining Board an appropriation from the State to make up for the amount turned over to the State at the end of the year. The last named seemed entirely hopeless as each one said it was easier to secure an amendment to the State law than to secure an appropriation. As this was a hopeless undertaking, interest was then centered on the amendments.

Dr. Clark, of Grinnell, member of the Senate, accepted our proposition that he handle this work for us in the Senate, and said that further visits from the legislative committee would be entirely unnecessary. As this committee has been some nuisance in years past and has received such courteous treatment at the hands of the members, it was their judgment to allow Dr. Clark to control this matter as he saw fit. Dr. Marston of the house was next interviewed with the same result as with Dr. Clark, and as both men have in the past been most friendly to the movement of the nurses, the committee felt that the work was well placed. As a very hard fight was on at the time for both the doctors' law and the dentists', on the same question, it is now quite evident that the nurses' amendments were considered of comparatively little consequence and were given little, if any, attention. Dr. Thomas interested himself in this work, but not as a member of the legislature, and his work was of little avail. All the committee has to report as a result of their efforts is that no attention was paid to the amendments and the bill remains as originally passed (I.S.A.R.N. Minutes, 1909, pp. 83-88).

The chairman of the legislative committee spent many hours meeting with members of the House and Senate in an effort to interest the legislative body in the concerns of the nurses. The members of the legislative body were not dealing with a voting constituent. The legislators were dealing with women.
According to Ashley (1976), nurses did not realize the full connection between the right to vote, which was a status independent from men, and professional status comparable to men. Nurses merely wanted the social sanctions and protection accorded other professional groups. Registration was a professional and an educational issue. Ashley states:

Nurses themselves did not identify their problem as a women's problem. Instead, their efforts were limited to the single issue of having trained nurses rather than untrained nurses recognized as the only people allowed to give nursing care for a fee. Though the nurses' movement did take place during the same period when women were struggling to get the vote, the two movements were not related or coordinated (p. 116).

Indeed, in spite of the difficulty with the State legislature, the Iowa State Association of Registered Nurses (I.S.A.R.N.) did not formally endorse Woman's Suffrage at the 1909 convention (I.S.A.R.N. Minutes, p. 271).

The 1909 convention heard the suggestion of the legislative committee that the chairman be paid a salary for the time spent in Des Moines during the session of the legislature and "be instructed to give personal attention to all matters placed in her hands with a firm determination to personally supervise the work step by step, during the time required to obtain satisfactory results" (I.S.A.R.N. Minutes, 1909, p. 89). The convention also voted to pay the "fees now due the two nurses on the Examining Board" (I.S.A.R.N. Minutes, 1909, pp. 88-89).

One month after the nurses' convention, July 1, 1909, Dr. L. A. Thomas retired, and Dr. Guilford H. Sumner of Waterloo became Secretary of the State Board of Health. Six months after assuming his duties he made the Fifteenth Biennial Report (1910) to Governor Carroll. In his
report he pointed out that the appropriated sum of $5,000 for public health purposes amounted to an "appropriation of one-fifth of a cent for each person" in Iowa (Fifteenth Biennial, 1910, 1912, p. 13).

Dr. Sumner submitted the expenses of the health department and noted that it was within the law and perfectly right that all surpluses in all various accounts kept for the State Board of Health be returned to the State in so far as appropriations are concerned; "but is all wrong to charge off surpluses in the Fee Account. The departments supported by fees should be allowed to use all the fees collected; for, when the fiscal year ends and the fees are charged off, the departments are left without funds" (Fifteenth Biennial, 1910, 1912, p. 16).

Dr. Sumner suggested that the coming General Assembly remand all fees to the departments from which they had been taken and in the future allow the departments to use the fees collected.

Dr. Sumner published an article in the January, 1911, Iowa Health Bulletin that compared the public health appropriations of other states with the Iowa appropriation. His article, titled "Iowa at the Tail-End of the Comet of Progress in Health Matters," states in part:

Why should the people of Iowa have less protection than those of other states? Iowa needs the best and her people are entitled to the same excellent care that is given to the citizens of other states . . . there is no other way to classify Iowa than to place her at the foot of the list (p. 58).

Thirty-two states and their public health appropriations are listed in the article. Pennsylvania with $1,500,000 is number one. Georgia with $21,500 is number twenty-one. Wisconsin with an appropriation of $11,500 is number thirty-one, and Iowa with the appropriation made in
1880 and still in effect of $5,000 was listed as number thirty-two (pp. 59-60). Two years later, when Dr. Sumner filed the Sixteenth Biennial Report of the State Board of Health, 1912,(1913), his suggestions were somewhat terse in that he stated:

As regards our suggestions, it is only necessary to say that we refer and have referred to our former Biennial Report, 1908-1910, and ask that every suggestion made in that report be executed and carried out, as I believe none of them have been considered sufficiently to have yet been enacted into law. It is hardly necessary to repeat our suggestions in this Biennial Report, as that would be needless expenditure of time and money, for it is easier to again read our Biennial Report of 1908-1910 (p. 10).

He further comments about the lack of necessary funds:

The annual appropriation of $5,000 has long ago ceased to be sufficient to meet the great needs of a state like Iowa. This amount when divided among two and a quarter millions of Iowa citizenship does not amount to very much per person, hence this amount should be increased many times. With this appropriation . . . the State Board of Health has been able to do much, but not all that should have been done . . . the Thirty-fourth General Assembly, increased the Secretary's salary but it did not increase the appropriation therefore . . . the salary of the secretary is paid from this $5,000 appropriation, and the balance is used for public health purposes (p. 18).

According to the "Nursing News and Announcements" section of the June, 1913, American Journal of Nursing:

During the last General Assembly Dr. Sumner secured for the nurses, $1400 which had gone into the state treasury according to an old law. As this was money obtained from examination fees, it now awaits the association's disposal, and a committee has been appointed to meet the members of the board of health for the purpose of having a nurse appointed to act as state inspector of training schools (p. 724).
Early Professional Period in Iowa Schools of Nursing, 1907-1918

The first report of the nurse examining board to the Iowa State Association of Graduate Nurses was given June 4, 1908, at the convention in Sioux City. The report was given by Clara L. Craine of Davenport as follows:

I take pleasure in reporting to you today some thing of the work that has come into my hands as a member of the State Board of Examiners for Nurses.

The first meeting of the Board was in August [1907], at which time preliminary work was done on minimum requirements, and a list of Training Schools was decided upon which should be declared in good standing with the Iowa State Board of Health until January 1, 1908 . . . .

October 22nd and 23rd a meeting was held at which the matter of minimum requirements for Training Schools was further considered. At this time a very warm discussion ensued in regard to the eligibility of the Training Schools connected with the Iowa State Institutions. Representatives of these institutions appeared before the State Board of Health to answer questions and consider how they could come within the requirements of the law. Your representatives were invited into this session and were asked to take part in the discussion which they did. We insisted that if these schools were to be included with the recognized Training Schools of Iowa, there attendants should be required to take at least six months in a general hospital. The final decision, however, rested not with us, but with the Board of Health (I.S.A.R.N. Minutes, 1908, p. 61).

Nutting (1912) pointed out the responsibility of the examining boards. The board had responsibility of "determining all standards, as well as of interpreting and enforcing them" (p. 56). Even with this awesome responsibility for the profession of nursing, the Iowa law had been enacted with the provision that the decisions of the State Board of Health were final (p. 59).

Nutting (1912) suggested that the board of examiners should be "carefully organized, with its powers accurately defined. It should
have suitable headquarters, properly kept records, and enough clerical assistance to do its work" (p. 56). The Iowa Board of Examiners for Nurses did not have a headquarters and the records are not clear as to the exact amount of influence they had in setting the minimum requirements for nurses and nurses training schools that were adopted January 22, 1908 by the Iowa State Board of Health. The requirements adopted stated the following criteria for applicants and for the curriculum.

Conditions for Admission to Training Schools
All applicants for admission to training schools for registered nurses must file credentials as follows:

1st. Satisfactory evidence of good moral character.

2nd. A certificate showing completion of Grammar School Course, (after July 1st, 1910, a High School Course will be required) or in the absence of such certificate the applicant shall pass a satisfactory examination equivalent thereto, such examination to be conducted under the supervision of the Principal of an accredited High School. An applicant failing in one or more branches in such examination, may be conditioned for one year at which time such deficiency must be removed.

Requirements for Training Schools
To obtain recognition by this Board, training schools shall conform to the following requirements:

1st. They shall require their matriculates to comply with the preliminary requirements prescribed by this Board, and keep an accurate record of each student's credentials.

2nd. The training school must be connected with a General or State Hospital (or Sanitorium) having not less than 25 beds, and the number of beds must be at least twice the number of students in the school, depending on the character of the hospital facilities, with private or ward practice.

Special or State Hospital Training Schools
Graduates of training schools connected with a special or State Hospital will be admitted to examination by this Board, only upon satisfactory evidence of having completed a course of six months instruction in the General Hospital of a training school of recognized standing with this Board. Said course may be taken during the last six months preceding graduation, or within one year subsequent thereto.
Branches to be Taught

The following branches must be taught by all training schools: (1) Elementary Anatomy; (2) Elementary Physiology; (3) Elementary Bacteriology and Pathology; (4) Elementary Materia Medica and Elementary Toxicoology; (5) Elementary Hygiene; (6) Dietetics; Domestic Science and Food Values; (7) Practical Nursing; (8) Surgical Nursing; including Gynecology, and the eye and ear; (9) Medical Nursing; including nervous diseases and contagious diseases; (10) Nursing in children's diseases; (11) Obstetrical Nursing, and practical experience in at least six cases; (12) Chemistry and Urinary Analysis; (13) Medical Jurisprudence; (14) Nursing of diseases peculiar to men for men.

Note - The State examination will include also the Rules and Regulations of the Iowa State Board of Health relating to infectious and contagious diseases and quarantine.

Period of Training

The period of instruction in the training school shall not be less than two (2) full years, (three (3) years being recommended.) Training schools having a three years' course, and wishing to send pupils outside the hospital in private cases, may pursue this practice only during the student's senior year; but said outside work shall not exceed three months of the course. Training schools having only a two (2) years' course will not be accorded this privilege unless they extend the course to three (3) years.

After July 1, 1910, no training schools will be in good standing with this Board, which does not require a three (3) years' course of study. It is earnestly recommended that all training schools forthwith adopt a three (3) year course.

Schedule of Subjects

The following schedule of subjects, together with the number of hours to be taught in each branch, is recommended by the Board; a rearrangement of the several branches, however, may be made to meet local conditions.

First Year

Anatomy ......................... 15 hours
Hydrotherapy ..................... 5
Practical Nursing including massage ........ 40
Physiology ........................ 15
Hygiene ........................... 5
Domestic Science (including dietetics and cookery, food values) ........... 20
Second Year
Medical nursing including nervous diseases, contagious diseases, and the Rules and Regulations of the Iowa State Board of Health relating to infectious diseases and quarantine. 36
Practical Nursing. 18
Children's Diseases. 15
Obstetrical Nursing and Obstetrics. 10
Materia Medica and Toxicology. 10
Surgical Nursing including eye and ear and Gynecology. 30
Preparation of food for sick. 20
Nursing Ethics. 3
142 hours

Third Year
Medical Nursing including nervous diseases and contagious diseases. 20
Surgical Nursing including eye and ear and Gynecology. 20
Electro therapeutics. 5
Medical Jurisprudence. 5
Nursing ethics. 3
Review. 50
Emergencies. 15

Training Schools maintaining only a two year course must arrange their schedule so as to cover the work outlined in the foregoing requirements ("Iowa State Board of Health Schedule of Minimum Requirements for Nurses and Nurses Training Schools," Fourteenth biennial, 1908, 1909, pp. 129-132).

The curriculum plan reflects the service ideology of training.

Students were sent into medical wards, surgical wards, and pediatric wards to obtain clinical experience in performing techniques and procedures that provided services in these departments. The skill orientation model met the needs of the hospital but not the needs of future practitioners or their clients. Transmitting factual information about
medical conditions, surgery, and treatments is not an appropriate method of teaching nursing or health maintenance. The focus was to provide service in hospitals.

Craine's first report of the nurse examining board to the Iowa State Association of Graduate Nurses also contained information about what happened when the training schools were notified of the Schedule of Minimum Requirements adopted by the Iowa State Board of Health. She reported:

April 23rd [1908], we were notified that the State Board of Health had sent out to all Training Schools whose graduates had applied for registration or appeared for examination, the schedule of minimum requirements which they had adopted January 22nd and that at their April meeting, they had decided to turn the matter over to the two nurses of the Examining Board, instructing them to ascertain and report what schools had come up to the requirements. The list turned over to us included sixty-seven Training Schools, thirty-eight of which are in Iowa. This list was divided between Sister Mechtildes and myself, the number assigned to me being 53. To each one of these a letter was sent asking for their present curriculum; a number had to be written to a second time; a few the third time; the total number of letters sent being 72. The result of this correspondence you will learn later as our report goes to Dr. Eiker, and from him to the State Board of Health for final action (I.S.A.R.N. Minutes, 1908, pp. 61-64).

The nurses communicated with the State Board of Health both directly and indirectly. The American Journal of Nursing had many articles about nursing practice and nursing education. The nurses apparently thought Dr. Louis Thomas and the members of the State Board of Health would benefit by reading some nursing literature. The motion was made that "we send a subscription to the American Journal of Nursing to Dr. Louis A. Thomas, Secretary of the State Board of Health. Carried"
Nutting (1912) discusses the importance of training school inspection by pointing out:

For adequate supervision of this branch of woman's education in any State, it will be necessary to develop further the idea of systematic and continuous inspection and supervision of hospitals and training schools. In the present stage of nursing education, where the relationships between the training school and the hospital, the physician and the public, present issues of a complicated and confused nature . . . there is urgent need of the most patient, careful investigation, study, and thought. Inspectors should be selected with the utmost care from those who have had exceptional education and training and who are recognized as experts in training school work (p. 57).

Iowa nurses recognized the difficulty in assuring compliance with minimum standards in training schools without an inspector of training schools for the State. At the 1908 convention a motion was made by Grace Baker of Cedar Rapids that "the secretary send a strong communication to Dr. Louis A. Thomas, Secretary of the State Board of Health, that it is the sense of this meeting that the State Board of Health employ a registered nurse to act as inspector of Training Schools in this State. Carried" (I.S.A.R.N. Minutes, 1908, pp. 66-67).

The month after the 1908 Iowa State Association of Registered Nurses convention, July, 1908, the regular meeting of the Iowa State Board of Health was held. Minutes of the meeting state that the Secretary of the State Board of Health was instructed to inform officials of the University Hospital of Iowa City that the Training School "has not been recognized for the reason that the University Hospital does not provide training in medical jurisprudence and that the sleeping facilities for the nurses of the Homeopathic Department are unsatisfactory,
unsuitable and inadequate" (Board of Nursing. Minutes, 1908, p. 14). At the time the University Hospital at Iowa City operated two schools of nursing, one connected with the Homeopathic School of Medicine, the other connected with the Regular School of Medicine.

A handwritten note entitled "Homeopathic Hospital in 1910" located in the Archives of the University of Iowa Libraries, Iowa City, Iowa describes the physical plant and some nursing practices:

Located at southeast corner of Dubuque and Jefferson St. Three story brick building faced Jefferson St. Kitchen, utility rooms and storage in basement.
First floor, office, Supt. of Nurses' quarters and lounge. Classrooms, nursery and dining room.
Second Floor. Operating room, Supply rooms, Men's ward - 16 beds (I think) Woman's ward, 16 beds. Private rooms - 5.
Third Floor, Dormitory for Nurses - 16-18.
Each nurse received $5.00 per month from U.I. for books. Nurses did all cleaning, waxing ward floors and halls. Two nurses assigned to kitchen to help prepare patients trays. Two nurses for night duty.
During the Senior year, a nurse was often sent into a home for private duty practice. The patient paid U.I. for their services.

In 1911 nurses were housed in a brick house on Jefferson St. Just east of St. Mary's Church. Then the third floor of Hospital was used for Internes' quarters. The Homeopathic nurses attended Bacteriology and Physiology classes with the U.I. Nursing School Classes.
Later the Nurses home was on West Jefferson . . . until the Homeopathic Medical School and School of nursing was closed in 1919 . . . My Iowa R.N. #1256 (Hayes, 1910).

Records indicate that Ira Mae Hayes was issued certificate number 1256 (Iowa Health Bulletin, Special Report, 1915, p. 128).

In three months, by October 15, 1908, at the Iowa State Board of Health meeting, Dr. Eiker presented and read a communication from the "management of the nurses' training school in connection with the College
of Homeopathic Medicine at Iowa City." The communication stated:

In accordance with the instructions given by this board at the July meeting the nurses' home of the College of Homeopathic Medicine has been remodeled and thereby bettered and the Training School in connection with the College of Medicine has installed the teaching of medical jurisprudence in its schedule of studies (Board of Nursing. Minutes, 1908, p. 15).

The Nurses' Committee recommended, in view of the fact that the deficiencies had been made up, the Nurses' Training School of the College of Homeopathic Medicine at Iowa City be placed in good standing with the board and that the Secretary be instructed to so notify the President of the University (Board of Nursing. Minutes, 1908, p. 15).

Graduates of training schools could be admitted to the state examination only if the training school from which they graduated was placed in good standing by the Iowa State Board of Health. In order to be placed in good standing the training school had to file a certified copy of their curriculum with the Iowa State Board of Health. Schools in good standing by October 15, 1908 were:

| Boone          | Eleanor Moor Hospital          |
| Burlington    | Mercy Hospital; Burlington City Hospital |
| Carroll       | St. Anthony's Hospital         |
| Cedar Rapids  | St. Luke's Hospital; Mercy Hospital |
| Cherokee      | Cherokee State Hospital Training School |
| Clarinda      | Clarinda State Hospital Training School |
| Clinton       | St. Joseph's Mercy Hospital    |
| Council Bluffs| Mercy Hospital; Edmundson Memorial Hospital |
| Creston       | Cottage Hospital               |
| Davenport     | St. Luke's Hospital; Mercy Hospital |
| Des Moines    | Mercy Hospital; Iowa Methodist Hospital |
| Dubuque       | Finley Hospital; St. Joseph's Mercy Hospital |
| Glenwood      | Glenwood State Hospital Training School |
| Ida Grove     | Conn Brothers Hospital         |
| Independence  | Independence State Hospital Training School |
| Keokuk        | Graham Hospital; St. Joseph's Hospital |
| Marshalltown  | St. Thomas' Mercy Hospital     |
Muscatine  Benjamine Hershey Memorial Hospital
Mt. Pleasant  Mt. Pleasant State Hospital Training School
Ottumwa  Ottumwa Hospital
Sioux City  Samaritan Hospital; St. Joseph's Mercy Hospital
Waterloo  Synodical Presbyterial Hospital
(Board of Nursing. Minutes, 1908, p. 20).

Maquoketa  Iowa Sanitarium Training School for Nurses
Muscatine  Bellevue Hospital Training School for Nurses
Iowa City  State University Hospital Training School for Nurses; State University Homeopathic Hospital Training School for Nurses
Des Moines  Iowa Sanitarium Training School for Nurses
(Board of Nursing. Minutes, 1908, pp. 66-67).

In 1912, the Bulletin of the United States Bureau of Education published information about Iowa Schools of Nursing. Schools were classified as either A or B. The A schools were connected with general hospitals. The B schools were connected with Hospitals for the treatment of nervous and mental diseases (Nutting, 1912). The A schools are listed in Table 1.

Beginning with the Minimum Standards for Training Schools in 1908, graduates were permitted to write the state examination only if they were graduated from an approved school. Schools were placed on the approved list when they met all of the minimum requirements. They were stricken from the list when they did not meet the minimum requirements. An examination of names of schools on the approved lists shows the list varied from year to year.

The schools apparently made an effort to graduate their students from an approved school. A History of Broadlawns School of Nursing Des Moines, Iowa, states:

In 1916 permission to open a school of nursing was granted . . . . Students were admitted under Miss Hanchette, R.N., director of nurses. At that time the bed capacity was
Table One

<table>
<thead>
<tr>
<th>Location</th>
<th>Name of school or hospital with which it is connected</th>
<th>Superintendent of Nurses</th>
</tr>
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<tbody>
<tr>
<td>Boone</td>
<td>Eleanor Moore Hospital</td>
<td>Mary Elizabeth Good</td>
</tr>
<tr>
<td>Burlington</td>
<td>Burlington Hospital</td>
<td>Miss C.C. Keeler</td>
</tr>
<tr>
<td>Cedar Rapids</td>
<td>Mercy Hospital</td>
<td>Sister Mary Alphonsus</td>
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<td>...do.....</td>
<td>St. Luke's Hospital</td>
<td>Grace E. Baker</td>
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<td>Centerville</td>
<td>St. Joseph's Mercy Hospital</td>
<td>Sister Mary Evangelista</td>
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<tr>
<td>Clinton</td>
<td>Agatha Hospital</td>
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<td>...do.....</td>
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<td>Rev. Mother M. Pius</td>
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<td>Council Bluffs</td>
<td>Jennie Edmundson Memorial</td>
<td>Ella M. Stimback</td>
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<td>...do.....</td>
<td>Mercy Hospital</td>
<td>Sister Mary Thomas, R.N.</td>
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<td>Davenport</td>
<td>...do.........................</td>
<td>Sister Mary Alphonsus</td>
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<td>...do.....</td>
<td>St. Luke's Hospital</td>
<td>Martha Oaks</td>
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<td>Des Moines</td>
<td>Iowa Methodist Hospital</td>
<td>Millicent Schear</td>
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<td>Sister Mary Machtildes</td>
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<tr>
<td>Dubuque</td>
<td>Finley Hospital</td>
<td>Alice E. Issacson R.N.</td>
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<td>...do.....</td>
<td>St. Joseph's Mercy Hospital</td>
<td>Sister Mary Ursula</td>
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<tr>
<td>Iowa City</td>
<td>Iowa State University Hospital</td>
<td>Mary E. Nesbit</td>
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<td>University Homeopathic Hospital</td>
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<td>Iowa Falls</td>
<td>Ellsworth Hospital</td>
<td>Margaret Stoddard</td>
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<td>Mary C. Jackson R.N.</td>
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<td>students graduates enrolled in 1911</td>
<td>capacity (beds)</td>
<td>average students sent into families</td>
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<tr>
<td>Location</td>
<td>Name of school or hospital with which it is connected</td>
<td>Superintendent of Nurses</td>
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<tr>
<td>...do.......</td>
<td>St. Joseph's Mercy Hospital</td>
<td>Sister Mary Daniel</td>
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<td>...do.......</td>
<td>Samaritan Hospital</td>
<td>Nellie M. Porter</td>
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<tr>
<td>Waterloo</td>
<td>Synodical Presbyterian Hospital</td>
<td>Aurilla J. Perry</td>
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<tr>
<td>students enrolled in 1911</td>
<td>capacity (beds)</td>
<td>average daily census</td>
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(Nutting, 1912, pp. 68-69).
sixty beds, sufficient for an accredited school. The next year the school was accredited on probation but it did not become [fully] accredited that year so the ten students enrolled in December 1917 were transferred elsewhere to complete their training. Several went to Iowa Congregational Hospital and one returned to graduate when the school did become accredited (Note 1, p. 6).

In 1916 this training school was connected with the Miners' and Industrial Workers' Hospital. The students were enrolled, but there were no graduates from the Miners' and Industrial Workers' Hospital. In 1918 the Miners' and Industrial Workers' Hospital was purchased by the Presbyterian Synod and a school of nursing established. This school was called the Samaritan Hospital Training School for Nurses. The Samaritan Hospital Training School for Nurses was placed on the approved list of schools of nursing by the Iowa State Board of Health in 1920. The first class was graduated in 1921. There were three graduates; Florence Campbell, Lyda Kumba, and Madeline Saunders. At the time of graduation the hospital was known as the Des Moines City Hospital with Miss Martha Hansen, R.N., as Director of Nurses. Broadlawns Polk County Hospital School of Nursing was organized as a continuation of the school which had been operating in the hospital while under city management (History of Broadlawns, (Note 1); Bulletin of Iowa Nurses' Association, 1961, pp. 8-9).

There were forty nine training schools in good standing with the State Board of Health on June 30, 1912. These schools were:

Atlantic Atlantic Hospital Training School
Boone Eleanore Moore Hospital
Burlington Burlington City Hospital
Burlington Mercy Hospital
Carroll St. Anthony's Hospital
Cedar Rapids          Mercy Hospital
Cedar Rapids          St. Joseph's Mercy Hospital
Cherokee             Cherokee State Hospital
Clarinda             Clarinda State Hospital
Clinton              Agatha Hospital
Clinton              St. Joseph's Mercy Hospital
Council Bluffs       Jennie Edmundson Memorial Hospital
Council Bluffs       Mercy Hospital
Cresco               St. Joseph's Mercy Hospital
Creston              Cottage Hospital
Creston              Unity Hospital
Davenport            Davenport Hospital
Davenport            Mercy Hospital
Davenport            St. Luke's Hospital
Des Moines           Des Moines General Hospital
Des Moines           Iowa Methodist Hospital
Des Moines           Mercy Hospital
Dubuque              Finley Hospital
Dubuque              St. Joseph's Mercy Hospital
Ft. Dodge            St. Joseph's Mercy Hospital
Glenwood             Glenwood State Hospital
Ida Grove            Conn Brothers' Hospital
Independence         Independence State Hospital
Iowa City            State University Hospital (Regular)
Iowa City            State University Hospital (Homeopathic)
Keokuk               Graham Hospital
Keokuk               St. Joseph's Hospital
Maquoketa            Iowa Sanitarium Training School
Marshalltown         St. Thomas' Mercy Hospital
Mason City           City Park Hospital
Muscatine            Benjamin Hershey Memorial Hospital
Muscatine            Bellevue Hospital
Mt. Pleasant         Mt. Pleasant State Hospital
Nevada               Iowa Sanitarium Training School
Oskaloosa            Abbott Hospital
Oskaloosa            Oskaloosa Public Hospital
Ottumwa              Ottumwa Hospital
Sioux City           German Lutheran Hospital
Sioux City           Samaritan Hospital
Sioux City           St. Joseph's Mercy Hospital
Sioux City           St. Vincent's Hospital
Waterloo             Synodical Presbyterian Hospital
Waverly              St. Joseph's Mercy Hospital

(Sixteenth Biennial Report, 1912, 1913, pp. 176-177).

Whether or not the schools were observing an eight hour day is a matter of interpretation. Some schools reported an eight or nine hour day for the Bulletin of the United States Bureau of Education, 1912,
Publication (Nutting, 1912). There is no indication of whether the eight hours included classes. Nights were often very much longer duty on the wards.

The Eight Hour Day

Bjornstad (1952) quotes Dr. E. E. Dorr's remarks at the graduation exercises of the first class of the School of Nursing of Iowa Methodist Hospital in Des Moines in 1903:

"Sometimes I feel that nurses ought to form a union that their hours of work might be regulated. I do not stand alone when I assert that twelve hours of each day is too long for any girl to be continuously engaged in one occupation. Eight hours would be sufficient" (p. 15).

The board of directors of the hospital apparently were in agreement with Dr. Dorr when he said in his opinion "it would be much better if our girls would devote three years in our hospital ... and go out well and strong and well-educated in their work than to spend two years and graduate in falling health ... (because of) long hours of labor" (p. 15). At least the board of directors persuaded the students who entered nurses training in 1904 to stay an extra year. However, it was not until 1939 that student nurses at Iowa Methodist Hospital gained an eight-hour day, forty-eight-hour week, including class time (p. 16).

A History of the College of Nursing the State University of Iowa, by Means (1951) states:

"By 1931 the School of Nursing provided an eight hour day, "except in cases of emergency." The student received one afternoon during the week and one-half day off duty on Sunday" (p. 7).
Wearin (1964) describes the Jennie Edmundson Hospital School of Nursing, Council Bluffs, practice of assigning students in 1919 as follows:

The student nurses are furnished with indoor uniforms and receive a monthly allowance of five dollars after they have been accepted. The third year they are paid ten dollars a month. The day nurses are on duty from 7 a.m. until 7 p.m. with three hours off for recreation and rest. Night nurses work from 7 p.m. until 7 a.m. with two hours off for rest. Nurses are allowed a half day each week and part of each Sunday. Two weeks vacation is given each year (p. 5).

The practice of being on duty at 7 a.m. until 11 a.m., off duty for classes and meal from 11 a.m. until 3 p.m., back on duty from 3 p.m. until 7 p.m. is called a "split shift." In 1953 students in hospital schools of nursing (in Iowa) were assigned "split shifts." Night duty was only eight hours, from 11 p.m. until 7 a.m.; however, all students were expected to attend classes held during the day.

Affiliation

Minimum standards for training schools were adopted by the Iowa State Board of Health in January, 1908. "Graduates of training schools connected with a special or State Hospital" were required to complete an additional six months instruction. In order to be admitted to the registration examination, the additional instruction must be in a general hospital of a training school with recognized standing. This requirement was the first recorded demand for affiliation for nursing students (Board of Nursing. Minutes, January, 1908, p. 9).

Training schools in the State Institutions were established prior to the Registration Act of 1907. The Tenth Biennial Report of the
Trustees, Superintendent, and Treasurer, of the State Hospital Training School at Independence (1891) states the rational for establishing a training school for nurses as follows:

The primary objective of this school is to make good attendants, and thus benefit the patients. A secondary consideration is to acquire knowledge and skills that will prove useful to the attendant all through life; another aim is to supply the state of Iowa with responsible persons, of both sexes, who can be employed as attendants or companions for the insane, when relatives prefer to have them kept and treated at home (Tenth Biennial Report, 1892, pp. 27-28).

Attendants were taught how to use fever thermometers, measure pulse and respirations, observe excretions and eruptions. "In general six winter months are given to lecture and study, the six summer months to clinical instruction in nursing." Clinical instruction was by opportunity and accomplished by physicians (Tenth Biennial Report, 1892, p. 27). The requirements for graduation were as follows:

Two years service in this hospital, the faithful attendance upon two courses of lectures and passing a credible examination in the content of three textbooks, entitles an attendant to a diploma (Tenth Biennial Report, 1892, p. 27).

Graduation of the first class at the Independence State Hospital in April 1892 was reported by the Trustees, Superintendent, Steward and Treasurer in the 12th Biennial Report of 1895. The advantage of having a training school was expressed:

In training schools connected with General hospitals in the cities, the pupils leave immediately after graduation. Here the compensation is increased and the graduates are encouraged to continue their service for a good long time, consequently the superintendent is so well supplied with experienced attendants that he can discharge them not only for violating the rules of the institution but also for inefficiency (Twelfth Biennial Report, 1896, pp. 30-31).
Nurses were expected to be willing and able workers, "the sympathetic and self sacrificing spirit of the Master is the crowning virtue of a nurse" (Twelfth Biennial Report, 1896, p. 31). Women were to be at least 18 years of age, men were to be 20, and none were accepted if they were over 30 years old. Women were to weigh not less than 125 pounds, men were to weigh no less than 160 pounds, both were expected to have completed a "good common school education" (Thirteenth Biennial Report, 1897, 1898, p. 28).

The State Hospital at Independence recognized the disadvantage for their graduates. They stated that the "science of nursing is taught, but the art of nursing is more fully acquired where accident cases, surgical, disease, lying in and children" are cared for. To compensate the student for this deficiency, the Hospital paid a higher rate to the members of the training school than other training schools were paying at the time because the "experience is not so varied and valuable if they want to be a professional nurse and a private duty nurse" (Fourteenth Biennial Report, 1899, 1900, pp. 27-28).

The majority of nurses and nursing students were female. It was not easy to attract men into nursing. According to the Fourteenth Biennial report of 1899, "higher pay" was needed at the State Hospital in Independence to "secure good men" (p. 30). It was not only the lack of pay, but also the belief that "under the existing social conditions nursing does not appear to be part of a man's sphere" which kept men out of nursing (Sixteenth Biennial Report, 1903, 1904, p. 5).
Who should be called nurse and who should be called attendant was clarified at the State Hospital in Independence, through the Fifteenth Biennial Report, 1901, with the words, "call only graduates of the School nurses" (p. 26). The question was further clarified in 1903 when the Superintendent reported that at the State Hospital in Independence it required two years of study to become a graduate attendant and three years of study to earn the certificate for graduate nurse (Sixteenth Biennial Report, 1903, 1904, p. 4).

At the State Hospital in Independence all of the attendants were required to attend the lectures and to receive the practical instruction provided for the third year's course. However, by 1906 no certificates had yet been issued to the pupils as graduate nurses. The reason given by W. P. Grumbaker, Superintendent of the State Hospital, was that "the course . . . implies that before a certificate as graduate nurse is awarded, the candidate shall have become proficient in administering massage. Unfortunately . . . we have been unable to institute anything save the most rudimentary . . . . We have, therefore, deemed it inadvisable to bestow the diploma on any of our third year scholars" (Grumbaker, 1906, pp. 536-537).

The improvement of training schools was of primary concern to Iowa nurses for several years. The ways and means of how to improve the schools "had become a familiar topic" (Wilson, 1932, p. 20).

According to Wilson (1932), the problem of improving the training schools was attacked in two different ways:
First a committee composed of Jane Garrod, Millicent Schaar and Mrs. Jennie H. Dodge sought to give direction in a code of ethics. They pointed out that improving schools is only the means of improving nurses, and improvement in nurses is traceable to their deportment, hence the necessity for a common rule of action for all . . . . Another committee composed of Grace Baker, Grace D. McEldery, and Elizabeth McMahon, began an investigation of the schools themselves as to courses taught and teaching equipment. They began with the schools in connection with the State Hospitals, four of them (p. 20).

The report of the committee on the investigation of training schools connected with hospitals for the treatment of the insane or state institutions was read and accepted by the Examining Board for Nurses.

The Report of the Examining Board for Nurses, given in Davenport, Iowa, May 21, 1912 by Sister M. Alphonsus Fox, Director of the Davenport Mercy Hospital School of Nursing and Member of the Examining Board included the report of the investigation committee:

Report of the committee of investigation of training schools connected with state institutions for the insane . . . the information concerning the Nurses Training in the various State Institutions has been secured entirely through correspondence, no member of the committee having recently visited any of the institutions.

The Independence State Hospital gives a three year course, the Training School classes lasting eight months each year. In the first year the class takes up Materia Medica, Anatomy and Physiology. In the second year Nursing and Psychology. The third year Minor Surgery and Invalid Cooking. The training also includes two months of actual experience in an infirmary ward. They try not to accept applicants under 18 years of age. The compensation varies from $21.00 to $35.00 per month, according to the length of service. They reciprocate with other state institutions having a training school equal to their own.
The Cherokee State Hospital gives a course consisting of didactic lectures on the subjects of Anatomy, Physiology, Materia Medica, Medical Chemistry, Surgery, Gynaecology, Hygiene, Bandaging, Eye and Ear, Foods and Feeding.

The lectures are illustrated by specimens and anatomical preparations. Lectures on the management of the patient and the culinary art, with special reference to the sick, are given once a week by the Superintendent of the Training School. The Course of Instruction comprises three consecutive years. The rule has been not to admit any one under nineteen years of age to the Training School.

The Clarinda State Hospital gives a three year course. There is no age limit and no affiliation. The attendance of the first and second year course is obligatory on all employees of the nursing department in the institution. The instruction in nursing is given by a trained nurse, in other subjects by the physicians. The third year course is not obligatory. The students of this course shall be selected from the graduates from the second year course on account of special ability and fitness for the work.

After this third year work and the passing of an examination on the topics studied, a diploma of "Trained Nurse" will be issued to the candidate.

The State Sanitorium for the treatment of Tuberculosis at Oakdale has just started its Training School. They will not try to compete with those schools at institutions more thoroughly equipped for such work but do expect to send out nurses who will be especially well trained along the line of Tuberculosis work. The length of the course is two years. They have no age limit. They have nothing in the way of affiliation. As to compensation, the nurses are paid from fifteen to thirty-five dollars a month with usual maintenance. They have mostly graduated patients on their list at present, and therefore the probation period has not been definitely arranged, it being found that by the time they are sufficiently able to stand full work, they have long passed the place where probation period is necessary. As to curriculum, the first year consists of Anatomy, Physiology, Elementary Bacteriology, Hygiene, Practical Nursing, Special Nursing Tuberculosis, Elementary Materia Medica, Bandaging, Some Dietetics. Second year work; Elementary work with diseases, Urinalysis and Laboratory Work, Elementary Obstetrics, Gynecology, and Children's Diseases, Surgical Nursing, some work in Massage with Hydrotherapeutics, etc., Materia Medica and Therapeutics. There is some special work in the third year for any who wish to take it. Signed, Grace E. Baker, R.N. Chairman (I.S.A.R.N. Minutes, 1912, pp. 189-192).
The Preliminary Course in Iowa

A move to improve the schools of nursing and nursing practice in the State of Iowa was begun in 1912 and 1913. The Iowa Board of Health Nurse Examiners Committee Minutes of 1912 state that nurses' committee was asked to prepare "a schedule of uniform reports on Nurses' Training Schools when a member makes his examinations in his respective district (Board of Nursing. Minutes, Oct. 31, 1912, p. 30). This was the first move toward uniform inspection of training schools.

The fact that many nurses were practicing without being registered was of concern to the Iowa Board of Health and to the nurses themselves. A committee, appointed at the 1912 convention of the I.S.A.R.N., secured the names and addresses of these delinquents and submitted them to the state board of health. There were approximately two hundred nurses practicing without registration. Some held positions in schools of nursing. October 31, 1912, Dr. Smith reported to the Nurses' Committee of the Iowa Board of Health that he had made an inspection of Agetha Hospital and St. Joseph's Mercy Hospital in Clinton and found that they "comply to all requirements of this Board except that they do not employ as their superintendents and teaching nurses, nurses who are registered in Iowa" (Board of Nursing. Minutes, 1912, p. 30).

At the I.S.A.R.N. 1913 convention, held in Des Moines, the nurses agreed on essential criteria as the basis of a program to improve schools of nursing. The criteria were as follows:

1. A training school inspector who should be a qualified nurse.
2. Two-year course to which would be added, three months preliminary course and time for specialized study.
3. Not more than fifty hours of duty per week.
4. Adequate living quarters and class rooms for students (Wilson, 1932, pp. 20-21).

The Iowa Board of Health Nurses' Department Committee was finding that record keeping within the schools was inadequate. "In most of the schools the system of keeping a record of the student nurses' work and credits was defective and inadequate and in some the instruction was too much like that suitable for students in medical college" (Board of Nursing. Minutes, 1913, p. 32). The Iowa Board of Health recommended that the "Nurses' Committee consider the matter of preparing for adoption by the Board of uniform system of keeping Nurses' Training School Records with the idea of a Record Book being printed and furnished by the Board for this purpose" (Board of Nursing. Minutes, 1913, p. 32).

In 1915, the Iowa State Board of Health published a Special Bulletin for the nurses and hospitals of the state. The purpose of the publication was to provide necessary information "which every Nurse and Hospital in the State should acquire" (Iowa Health Bulletin, 1915, p. 11). The rules governing the training of nurses and management of training schools were:

Rule 1 relates to the requirements as regards superintendent and teaching force.
Rule 2, conditions for admission to training schools.
Rule 3, requirements for accredited training schools in the State of Iowa.
Rule 4, course of instruction.
Rule 5, special or state hospital training schools (p. 11).

The 1915 Special Bulletin of the Iowa State Board of Health, "Special Notice to Superintendents of Training Schools," stated:
Boards Authority. In accordance with the provisions of Chapter 139, Acts of the Thirty-second General Assembly . . . the Iowa State Board of Health has formulated and adopted the following schedule of minimum requirements for Nurses' Training Schools and administration thereto. This schedule will take effect and be in force on and after July 1, 1916. After July 1, 1917, no Training School will be regarded as in good standing . . . unless such a school conforms to all of the requirements herein prescribed; nor will the graduates of such institutions receiving their diplomas subsequent to July 1, 1917, be admitted to examination . . . for . . . registration, until all requirements have been met.

Requirements as Regards Superintendent and Teaching Force. Rule 1. No Training School for nurses will be recognized as in good standing . . . whose Superintendent and teaching force are not registered nurses in the State of Iowa . . . All Training Schools . . . shall make application on the regular form provided by said Board, which form shall contain all the information relative to the hospital management, its course of study and qualifications of its Superintendent and teaching force. Said application shall be filled out . . . filed with the Secretary . . . and shall be presented by the Secretary to the Board for the Board's consideration as to whether the Training School . . . shall be placed upon the accredited list or rejected . . . All schools for the training of nurses that do not make application in accordance with this rule will not be in good standing with the Iowa Board after July 1, 1917.

Conditions for Admission to Training Schools. Rule 2. All applicants . . . must file credentials as follows: 1st. Satisfactory evidence of good moral character. 2d. A certificate showing the completion of a Grammar School and not less than one year of a High School Course, of . . . equivalent thereto . . . an applicant . . . may be conditioned for one year, at which time such deficiency must be removed.

Requirements for Accredited Training Schools in the State of Iowa. Rule 3. The Hospital must have a capacity of not less than thirty-five beds and a daily average of twenty-five patients. The hospital must afford proper facilities for conducting a Training School for Nurses. It must provide experiences in the following departments of nursing: Medicine Surgery, Obstetrics, and Children's Diseases. It must provide a systematic course of theoretical instruction in medical, surgical and obstetrical nursing and the divisions under these major subjects. Due attention must be given to the home life of the student. There must be a living room, a class
room, a demonstration room, and adequate equipment for teaching purposes. There must be a sufficient number of airy sleeping rooms; individual rooms are recommended. There must also be special provisions for night nurses' rooms. The diet must be simple, wholesome, well cooked and ample. The head of the Training School must be a Registered Nurse and must possess qualifications requisite for the administration of the Training School; she must have ability for teaching; she must be capable of guiding the student in moral discipline and of maintaining a high standard of educational and moral efficiency in her work.

A complete record must be kept of the students . . . qualifications for admission, class and lecture work, practical work, moral standing, general ability and efficiency.

Course of Instruction. Rule 4. A Three month's preliminary course is required for probationers. The regular course of instructions, theoretical and practical, must cover a period of three years . . . . When schools cannot provide opportunity for practical experience in any one major branch, they must affiliate with other approved schools, having . . . the required experience.

Training Schools may not place their pupils on special cases in the hospital until they have completed their first year; nor for a period exceeding six months during the course . . . . In cities maintaining a visiting nurse, it is recommended that senior pupils be given at least one month in this branch of the work.

The system of instruction as herein outlined is required as a guide in planning courses of study for Training Schools. It will form the basis of determining the standing of Training Schools . . . . Revision by the Iowa State Board of Nurses' Examiners will be necessary from time to time in order to meet the increased demands upon the profession. By establishing a uniform method of instruction, it is hoped to construct a sound educational system for students of the nursing profession of our State.

Examination papers and records . . . must be kept for State Board of Health inspection.

Special or State Hospital Training Schools. Rule 5. Graduates of Training Schools connected with special or State Hospitals wherein the course of study is not complete, will be admitted to examination by this Board, only upon satisfactory evidence of having completed a course of one year's instruction in the Training School of a General Hospital of recognized standing with this Board. Said course may be taken the last year preceding graduation or within one year subsequent thereto (Iowa Health Bulletin, 1915, pp. 17-19).
Standard Curriculum. All Training Schools in the state were to follow the same curriculum. According to the Special Bulletin, 1915, the schedule of subjects, "together with the number of hours to be taught in each branch, is required by the Iowa State Board of Health . . . this schedule must be followed . . . and each graduate must have completed the course and received the diploma before being admitted to examination for a nurse's certificate" (p. 19). In addition the hospital training schools were advised that they were "subject to visitation and examination by a committee . . . appointed by the Iowa State Board of Health, for the purpose of determining the . . . quality of the . . . teaching and training force, or faculty" (p. 19).

The subjects, in the order they were to be taught, were listed. It is interesting to note that the number of instructional hours in theory dropped from the 365 recommended in 1908 to a total of 195 hours of instruction in theory in 1915. However, the three months preliminary course listed the following content:

First Month. Talks on nursing as a profession.
   Qualifications of nurses.
   Personal Hygiene.
   Talks on care of rooms.
   Care of beds and mattresses after dismissal of patients.
   Care and protection of pillows, bed covers etc.
   Practical work in caring for pupils' rooms and their bath rooms.
   Talks on hospital routine, rules and foundation of ethics.
      Taking notes of same.
   Explanation of utensils and their use.
   Talks on care of all bed utensils, with disinfection and sterilization.
   Care of soiled linen.
   Preparation of trays and serving food, with explanation of different diets.
Serving and feeding helpless patients.
Care of linen rooms, service rooms, and bath rooms.
Talks on bed making, with demonstration.
Talks on answering patients' calls.
Making supplies under supervision.
Lights, ventilation, and management of same.
General hygiene of house.
Quiz on month's work.

Second Month. Talks on bathing, demonstration of bathing convalescent patients (bed and tub).
Cleaning and care of rubber good. Points in making patients comfortable.
Morning and evening toilet of patients.
Bed making for convalescent and operative patients.
Changing of position of patients. Changing of bed clothing.
Talks on taking pulse, temperature, and respiration.
Care of thermometers. Care of patient's clothing.
Care of cloths room.
Talks on appliances: pads, rings, cradles, hot water bags, bottles, bricks, head rests, etc.
Care of specimen bottles and collecting of specimens.
Talks on the following, taking notes of same:

BATHS:
- Sponge bath to reduce temperature. Packing, Tubbing
- Application and care of ice bags, ice caps, and ice coils.
- Medicated baths. Hot air baths. Sitz baths.
- Continuous baths.

ENEMATA:
- Emollient. Stimulating. Anti-spasmodic. Anthelmintic
- Carminative.
- Medicated -
  - Preparation of patient.
  - Method of giving.
  - Objective of giving.

DOUCHES:
- Vaginal and vesical.

CATHERIZATION:

POULTICES:
- Spice, bran, flaxseed.

PLASTERS:
- Antiphlogistine, mustard, belladonna.
- Vesicants. Cupping, Leeches. Fomentation, hot and cold.
Terpentine stupes. Ice pledgets. Irrigations, eye, ear, and nasal.
Quiz on month's work.

Taking temperature, pulse, and respirations. Hypodermics.
Talks on the following and taking notes of same:
Hypodermoclysis. Disinfection and sterilization.
Care of excreta from infectious patients. Care of isolated patients.
Care of mouth in fever patients. Disinfection of hands.
Disinfection of surfaces. Surgical supplies for bedside dressings.
Fumigation of rooms. Care of contagious and infectious patients.
Positions: dorsal, lithotomy, Fowler's, Sims, Trendelenberg knee-chest.
Elementary work in drug-room, diet kitchen, supply room, dressing-room, surgical department, medical department, children's department, operating room

Dr. Guilford H. Sumner, Secretary of the State Board of Health, acknowledged the Members of the Examining Committee, Catharine Earhart, Jennie Johnson, Dr. W. L. Bieering, President of the Board of Health, and others who helped formulate the Special Bulletin.

One contributor to the Special Bulletin was Dr. Charles Sumner Chase, who wrote "The Nurse's Confession of Faith," and dedicated it "to the large company of self-sacrificing and efficient nurses who constitute the alumnae of the various training schools of our state." The "confession of faith as relates to my sacred calling of ministering to the wants of others" contains the following resolves:

First: To devote my life, its energies, its capabilities, its hopes and its results to uplifting . . . healing and helping . . . aiding . . . to make life happier and to lift its social service upon a higher plane of living.
Second: To fit myself by tireless training . . . that I may never bring dishonor . . . upon so worthy and sacred a calling.

Third: To cultivate every attribute of mind and heart that may make my ministrations . . . lofty and all-praiseworthy.

Fourth: To esteem as a high privilege the opportunities that shall be open to me . . . to leave only pleasant recollections when my service shall have terminated.

Fifth: To the kind-hearted and helpful physicians with whom it will become my privilege and duty to serve at the bedside of the suffering, I pledge an instant, constant and faithful service. To serve with them is pleasant than to command alone.

Sixth and Lastly: To serve also in that larger field of the great world's activities . . . I shall count an equal privilege and honor as compared with all else in my life of service . . . unto the end of my life (Iowa Health Bulletin, 1915, p. 2).

**Legislative Activity**

The nurses worked long hours to secure a stronger nurse practice act. An account of how they accomplished some of their goals is given in the minutes of the convention of the I.S.A.R.N. held in Waterloo, Iowa, May 23, 1911. The report of the Legislative Committee was given by the Chairman, R. Estella Campbell, and continued by Louise Postelwait of Dubuque, who was the representative of the Association at Des Moines during the sessions of the legislature, the combined report stated:

The Chairman of the Legislative Committee wrote many letters in an attempt to secure a nurse who would take up the work at the state house during the legislative session in 1911 and finally secured Miss Postelwait whose report you will soon hear.

Upon Miss Postelwait's arrival soon after the opening of the session, your chairman went with her to the state house to get the lay of the land, to get acquainted with some of the legislative members and to secure a member of each body to handle our bill.

Our chief fight was to amend the laws so that the clause in regard to nurses practicing should be made compulsory, and that none should practice as registered, trained or graduated nurses except those holding certificates.
As has always been true, Senator Saunders of Council Bluff fought this measure. Your committee succeeded in obtaining the approval of the Public Health Committee and having it recommended as amended, but on the floor of the senate it was again amended until the clause had lost all force. On March 14th a visit was made to the state house by Millicent Schaar and your Chairman, Miss Postalwait having returned to Dubuque with the assurance that the bill was safe and all trouble over, to ascertain the truth of the report regarding "Dr. Saunders" amendment. Finding that the bill has passed the house in good order, but had been amended in the senate and returned to the house, we at once instructed our representatives to hold it unless it could be sent back to the senate for consideration. On March 25th the bill was returned to the senate for reconsideration with the result that it went through with the clause that no nurse can practice as a registered or graduated nurse without holding a state certificate.

Respectfully submitted, Estella Campbell, Chairman.

January 24, arrived in Des Moines 9:10 p.m. and saw Miss Campbell who explained the work and directed me what to do. Went over to the capital and secured a few copies of the registration law. Returned to Y.W.C.A., then went out to St. Catharine's Home and found I could get a room and board there.

January 25, Saw Miss Campbell who marked the changes in the law as the nurses wanted. The only changes were in Chapters 16 of the Supplement to the Code, 1907, inserting the words "graduate or trained" after word "registered" . . . .

Went to capital to see the physicians who are on the nurses' examining board, as the State Board of Health was in session, to get their approval of the changes, but was unable to see them until afternoon, at 2:00 p.m. Miss Campbell went with me. We met Dr. Hanchett of Council Bluffs, Dr. Decker of Davenport and Dr. Summer. Miss Campbell succeeded in getting their approval to the changes. They they referred us to Senator Bennett, who is chairman of the health committee of the senate and also a physician, and Representative Finlayson, who is chairman of the health committee of the house.

Met Senator Schiu of Dubuque who introduced me to Senator Bennett, and made an appointment for 1:00 p.m.

January 26. Saw Senator Bennett, and succeeded in getting him to consider the matter of introducing the bill; also Representative Finlayson, and said he would consider it.

January 27. Through Senator Bennett met Senator Jewell and Senator Chapman, also Senator McCullough, all physicians. Senator Jewell not very favorable toward bill. Others
friendly toward it. Assembly adjourned at noon to convene Monday at 10:00 a.m.

January 30. Went to capital. Saw Representative Finlayson who had bill drawn up but said he was too busy, but to see representatives from my own county. Met Representatives Miller and McCullough of Dubuque. Both friendly toward the bill and promised to do all they could.

Also saw Senator Bennett but so far he had not done anything, and was not in favor of having the word "trained" used, saying it was too broad a term to use and if it was omitted he would introduce and support the bill, and that he wished to see Dr. Summer before he said just what he would do.

January 31. Talked again with Representative Miller and Representative McCullough of Dubuque, also Representative O'Connor, and they advised me to have the bill taken up by the senate and get it through there first. Saw Senator Bennett again, but he had not been able to see Dr. Summer, but promised he would try and see him before he left the building and would let me know definitely the next day just what he would do.

February 1. Went with Senator Bennett to see Dr. Summer, and acting upon the advice of Dr. Sumner decided to leave out the word "trained" as they both thought it too broad a term, so Senator Bennett said he would introduce the bill and support it.

February 2. Bill introduced before the senate. Miss Campbell went with me before the health committee of senate in the afternoon. Bill referred to sub-committee.

February 3. Saw sub-committee. Senators Chapman, Legel and Malmberg; all seemed to be in favor of bill and Legel even thought the word "trained" should be used.

Assembly adjourned to convene Tuesday at 10:00 a.m.

February 7. Miss Campbell thought it best to have bill introduced before both houses, so Representative Miller of Dubuque introduced bill in house.

February 8. Went before Health Committee of house. Representative Miller of Bremer opposed bill; referred to sub-committee composed of Representatives Shankland, Linman and Brady.

February 9. Talked with Representative Linman and he was not in favor. Thought a good way to get the members of senate and house interested was to send a letter and copy of bill to nurses and training schools in different parts of the state; and have them write to their senators and representatives, so secured list of registered nurses and addresses from Miss Schaar of Methodist Hospital and sent out twenty five letters to various parts of state.
February 10. Talked with sub-committee of house and they said they would send in a favorable report.
February 11-13. Met quite a few of the members of the house and succeeded in getting them interested.
February 15. Bill on house calendar for passage.
February 16. Talked with Senator Bennett and he said the sub-committee report not favorable, said they had no objections to the bill but did not think it of sufficient importance to bring before the General Assembly, therefore committee recommended it for indefinite postponement.
February 17. Bill passed the house. Eighty-seven voting aye, one nay; absent or not voting 20.
Senator Bennett said that he would call it up in the senate and do what he could.
February 18. Returned to Dubuque. Time spent, three weeks and five and one-half days.
The following is the bill as it passed the house and senate on April 1st and 3rd:
Supplement to the Code, 1907, as amended by Chapter 157, Acts of the Thirty-third General Assembly, be and same is hereby repealed and the following enacted in lieu thereof: On and after the taking effect of this act, no person except one holding a certificate under Chapter 16 . . . shall advertise to be or assume or use the title of registered or graduate nurse; or use the abbreviation "R.N." or "G.N." or any other letters of figures to indicate that the person using the same is a registered or graduate nurse; and it shall be unlawful for any nurse to practice nursing as a registered or graduate nurse within this state without having first registered as provided . . . . Respectfully submitted, Louise Postelwait.
Motion made by Miss Edith Robinson of Des Moines that we accept this report and commend the work of the Legislative Committee. Motion carried (I.S.A.R.N. Minutes 1911, pp. 143-152).

A Report of the I.S.A.R.N. 1913 convention published in the American Journal of Nursing, June, 1913 stated that the nurses had won support in their efforts to improve nursing practice in Iowa. The report states:

The Iowa State Association of Registered Nurses held its tenth annual meeting at Des Moines, in the Savery Hotel, May 1 and 2 . . . . Hon. George Cosson, attorney-general of the state, gave a splendid talk in regard to the registration law and expressed his willingness to work with the nurses to see that it was enforced. He also talked on equal suffrage and told what advantage that
would be to the members, not only as women but as an organization . . . . Almost a unanimous vote was taken to have the tenth annual convention of the Iowa State Association of Registered Nurses go on record as endorsing equal suffrage (pp. 724-725).

World War I, Iowa Nurses

The State University of Iowa Bulletin (1918) summarized the effects of the European War (W.W.I.):

Even before the opening of the great war an unprecedented demand for nurses had manifested itself, and since the war began this demand has grown into an imperative summons. Before the present year is over America will have called to arms between two and three millions of men. That many thousands of nurses will be required both in this country and over seas, and not only for ourselves but also for our allies, is so obvious as not to need statement. Already our Government has called for thirty thousand, or nearly half of the trained nurses of the land, and the conflict, so far as America is concerned, has only just begun.

No one can doubt that the women of this country will respond freely to the call for service. As the men are marching bravely to camp and field, so the women will rally forth to care for our soldiers and to attend the sick whom these leave behind. It is the call of patriotism.

Under these circumstances it has become evident that the institutions which exist for the education of nurses must provide larger facilities for training and must quicken their efforts to gain the results desired. To this end the American Red Cross has offered its support to the establishment of a large training camp for this summer at Vassar College, where many women will pursue a preparatory course for the training of nurses. The University of Iowa opens its own facilities for the same purpose and will conduct a similar course during the summer months. This course is virtually identical with that of Vassar, with the exception of one feature of the requirement for admission. The American Red Cross has given its official endorsement of the University's plan, and the Iowa State Board of Health its approval of the proposed modification of the subsequent hospital training (p. 2).

The University of Iowa Bulletin (1918) did not promise the prospective student service in France, but did recognize that "Many who
contemplate entering the profession of nursing will be eager to serve in the hospitals of France. Whether or not this opportunity will come, probably no one is in a position to say; the duration of the war will yield the answer to the question." The plan to send 20,000 nurses with each million men was revealed. Employment prospects for the future were pointed out. "The depletion of the country's supply of nurses and the new openings now available . . . make it certain that no competent trained nurse will lack employment, whether it be in war or in peace' (p. 5).

The Social Status of Nursing

The public acceptance of hospital schools for nurses training served as recognition that women could provide public service. Caring for the sick and helpless had long been considered the work of women. Because this caring task was of paramount importance to hospitals and to families in communities formal training programs for nurses took on increasing value. Lowering the mortality rate, teaching the public about diseases, and preventing the spread of disease were the center of the nurses social contribution.

The predominant influence of a narrow service ideology in nursing education set limits to the growth of nursing. Disease orientation, the medical model, and the universal practice of having hospitals prepare nurses to function as professionals in schools, industries, clinics, health departments, and various other systems did very little or nothing to increase nursings' development as a health profession.
The Early Professional Period: A Summary

Has the Woman's Movement had an impact on the development of nursing education? The question must be examined in light of the developments of the early professional period of nursing.

The nurses viewed registration as a professional and an educational issue. They did not identify their problem as a woman's issue. Their efforts were limited to the single issue of providing trained nurses rather than untrained nurses to care for the sick. The goal of the early nursing leaders was to gain social sanctions and protection for the profession of nursing. Nurses wanted to be recognized as a profession. There were three organized professions in the health field; dentists, physicians and nurses. Nurses wanted to be recognized in the same manner as were the dentists and physicians.

The first registration laws gained the legal recognition desired by the nurses. This recognition did not, however, obtain for them the freedom to function independent of men as professionals. Instead, the laws served to make more evident the nurses' subservience to the physician.

The right to vote, a status afforded men, and full professional recognition, also a status afforded men, was not seriously considered by most early leaders in nursing. Nursing education needs and adequate care of the sick clouded the issue. The recognition won through the registration acts was that of practicing nursing under the supervision of physicians.
What has been the effect of medical domination on the development of nursing education? How did economic factors influence the development of professional nursing education? These questions are closely related. Many physicians served as hospital administrators. Hospital administrators, as a rule, were not unhappy with the apprenticeship system of nursing education.

The legal incorporation of inequality of physicians and nurses in the law gave possible legal sanction to medical sexism. The physicians, usually men, were to supervise nurses, usually women. This supervision was to occur whether or not the physician was physically present. This myth of supervision was as unrealistic then as it is now. It is literally an impossibility since, in most cases, physicians are not present in the settings where nurses are engaged in the practice of nursing.

Early nursing leaders soon found that the registration acts did not help end the commercial attitude toward the maintenance of hospital schools of nursing. The development of the profession of nursing could not be achieved in an atmosphere where the control over the nurse's education was in the hands of those who wished to exploit her for her labor. Instead, the apprenticeship system served as a means of keeping nurses oppressed both economically and professionally.

Apprentice nurses were taught to be loyal to the hospital. The nurses were to be obedient and docile. The poor working conditions were accepted in a spirit of unquestioning loyalty to the hospital.

With no public body outside of the hospital management regulating apprenticeship practices the problems increased. There was no numerical limitation placed on the number of apprentices. Each hospital was free
to meet its own need for nursing service. The practice of increasing the numbers of students to meet the demands of the hospital is illustrated by an outcome of the eight-hour-law in California. The shorter hours meant greater numbers of students to provide nursing service. There was no thought of employing more graduate nurses. Clearly, the eight-hour system in schools did not alter the fact that student nurses carried the workload in the hospitals. Hours were arranged and the number of students increased so that students still provided the majority of the nursing care.

Organized nursing campaigned for a shorter work day for the students, not necessarily as part of a labor movement. Nursing educators desired affiliation for students. Affiliation provides a wider range of clinical experience. In addition, a preliminary learning period was needed to allow the student nurse an opportunity to learn some basic skills prior to caring for the sick.

Nursing leaders moved to gain control of the profession by gaining control of the education for the profession. Slowly the state nurses' associations were able to alter the laws, or the rules and regulations, controlling nursing schools. Shorter work weeks were initiated for the student nurse. Preliminary learning periods became a reality. Affiliation was mandated in most states.

Much of what the nursing leaders were doing did not alter the paternal attitude toward nurses. The leader's efforts did not result in lessening the economic exploitation of student nurses. There was not a change in the commonly held attitudes toward women, especially
The political and social atmosphere of the time was not yet ready for women in nursing to create a different image in the public's mind.

The era of the early profession was dedicated to attempting to move nursing education away from apprenticeship. Nurse educators desired a college based nursing education program. Organized nursing launched a campaign to increase educational provisions in schools of nursing. This campaign led some physicians to fear that nurses would become the equals of physicians in knowledge and skill and would thus usurp the authority of the physician in the sickroom. In an effort to prevent this, the medical profession devalued the importance of education for nurses and warned nurses of the dangers inherent in their attempt to go beyond a certain level of knowledge.
This chapter examines the significant events in nursing education from 1918-1930. The events are discussed in relation to the questions of the research study. Each area of study is examined first from a national perspective, then from the perspective of the State of Iowa.

As America entered World War I, the nurses of the nation faced the challenge of providing nurse manpower for both the military and the civilian populations. Many women, trained and untrained, wanted to provide nursing care on the battlefield. Schools of nursing were asked to increase their admissions. Experimental programs for training nurses were launched.

The war demonstrated that women could serve in useful positions in time of national crisis. However, women were still not granted the same recognition as men. The discussion of Iowa during the war reveals that Iowa physicians serving in the war effort were recognized merely because they participated. Iowa nurses were not named unless their service was outstanding. Each one of the physicians leaving from Jennie Edmundson Memorial Hospital of Council Bluffs is listed by full name and rank. The nurses, more than twice as many, are known only as "the nurses." This point illustrates both the social position of women and the physician domination of the health care system.

The influenza epidemic is discussed to point out the fact that the education of nurses was secondary to patient care. During the epidemic, classes almost ceased. The self-sacrificing nurses were expected to increase their hours of labor. The health and welfare of the nurse
was secondary to that of the patient. The nurses' recognition for personal achievement was almost nonexistent. A probably result of this lack of recognition was the acute shortage of student nurses following the war and epidemic.

The economic influence on the development of nursing education is illustrated in the discussion of the relation of the schools to the hospital. The increase in the number of schools clearly illustrates the fact that schools were established as a reaction to hospital needs for nursing service.

The continued requirement of "good moral character" illustrates the continued influence of religion on nursing and nursing education. Most schools required "character" references from applicants. Perhaps the "good moral character" requirement also reflects the influence of Nightingale. Prior to Nightingale nursing existed in a low and dismal state. No one who could possibly earn a living in some other way would act as a nurse.

The deteriorating conditions in nursing education are validated in the discussion of the Goldmark Report and the grading of schools of nursing. The economic influence was the major factor in the decline of nursing education. Hospital care for patients increased. Since hospital administrators viewed nursing students as a necessity, and because their labor could be utilized at very low cost under an apprenticeship program, the number of nursing schools rapidly increased. While the number of nursing schools increased, the quality of nursing education decreased. Far too many nurses were graduated, many with in-
adequate training.

The effect of medical domination on the development of professional nursing education is discussed in relation to the development of university schools of nursing. In 1923, the Goldmark report pointed out that by establishing independent university schools of nursing, administrative exploitation of the labor of student nurses in hospitals would lessen. Basing the occupational training of a group in a university setting is a primary strategy for attempting upward occupational mobility. This is especially true since the academic revolution transformed the universities into just such professional training centers. The status of the university is considered necessary for increasing the status of the occupation trained there. However, with nursing, the strategy could not work because the work performed by the nurse is not totally independent. Through the laws, nurses had placed themselves under the supervision of physicians. The strategy to elevate nursing to a professional status must also involve changing laws defining the practice of nursing.

Nursing in World War I

An American army of three and a half million men was assembled, and over two million of this force were transported to France. American women wanted to help the fighting men and interest in nursing began to rise. Many women, without prior training, were eager to go to France to serve as nursing aides. These women were willing to go at their own expense and therefore enrolled in intensive Red Cross courses. On April 8, 1917, Clara Noyes, Director of the new Red Cross Bureau of Nursing, wrote to Mary Adelaide Nutting:
Surely we need your prayers. There are moments when I wonder whether we can stem the tide and control the hysterical desire on the part of thousands, literally thousands, to get into nursing or their hands upon it.

Tell Annie [Goodrich] of Albany that if I were not convinced before, I should be now that the most vital thing in the life of our profession is the protection of the use of the word nurse. Everyone seems to have gone mad. I talk until I am hoarse, dictating letters to doctors and women who want to be Red Cross nurses in a few minutes, not knowing the meaning of the word nurse and what a Red Cross nurse is (Noyes, Note 2).

Mary Adelaide Nutting soon headed a Committee on Nursing, formulated for the expressed purpose of determining the "wisest methods of meeting the present problems connected with the care of the sick and injured in hospitals and homes; the educational problems of nursing; and the extra-ordinary emergencies as they arise" (U.S. Council, 1917, pp. 1-5).

The Committee on Nursing was attached to the General Medical Board of the United States Council of National Defense and was granted federal status. Most of the committee's work was financed from funds contributed by friends of nursing and nurses themselves (Sellew & Nuesse, 1946).

During the period of active American participation in the war, about 22,000 nurses enrolled in the Army Nurse Corps. Of these approximately 11,000 served in government hospitals in the United States and 10,000 were sent overseas. Nurses enrolled in the American Red Cross, an additional 11,000 nurses, served as the unofficial reserve of the Army Nurse Corps. In total approximately 33,000 nurses served during the war (Sellew & Nuesse, 1946, p. 307).
Every nurse enrolled in the Army Nurse Corps might be taken away from the community where she was needed. An increasing problem was to meet the nursing needs at home. One answer to the problem was to increase the supply of student nurses. A widespread campaign was launched in an effort to attract students into nursing.

Nursing had received some unfavorable publicity earlier when the U.S. Department of Commerce and Labor issued the "Report on the Condition of Women and Child Wage-Earners in the United States." The 1911 report stated that the nurse was subjected to periods of long and exhausting mental and physical strain. Further, the report stated, the nurse's position made it convenient for her to "become a hard drinker or a drug fiend, and when a woman adopts either habit the chances of her going wrong in other ways are much increased." Even worse, the nurse was "in a position which makes it easy for men to essay advances toward her if they have any desire in that direction." The nurse did not have the protection of working in public, in contrast to women who worked in a store or factory. There was also no guarantee that all the patients would be female, and "when nursing a man, the opportunities for complications are evident" (pp. 87-89). Conditions in nursing schools were also held up to public attention. The December, 1913, Trained Nurse and Hospital Review contained a criticism of the quality of food given student nurses ("Are Nurses," 1913, pp. 364-365). In contrast, the July, 1918, Ladies' Home Journal urged women to help the "boys over there" by enrolling in schools of nursing.
Entitled "A Distinct Call to Women," the editorial asked:

Have you felt that you could best answer the war's appeal to you by entering the nursing service? Then this is the day of your opportunity, provided you are in earnest and wish to set your patriotic impulses free in the place where they will do the most good.

That place is in a regular nurses' training school, such as is conducted in nearly every hospital in America. Many women, untrained in nursing, have been disappointed to learn that their services were not wanted on the field of battle, nor even in a base hospital.

It is the professional nurse only who has been called and accepted, and more than a thousand of her are now in active service. More thousands will follow soon. They are the finest of their profession, and they go gladly; but do you realize that each one is leaving behind her important work in civil life, which must now be done by someone else?

We have no right to expect - though we may hope for - a short war. We must put away makeshift methods and think of a year from now, two years, perhaps even three years. The woman who enters training today is the woman who a little later will be prepared to take the place at home of the nurse has gone, or even to follow her to the Front.

The Red Cross earnestly hopes that many young women, particularly those with the advantages of a good education, will let their desire to be of service take a most practical form and prepare to enter a profession which has been called upon to do so noble a work (Taft, 1918, p. 22).

Efforts to attract women into nursing included an appeal from the General Medical Board Committee to the leading training schools to increase their enrollments to the limit of their capacities, resources, and clinical facilities. As a result of these recruitment measures, the number of students entering schools of nursing during the year 1917-1918 increased by approximately 25 percent. This meant that instead of a yearly number of 12,000 to 15,000 graduate nurses, the nation would have 15,000 to 18,000 graduate nurses available in 1919 and 1920. The wartime publicity campaign for student nurses was the first to be organized on a large scale, and it was very successful (Bonner, 1921).
According to the report entitled *The Work of the American Red Cross During the War* (1919), the student nurse reserve was organized by the State Division of the Woman's Committee. This committee had been appointed by the Council of National Defense. The campaign to enroll student nurses started July 29, 1918, and enrolled 13,800 young women. The women pledged themselves to be in readiness anytime up to April, 1919, to take a hospital training course of from two to three years. The prospective student promised to be physically fit, of good moral character, and have some high school training. In return the student would receive training, board, lodging, and in some cases enough money for uniforms and books (pp. 94-96).

The unnamed author of the report took the opportunity to comment on the significance of the campaign:

*The nurses' campaign is significant. It appealed to the age old instinct of women to care for the sick and suffering. On the other hand, it put her in her old, old position of giving everything, receiving nothing, not even "honorable mention"* (p. 97).

Another very successful effort, that to attract better-educated women into nursing, was the Vassar Training Camp experiment. An intensive preparatory nursing course was offered during the summer school at Vassar. At the close of the summer the students selected a cooperative hospital school of nursing to complete the balance of their training (Clappison, 1964).

Five additional universities: Western Reserve in Cleveland, the University of Cincinnati, the University of Iowa, the University of Colorado, and the University of California, set up similar courses, the
difference among them being the admission requirement. Vassar Training Camp had opened with college graduates as students. The similar courses offered in the five additional universities permitted high school students to be enrolled (Kalisch & Kalisch, 1978, p. 304).

According to Kalisch (1977), the Army School of Nursing was authorized by the Secretary of the war on May 25, 1918. The school was planned as a war measure, but it was also intended to place the Army Nurse Corps on a sounder foundation by serving as an educational institution capable of "contributing to medical research and of securing for Army hospitals a progressively better grade of nursing" (p. 255). Annie W. Goodrich was named as first Dean of the school. Candidates for admission into the Army School of Nursing had to be between 21 and 35 years of age, in good physical condition, and of good moral character. All were high school graduates and many were graduates of normal schools, colleges, or universities (p. 255).

**Battle Wounds**

The modern weapons changed the type of war. Trenches were dug to protect the armies from artillery attack. Barbed wire offered protection from a surprise attack. Military nurses soon saw the effects of modern artillery fire. Fragmentation shells caused extensive, deep, and ragged wounds. Wounds often cut across different organs of the trunk producing multiple injuries. The muddy trenches contributed to soil entering the open wounds and causing infection.

Surgical asepsis was impossible under the circumstances. The solutions known to act as antiseptics were harmful to living tissue. Medical
researchers were attempting to find suitable answers to the problem. An acceptable answer, for the time, was found by surgeon Alexis Carrel and chemist Henry Dakin, who developed a method of disinfecting wounds with the use of a weak chlorine solution in continuous irrigation (Kalisch & Kalisch, 1978, p. 313).

Poison gas caused injuries and fatalities beyond immediate comprehension. Margaret Dunlop (1921), serving in France, shared her experience in a Base Hospital:

These patients were horribly gassed and were pictures of misery and intense suffering. They poured upon us in great numbers - 200 in less than forty-eight hours - and their sufferings were pitiful to see, but their bravery, unselfishness, and fortitude were impressed upon us very fully. The nurses worked hard and faithfully during this short period, but the awfulness and immensity of suffering and cruel barbarity of war upon the individual were a soul-harrowing experience to them (p. 85).

According to Millard (1936), after a gas attack the burned and sightless faces made nursing care difficult:

November 8th, 1918:
More and more Americans in the death ward. Gas cases are terrible. They cannot breathe lying down or sitting up. They just struggle for breath, but nothing can be done . . . their lungs are gone . . . literally burnt out. Some with their eyes and faces entirely eaten away by the gas, and bodies covered with first degree burns. We try to relieve them by pouring oil on them. They cannot be bandaged or even touched. We cover them with a tent of propped-up sheets. Gas burns must be agonizing because usually the other cases invariably are beyond endurance and they cannot help crying out (p. 108).

**Influenza Epidemic**

A massive influenza epidemic caused many more deaths than did the fighting. The estimated number of influenza deaths worldwide ranged from
a low of 15 million to a high of 30 million, with most estimates running around 22 million ("Deaths," 1919, p. 225).

The influenza epidemic in America was in full force when the news of the Armistice came. Many students who had entered nursing solely because of patriotic appeals left training immediately after the armistice. The problem of caring for the civilian sick, therefore, was worse in the winter of 1918 than during the war (Sellew & Nuesse, 1946, p. 309).

According to Sellew and Nuesse (1946), the student nurses of World War I who carried the brunt of the nursing load in the home hospitals have "seldom received sufficient recognition. It was a period of twelve-hour night duty and fifty-six or more hours per week of day duty" (p. 309). There was little teaching or supervision. "In all too many schools only the barest essentials inherent in the art of nursing were taught . . . . These students actually bore the brunt of the 'flu' epidemic and many contracted the disease" (p. 309).

A Shortage of Students

There was a shortage of approximately 55,000 trained nurses in the United States in 1920 (Kalisch & Kalisch, 1978, p. 327). Many young women had entered schools of nursing because of patriotic motivation, and consequently, when the war was over large numbers left the nursing schools.

An article in the March, 1919, issue of Modern Hospital addressed the issue of the shortage of nurses:

In our experience the scarcity of physicians has been much more marked than the scarcity of nurses, particularly in regard to those rendering medical care to the poor, the
great mass of our population. Why is it that the scarcity of physicians has been taken as an inevitable result of war conditions, while the shortage of nurses is laid at the door of the nursing schools? The remedy suggested is . . . to produce a large number of insufficiently trained nurses to meet this shortage . . . we hear nothing of the royal road to medicine via a short course, nor the plea that the "high standards of admission" are the cause of the shortage of physicians (p. 209).

Even with a shortage of trained nurses, Isabel Stewart, Assistant Professor, Department of Nursing and Health Teachers College, Columbia University stated that the war had a positive effect upon nursing education. In a bulletin issued by the United States Bureau of Education, entitled "Developments in Nursing Education since 1918" Stewart (1921) stated:

Probably the greatest contribution of the war experience to nursing lies in the fact that the whole system of nursing education was shaken for a little while out of its well-worn ruts and brought out of its comparative seclusion into the light of public discussion and criticism. When so many lives hung on the supply of nurses, people were aroused to a new sense of their dependence on the products of nursing schools, and many of them learned for the first time of the hopelessly limited resources which nursing educators have had to work with in the training of these indispensable public servants. Whatever the future may bring it is unlikely that nursing schools will willingly sink back again into their old isolation, or that they will accept unquestionably the financial status which the older system imposed on them (p. 6).

Relation of School to Hospital

The relation of nursing schools to hospitals was a topic of discussion among physicians, hospital administrators, and nurses. Parsons (1921) stated in part, "If the institution is not in a position to finance the nursing department as a school, it has not the right to
undertake that educational function." Parsons (1921) discussed the practice of twenty-four hour duty hospitals where the special nurse sleeps in the room with the patient as "another of the reprehensible practices seldom justified by the necessity of the patient" (p. 137).

Both Stewart and Parsons voiced the belief that nursing education would have no future unless and until it was financially independent from the hospital. In "Developments in Nursing Education Since 1918" Stewart (1921) wrote:

The plain facts are that nursing schools are being starved and always have been starved for lack of funds to build up any kind of substantial educational structure. As someone has recently said, the nursing school has been literally buried in the hospital, and few people have been aware of its existence. It has fed on the crumbs that fell from the hospital table - a very frugal table, as everyone knows. The educational interests of the school have had no chance whatever against the pressing economic interests of the hospital, and is probable that even if the hospital recognized its educational obligations, which it has never done, it would find considerable difficulty in meeting them as they should be met (pp. 17-18).

Parsons (1921) wrote in "Relations of Nursing Schools to Hospitals":

Finally, I would call attention to the fact that any nursing school that desires to attract an intelligent class of candidates should be so organized that financially and educationally the student's interests will be protected, and a change of personnel will not hazard her education nor endanger the value of her diploma either in the immediate or distant future. This leads us to the conclusion that the schools of the not distant future must be definitely connected with recognized colleges or universities, or, if with hospitals, the school department must be so directed and financed that it will be able to compete in the excellence of its instruction with university schools. In the future applicants will seek institutions that have a solid foundation (p. 138).
Increased Number of Schools

From the vantage point of the hospital administrators in the 1920s, student nurses were necessary and could best be secured by an apprenticeship system of education (Kalisch & Kalisch, 1975, p. 222). The public readily accepted the views of representative physicians, nurses, and hospital authorities that hospitals were the proper place to educate nurses. The attitude of hospital management was simply to treat the education of nurses as of peripheral importance to the institution (Borden, 1925, p. 119).

The number of additional nursing schools that were established increased. In 1920, there were 1,755 schools of nursing in the United States. By 1923, there were 1,964 and by 1927, there were 2,286 (Kalisch & Kalisch, 1978, p. 329).

According to Kalisch and Kalisch (1978), during the same time span student enrollments rose from 54,953 in 1920 to 77,768 in 1927.

The May, 1928, issue of Modern Hospital points to the decline in the number of hospitals without nurse training schools. In 1926, there were 5,261 hospitals without nurse training schools. In 1927, 4,521 hospitals did not have training schools. This would indicate that 740 schools of nursing opened in one year. The difference between the increase of 531 schools reported by Kalisch and Kalisch (1978) and 740 reported by Modern Hospital (1928) may be attributed to whether or not the schools were approved by the respective state board of nurse examiners. The Modern Hospital (1928) report stated the greatest increase was shown in New York State. Pennsylvania ranked first in
number of schools with 194 training schools for nurses, while New York, "having added eighteen, holds second place with a total of 179 schools; Illinois, with a total of 152 schools. . . . is in third place, and Massachusetts comes fourth, with a total of 125 schools, thirteen of which have been started within the last year" (p. 150).

The Goldmark Report

In January, 1919, largely through the efforts of Mary Adelaide Nutting, a Committee for the Study of Nursing Education was appointed by the Rockefeller Foundation. The Committee was to investigate "the proper training of the public health nurse" (Goldmark, 1923, p. 7). Financial support for the study was provided by the Rockefeller Foundation. The committee of 19 chaired by C.E.A. Winslow, a professor of public health at Yale University, included six nurses: Mary Beard, Annie Goodrich, Mary Adelaide Nutting, Lillian D. Wald, S. Lillian Clayton, and Helen Wood. The committee also included 10 physicians, among whom were two hospital superintendents and two lay representatives. Josephine Goldmark, a social worker and author, was the committee secretary.

An extensive survey of the more than 1,800 hospital training schools in the United States was obviously beyond the possible resources of the Committee. Therefore, it was decided to select a small group of schools for intensive study. Twenty-three schools were finally selected, representing large and small, public and private, general and special hospitals in various sections of the United States. Each school was studied in detail by two types of investigators, one a practical expert
in nursing education, and the other an experienced educator from outside the field of nursing. The investigation of these schools covered the records of 2,406 students (Goldmark, 1923, pp. 18-23).

The Goldmark Report was published in 1923 as a document entitled Nursing and Nursing Education in the United States. This report emphasized the desirability of establishing university schools of nursing to train nurse leaders. The report pointed to the fundamental faults in hospital training schools and identified the primary barriers to higher standards as the lack of financial support for nursing education.

The Committee stated "while training schools for nurses have made remarkable progress, and while the best schools of today in many respects reach a high level of educational attainment, the average hospital training school is not organized on such a basis as to conform to the standards accepted in other educational fields" (Goldmark, 1923, p. 21). Formal instruction in schools of nursing was too casual and uncorrelated, and the educational needs and the health and strength of the students were often sacrificed to hospital service demands.

The final conclusions were briefly summarized by Goldmark (1923):

From our field study of the nurse in public health nursing, in private duty, and as an instructor and supervisor in hospitals, it is clear that there is need of a basic undergraduate training for all nurses alike, which should lead to a nursing diploma. Post graduate training in any one of the three nursing specialties listed above should be given after completion of the basic undergraduate course and should lead to a further diploma or degree (p. 36).
Some of the practices of hospital training schools in regard to their students received special comment from the Committee. Among these were the assignment of students to one of the main hospital services, either medical or surgical, without concurrent instruction in the diseases or conditions of patients committed to their care. The practice of making students responsible for care of critically ill patients without adequate teaching or supervision, and the assignment of students to night duty after a very short orientation also received unfavorable comment from the Committee.

The basic conclusion reached by the Goldmark Committee was that the training of nurses was a serious educational undertaking that must be directed by those who were primarily committed to quality nursing education, not nursing service. The Committee emphasized the fundamental need to recognize the hospital school as a separate educational department, established for the purpose of giving students an education in nursing.

At the time when nursing leaders were making a strong effort to upgrade the schools of nursing and establish connections with colleges and universities, the Board of Trustees of the American Hospital Association came out with their statement expressing the collective views and policy of that organization. In 1925, at the annual convention, Richard P. Borden, a "Senior Trustee" of the Association presented to the membership the following credo:
We are thoroughly of the opinion that a nurse should have a fundamental education in theory and practice of many essential subjects, but we do not believe that the value of the nursing profession may be enhanced by any system which places preliminary education, theoretical training, and specialized branches in a class above hospital schools which provide for the training of the bedside nurse in conjunction with the knowledge to be acquired from books and precepts (p. 119).

The matter of recognizing the hospital school as a separate educational department with the purpose of educating nurses was addressed in 1929 by Robert E. Neff. An authority in administration of hospitals, administrator of the University of Iowa Hospital, and future President of the American Hospital Association, Neff spoke very frankly of the position of nursing education within the hospital. Addressing the Iowa League of Nursing Education, he said

The placing of nursing education as first consideration is not to be expected. The needs of the nursing service in the hospital, instead of how many students may be properly educated, seems to be the basis upon which we operate our training schools today. Hospitals are proud to mention the education of the nurse as one of its chief objects, but cannot contribute to the development of nursing education to the extent that other departments of the institution suffer, its budget be placed in jeopardy and the patient be charged to any considerable extent in the education of the nurse. This attitude should not be interpreted as a lack of interest or generosity on the part of the hospital. The hospital is interested in nursing education and desires to maintain its place in promoting nursing education, and will develop and promote the standards of education as far as its financial condition will permit (Neff, 1929, p. 1119).

The question of the willingness of hospitals to support education in so far as their budget allowed can be challenged, Neff went on to say:
The majority of general hospitals do profit financially by their training school relationships. In this day when there is urgent need for the raising of nursing educational standards this condition should not exist. The hospital, however, should not be accused of profiteering in this respect. The situation may be explained, perhaps, by the fact that it has been the usual order . . . (Neff, 1929, p. 1120).

The usual order was also apparently desired by the medical profession. Dr. Lewis A. Sexton (1932), president of the American Hospital Association, told the 1931 AHA convention that people could be educated beyond their "sphere" of usefulness. He wanted . . . nurses who enter the profession for the love of the work and the good they may do; nurses who are willing to give of themselves to make the long, weary hours of illness less irksome; nurses the sight of whom is an inspiration and joy to all who may be unfortunate enough to need their services . . . the man or woman whose needs call for that gentle touch that soothes an aching brow cares little for a knowledge of the solubility of salicylic acid or the atomic weight of sulphur (p. 197).

Some state medical societies spoke in support of the apprenticeship education for nurses, and against higher educational standards. The Michigan Medical Society's Committee on Nursing Service and Education announced its position in 1928:

The Committee believes that nurses are overeducated. Whether it is the amount of learning or the manner in which it is acquired, it is more difficult to get the desired service from the higher trained nurses. The higher entrance requirements and the elaborate training given have helped to increase the cost of nursing . . . .

The Committee recognizes the following principles for endorsement by the state medical society: (1) nurses are helpers and agents of physicians, not co-workers or colleagues; (2) physicians should have part in the direction of the training of nurses and in its limitations as should the hospitals which give the training; (3) the training of nurses should be simplified and the time of undergraduate training reduced to not more than two years; (4) the apprenticeship system must be maintained (Journal of the American Medical Association, 1928, p. 1296).
University Schools of Nursing

The University of Minnesota is generally recognized as having the first training school for nurses. In 1909, Richard Olding Beard organized the nursing department as an integral part of that institution. The school operated under the college of medicine and offered only a diploma to its graduates. However, prior to this time, schools of nursing on college campuses had function with no relationship to the academic community (Sellew & Nuesse, 1946).

By 1916, there were 16 colleges and universities that maintained some type of a relationship with nursing education. A growing development in several universities was a combined academic and professional course of four or five years, leading to a nursing diploma and a bachelor of science degree. Generally the student was admitted upon completion of high school for two years of preliminary work in the university. This was followed by two years of nurse training in a hospital, followed by a year of clinical work and study in a specialized branch of nursing (Bridgman, 1953).

By 1925, although there were 25 colleges and universities conducting nurse training schools and granting either the A.B. or B.S. degree in nursing, the enrollment in these schools was only 368 (Kalisch & Kalisch, 1978, p. 338). According to Bridgman (1953):

Even the collegiate school of nursing, however, is often regarded as a facility for the primary purpose of servicing the hospital . . . . Significant evidence of this . . . is the fact previously mentioned that the budget for nursing education is so often part of the hospital budget, frequently without clear differentiation from nursing service, rather than part of the educational budget of the university . . . . Even when
the clinical facilities for the nursing program are on the university campus or readily accessible, segregation in a nurses' residence is usual, with the result that the nursing students are deprived of contact with the diverse interests which for other students contribute so largely to both educational and social values of college life (pp. 100-101).

With the affiliated university hospitals dependent upon the nursing student body for nursing care of its patients, emphasis upon the three year course of study for almost all students was not surprising.

In an effort to support some of the recommendations of the Goldmark Committee, the Rockefeller Foundation supplied financial support for an experiment in nursing education to be carried out under the auspices of Yale University at New Haven. In February, 1924, Yale School of Nursing opened as the first school of nursing established as a separate university department with an independent budget and its own Dean, Annie W. Goodrich. The school was so successful that in 1929 it was given a permanent endowment by the Rockefeller Foundation of one million dollars (Sellew & Nuesse, 1946). Western Reserve, a collegiate school of nursing, had been endowed by Frances Payne Bolton in 1923. Western Reserve University, from its inception, included many college graduates among its students. The Hospital School of Nursing at Vanderbilt University was upgraded to a full-fledged academic unit of the University with the assistance of an endowment from the Rockefeller Foundation, the Carnegie Foundation, and the Commonwealth Fund (Kalisch & Kalisch, 1978, pp. 337-340).

The promising beginning of collegiate level nursing education lagged. Opposition from physicians, hospital administrators, and many
nurses kept efforts to improve nursing education at a minimum. Hospitals, on the other hand, were expanding. There were 7,370 hospitals in America in 1924, with a total bed capacity of 813,926. Student nurses were needed to care for the hospitalized patients. Hospital schools of nursing continued to open (Kalisch & Kalisch, 1978, p. 343).

The Grading of Schools of Nursing

The National League of Nursing Education began at an early date to advance the principle of accrediting schools of nursing. General education and medical education had been accrediting schools and nursing leaders felt the movement toward accreditation should be extended into schools of nursing. In 1926, a committee sponsored by the National League for Nursing and the American Medical Association was formed to study the problem (Sellew & Nuesse, p. 322).

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 and one alternate each from the American Medical Association, the American College of Surgeons, the American Hospital Association, and the American Public Health Association. The committee was supported in part by a gift from Frances Payne Bolton, and contributions of thousands of nurses.

May Ayres Burgess was named Director of the study. In 1926, the Committee began its program of three separate studies: (1) an investigation into the supply and demand for graduate nurses; (2) a "job analysis" of what nurses did and how they should be taught; and (3) the
grading of schools of nursing. The 1928 publication of *Nurses, Patients, and Pocketbooks*, was the result of the supply and demand study. This study showed that there was an oversupply of graduate nurses, and unemployment among graduate nurses was serious. Annual income, especially for private duty nurses, was inadequate (Burgess, 1928).

E. P. Lyon, Dean, University of Minnesota Medical School, in an address given to the Minnesota State Registered Nurses' Association, and to the Illinois State Nurses' Association in 1931, and printed in the May 1931, *Modern Hospital*, illustrates the problem of oversupply of graduate nurses as:

Suppose every business or industry needing ten or more stenographers should say: "We will have a stenographic school; we will have the president's secretary do the teaching (that will cost us nothing), the vice-president's and treasurer's secretaries will help (also without expense to us); we will keep our pupils three years and after the first six months expect them to do full work — including Sundays; we will give them board, lodging, laundry — and a swimming pool; at the end of three years we will have a little celebration, perhaps in a church, and give each one a cheap gold pin; we will then take in a new group of girls to do our work; we will recommend our graduates to people who need stenographers; regretfully we may hire a few ourselves when we can't get student stenographers enough." Imagine the condition of affairs in the stenographic profession! And isn't this a fair if somewhat high-lighted picture of nursing education as it actually exists at the present time? (pp. 124-126).

The contrasting situation with the education of physicians was also pointed out by Lyon (1931):

When Medical education was at its worst, about twenty-five years ago, there were 160 medical colleges, far too many and many far too poor. Even at the worst, however, these schools were controlled by medical men, amenable to medical opinion, influenced by medical
tradition. When the profession as a whole, through the Council on Medical Education and the Flexner Report, became aware of the conditions in medical education, self-respecting doctors could no longer run nor remain connected with a profit making college. An era of closing poor schools, of mergers and of transfers to universities ensued. In a few years the situation was changed completely. But in nursing, the building of new hospitals and the founding of new nursing schools goes merrily on. The more hospitals, the more pupil nurses, the more graduate nurses. But the more hospitals, the fewer sick persons outside of the hospitals, the narrower the field for the graduate after she is out. Undoubtedly this is true in spite of the larger number of sick cared for by trained nurses now as compared with former times (p. 124).

The Grading Committee's findings were published in a series of reports and in a final summary called Nursing Schools Today and Tomorrow, published in 1934. In addition to the oversupply of nurses and inadequate wages, the Committee found poor training, lack of clinical resources for the existing educational programs, long hours of work, and a lack of prepared teachers (Burgess, 1934).

Poor Training

A report of the American Nurses' Association Survey published in the November, 1926, issue of Trained Nurse and Hospital Review revealed that minimum entrance requirements to schools of nursing were lacking. Of the 1,500 schools that responded to the survey, 224 had a minimum entrance requirement of four years of high school. In three percent of the schools, none of the students had beyond an eight grade education. One year of high school was a requirement of 54 percent of the nursing schools. Two years of high school was required by 27 percent of the schools. The size of schools was also revealing. Of the 1,500 schools
responding, there were 440 schools in which the entire student body was composed of 19 or fewer students. Well over half of the schools had 50 or less fewer students ("Some Problems," 1926, pp. 507-509).

Lack of Clinical Resources

According to the Grading Committees report, many schools of nursing were found in small hospitals. One hundred and eighty-five schools were connected with hospitals having a daily average of fewer than 25 patients; 562 schools had a daily average of fewer than 50 patients. Therefore, one-third of the schools were too small to make adequate instruction feasible. Another 467 schools had a daily average of 50 to 99 patients, which was below the recommended minimum of 100 considered essential for adequate clinical instruction ("Some Prob.," 1926, p. 508).

Mary Adelaide Nutting (1923) wrote of the Committees work, in an article entitled "How Can We Care for Our Patients and Educate the Nurse?" she stated:

Not so familiar [as the lack of equipment], however, and very serious are the differences in the allotment of time for training in the various essential services. In medical service where the assigned period of training might be seven and one-half months, some students would have five and one-half months, and others twelve and one-half months. In surgical service, where the training is usually longer than the student needs, simply because in many hospitals there is a preponderance of surgical patients, the allotted time may be eleven months, but students may be kept in that service from fourteen even up to eighteen months. The children's service may call for but two months of training, but in one hospital half of an entire class had only six weeks and one student had no training at all. In obstetrics with a requirement of three months, one student might have five months, and another only three weeks of training. Quite commonly, a student is kept on in a particular service after her required training in it is completed precisely because she has become efficient in that branch of work (p. 3).
Long Hours and Lack of Prepared Teachers

Burgess (1926b) revealed the great variation in the hours of duty per week required in the 1,500 nursing schools that responded to a survey. The average number of hours required was 55. Compared with the 38 hours of work per week required of most factory workers, nursing students were overworked. Schools reported:

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<td>35-44</td>
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<tr>
<td>45-54</td>
<td>659</td>
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<td>55-64</td>
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<td>65-74</td>
<td>73</td>
</tr>
<tr>
<td>75-84</td>
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(Burgess, 1926a, pp. 507-508).

When a teacher was defined as a person in the school of nursing whose main job was instructing, Burgess (1926a) compiled the following figures: (p. 509)

<table>
<thead>
<tr>
<th>Number of teachers</th>
<th>Number of schools</th>
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<tr>
<td>None</td>
<td>549</td>
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<td>1</td>
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<td>18</td>
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Lyon (1931) summed up the problem:

...there are far too many schools. I was amazed recently to learn that they number about 2,200. Over two thousand nursing schools in the United States and seventy-six medical schools! Twenty-two thousand nurses graduated in 1930 to join the ranks of the unemployed! The situation would be comical if it were not tragic (p. 124).
The onset of the Great Depression found schools of nursing in the midst of a period of stress and turmoil brought on by overexpansion of the educational system and continued massive exploitation of student labor in hospital schools of nursing.

Iowa in World War I

On April 6, 1917, the day that Congress formally declared war against the German government, both Houses of the Iowa Legislature adopted a resolution to pledge all of the resources of the State of Iowa to the Government of the United States (Harlan, 1931, p. 295). There were no negative votes in either House.

Another concurrent resolution was adopted April 13, 1917. This resolution placed emphasis upon agricultural production and the preservation of food. The importance of food was stressed partly because of Herbert C. Hoover's achievement in rationing food for "starving Belgium" (Harlan, 1931, p. 296).

Steps to prepare the country for war were taken long before the formal declaration of war. In August, 1916, a Council of National Defense had been authorized by the Congress. After the war was declared, this Council enlarged its activities through the organization of State Councils of Defense and from that to county councils. The food committee was one of the branches of the general organization. However, in August, 1917, Congress passed the Lever act which legalized the voluntary activities that had been carried on by Mr. Hoover as food controller under appointment from the President. Under the Lever act Mr. Hoover was appointed food administrator.
The Iowa Division of the Council organized to encourage canning of fruits and vegetables. According to Clarke (1918), Iowa women were asked to sign pledge cards, pledging to conserve food and support the war effort. However:

In carrying on the food pledge campaign in Iowa it was necessary to deny frequently many stories that had been industriously circulated. The most common of these was those signing these cards will have their canned fruits and vegetables confiscated by the government agents. One of the cheering illustrations of genuine patriotism, however, was brought out by this rumor. In Webster County when the workers from the woman's committee was securing pledges, they asked one housewife for her signature and were surprised and touched when, after signing promptly, she asked very honestly if she would know when the man from the government was coming as she was canning and preserving all she could so that she would have her share ready. Truly this patriotic Scandinavian woman sets an example to some native Americans (pp. 268-269).

Fairchild (1927) states that Major Donald Macrae, a Council Bluffs physician, received permission from the surgeon general of the army to organize a unit. The unit was "formed in short order and given the name K, in spite of the fact that it was the first letter unit ready for service, April 1917" (p. 60). The full names and ranks of the twelve medical officers forming Hospital Unit K are listed. The nurses are not named. Seven of the physicians were from Council Bluffs. "Sixteen of the twenty-one nurses were from the Jennie Edmundson Memorial Hospital of Council Bluffs" (pp. 60-61). On January 15, 1918, all sailed to France. At Angers, France "a strong attempt was made to break up Unit K, but by exerting strenuous efforts we were able to keep the organization intact" (p. 61).
According to the Wearin (1964), "the Report of 1917 tells us of the Unit K made up of the Doctors on the Edmundson Staff and the graduate nurses from Edmundson who answered the call of their country . . . . All the members of the Unit K nurses Corps were entertained at the Nurses Home just before leaving for 'over there'" (p. 5).

Some Iowa nurses were honored for their work during the war. The August, 1919, *American Journal of Nursing* announced:

Amy Beers, superintendent of the Jefferson County Hospital, who was Chief Nurse of Hospital Unit R in France, has received from the French government a diploma and medal of honor for her excellent work. The medal was awarded March 18, in Paris by the French Minister of War. The diploma translated reads about as follows: "In the name of the President . . . has awarded a medal of silver to Nurse Amy Beers, who lavished her care most devotedly and assiduously on our wounded . . . . Hospital Unit R is proud of this distinction was by its Chief Nurse (pp. 893-894).

The Epidemic

Mousel (1954) describes the influenza epidemic of 1918 as pandemic, meaning existing everywhere:

The last months of World War I, in the fall of 1918, were harrowing with the ravages of the great influenza pandemic. It raged over wide areas during the summer, from May to July. Then, in a fiercely virulent second wave, it broke out again in latter September and early October, spreading over the whole world. In Iowa most schools and other public places were closed through October and November. This wave subsided in December; but a third somewhat less deadly outbreak occurred the next spring. Within the year it took a toll of twenty million lives. Its death-dealing virulence was thus comparable with that of the plagues of the Middle Ages (p. 225).
Bjornstad (1952) reports the epidemic struck suddenly in Iowa. The patient "apparently well prior to the onset, was in a state of physical and mental exhaustion 18 to 24 hours later, with severe headache, general malaise, sore throat and cough, with later chest complications of pneumonia, pleurisy with effusion, and encephalitis" (p. 55). At the Iowa Methodist Hospital in Des Moines, the pharmacist, Miss McCredie, and several nurses died during the epidemic.

The epidemic entailed long hours of duty for the nurses, as many "as sixteen hours at a time, unrelieved . . . Many of the nurses went back to work with depleted health, asthenia, malnutrition, and anorexia" (pp. 55-56).

Bjornstad (1952) revealed the plight of the army base hospital at Camp Dodge:

During the influenza epidemic, the American Red Cross appealed to the hospital [Iowa Methodist at Des Moines] for senior student nurses to serve at the army base hospital at Camp Dodge. Ten students were spared for this patriotic service, and the volunteers, after their return in January, 1919 were awarded by the hospital a silver star emblem to be worn on the left sleeve of the uniform. They were Dorothy Bennett, Gladys Dittmer, Mabel Howard, Vivian Miller, Elizabeth Shaffort, Hazel Segner, Florence Steinberger, Alma Van Horn, Hazel Wilson, and Herda Witter (p. 56).

A Shortage of Students

The short history of the Jennie Edmundson Memorial Hospital School of Nursing written by Wearin (1964), and published in the Jennie Journal, speaks of a shortage of students during the early 1920s.
The entry for 1919 states that there were 37 students in the Training School with 12 graduates. In 1920, the pathological laboratory was equipped under the direction of Dr. E. T. Manning of Omaha. Routine blood and urine examinations "are done for every medical and surgical patient entering the hospital . . . . All senior students spend a certain amount of time in the laboratory" (p. 6).

The same year, 1920, plans were made for building a new wing to meet the increasing patient load. A shortage of students was reported; however, exact numbers were not given. By 1921 the new wing was well under way, the pathological laboratory was entirely under the control of the hospital, and there was a complete change in the personnel of the faculty. Miss Nesbit resigned, Pauline Martignoni was hired. Thirteen students graduated in June.

There were 29 students in the Training school in 1922. Eleven students graduated in June. The new wing was occupied in May, 1922. There were 45 students in the Training School in 1923, five graduated in June. The year 1924 report indicated 45 students in school, 10 graduated. A new Superintendent, Dorothea Ely, and a new instructor Carrie Louer were employed. Miss Ely served for approximately two years, she was replaced by Georgia Shively.

The student shortage was apparently over. In 1926, there were 53 students in the school, 19 graduated in June and 23 students were admitted. Sixty-five nurses were in school in 1927, 14 graduated and 33 were admitted (pp. 6-7).
This short history of the Jennie Edmundson Memorial Hospital School of Nursing illustrates the point made by Mary Adelaide Nutting (1923). Nutting states:

Not only has this phenomenal number of new schools been created, but existing schools have steadily and notably enlarged in response to the extension of the hospital with which they are connected. In whatever direction the hospital has grown, the school has stretched itself to meet the new nursing demands (p. 306).

A second point illustrated is one made by May Ayres Burgess (1926 b), Director of the Committee on Grading of Nursing Schools, Burgess states:

An educational friend, the other day, on seeing this diagram, commented: "I don't know anything about nursing schools, but I do know just by looking at that diagram that something is seriously wrong with them. No system of education can possibly be in a healthy condition if half of its leaders quit their jobs every two years." That stands to reason. It takes longer than two years to build up a worth while school. Every change of superintendents disturbs the existing machinery; and if those changes come often, there is little chance to develop anything of permanent educational value (p. 69).

Burgess concluded her article with some observations about being the superintendent of a training school. She stated that the "salaries are too low. Worse than that, the superintendent holds two jobs; she is supposed to run a school, but she is also supposed to furnish nursing care to the hospital" (p. 69). As others before her, Burgess recognized that the situation was a difficult one. The two positions often clash, and each time the superintendent "bears the brunt of the collision" (p. 69)

Another important point Burgess stressed was that the superintendent carries heavy responsibility but not the authority. Often the superintendent has no access to the hospital board. She has no budget. She is
not prepared for her own job. Burgess (1926b) suggested:

Probably the biggest contribution that hospitals could make to nursing education would be to cut down this 50 per cent turnover of superintendents; but to do this they must, first, help to devise some method of advanced professional training of a solidly practical sort, so that there will be a bigger supply of competent candidates; and, second, make the position of superintendent of nurses sufficiently dignified, and with sufficient pay and authority, so that when the hospital gets a good woman it can keep her.

In conclusion, let me sum up this discussion by telling you what the typical nursing school is like:
- It is in the North Central States.
- It requires one year of high school for entrance.
- It has twenty-eight students.
- It is attached to a hospital.
- The hospital has a daily average of sixty-five patients.
  - Students work a fifty-six hour week.
  - The school employs one full time teacher.
  - Its present superintendent has been on the job for two years and has just presented her resignation (p. 70).

Student Nurse Life

Time and fashion changes altered student nurses uniforms, but not without expressed permission of hospital authorities. For example, Bjornstad (1952) reports that in 1921 students of the Iowa Methodist Hospital School of Nursing in Des Moines were allowed to wear oxfords rather than the high shoes of earlier years. However, the oxfords were to be black in color and "students in the thirties were still irked by having to wear black stockings and shoes" (p. 58).

Discipline or control of students was both covert and overt. According to Bjornstad (1952),

Students did not take part extensively in the post-war [W.W.I.] fad of hair-bobbing. There was no regulation against it, but Miss Ankeny [Superintendent of nurses]
shrewdly ruled that those with bobbed hair must wear hair nets. The straight unshingled uncurled bob then in vogue did not lend itself to the use of a hair net; so most students kept their tresses long (p. 58).

Hand written minutes of the Iowa University Training Hospital Nurses Student Council dated December 17, 1923 contain the announcement that all nurses having bobbed hair "will be compelled to let it grow out, and that no further transgressions against this rule will have the sanction" of the student organization (Iowa U. Minutes, December 17, 1923, p. 79). At the same meeting the students decided to request permission to have lights on until 11 p.m. if they were "quiet at 10 p.m." (Iowa U. Minutes, December 17, 1923, p. 78)

The July 28, 1928 minutes of the Iowa Board of Nurse Examiners discuss a student dismissed from Mercy Hospital, Waverly, for smoking. The Board suggested transfer to some other hospital school of nursing and probation of four months. The Board further recommended that the student make a personal application and give a very frank history (Board of Nursing. Minutes, 1928).

On August 10, 1929 the Iowa Board of Nurse Examiners ruled that time could not be added to a nursing program for the purpose of punishing a student. Time added for punishment was not allowed under the law, the Board wished this fact be conveyed to those schools of nursing where such situations arose (Board of Nursing. Minutes, 1929).

The August, 1919b, American Journal of Nursing announced "Lutheran Hospital [Hampton] is perhaps the first in Iowa to adopt the eight hour day for its training school. This will be in force after September 1" (p. 893).
Not being allowed to visit the schools as frequently as they would care to, and having to function from reports submitted to the Nurse Examiner Committee by the hospital management was apparently frustrating to the members of the examining committee. One method selected to determine what was actually happening in the schools of nursing was to interview the graduates when they appeared to write the examination.

A report of the oral interview of nurses taking the state examination on July 30, 31, 1918, was compiled by Clara A. Swank, and Helen S. Hartly, nurse members of the Examining Committee. In part the report states:

Abott Hospital, Oskaloosa. [Three students reporting] Placed on special after 6 months. Was sent out into homes for three months. Have classroom with most classes in evening, some in afternoon. Day Duty: ten hours, with half days during week and extra time on Sunday when possible. Night duty: twelve hours, three days off after period of six weeks .... Abbott Hospital reports not sending nurses into homes.

Atlantic Hospital, Atlantic [Five students reporting] Was sent out into families for six months ....

Bellevue Hospital, Muscatine [One student reporting] Sent out into homes for six months during 2nd year. Placed on special in hospital during third year ....

Hershey Hospital, Muscatine [Two students reporting] Sent out into homes for short time to assist in obstetrical cases. Placed on special duty in hospital after the 6th month -- about one-half work is special ....

Cottage Hospital Creston [Two students reporting] Sent out into home for 1 month during 2nd and 3rd years. Placed on special in hospital after 6 months. All classes in classroom after 7:00 p.m. ....

Glenwood State Hospital [One student reporting] Sent out into homes for three months during the 2nd and 3rd years. Placed on special in hospital during 3rd year ....

Mercy Hospital, Ottumwa [One student reporting] Sent out into homes for about six months during the last year. Special hospital duty after the 8th month ....
St. Joseph, Sioux City [Seven students reporting] Was sent out into families one month. Given special after the third month. Night nurses have classes in morning. Other classes held in the afternoon and evening . . . . Samaritan Hospital, Sioux City [Five students reporting] Began specializing after third month; spent one year out of three in specialling, sometimes more . . . . (Report of Oral Interview, 1918).

Minutes of the Iowa Board of Nurse Examiners, dated September, 1922, report a visit to the Atlantic Hospital Training School for Nurses in Atlantic, Iowa, by Ann Drake, R.N.:

Visited Atlantic Hospital, January 20, 1922, met Miss Donnelly, Superintendent of Training School. Find that various recommendations to the Board have not been acted upon. The nurses are still housed in the hospital. Four of them sleeping in two double beds in a small room. There is no classroom or demonstration room. Classes are held in the dining room, the only equipment being a small black board. There are no records of any class work and no grades for practical or theoretical work. The only record gives the time on day duty, night duty, hours off, days off, and vacations. Nurses have been accepted with less than the educational requirement of one year of high school. The hospital building is very good.

The Superintendent of Nurses has recently equipped a sun parlor very comfortably as a sitting room for the nurses. Prior to this there was only a small room in the basement which nurses could use. Recommendations that since the hospital board has not complied with the recommendations for bringing their training school to meet the requirements of accredited schools in Iowa, that this school be struck from the accredited list of this Board. Signed Ann M. Drake. Motion Carried. Nurses who will complete the required courses this year shall be admitted to the examination and those who will not finish must complete their course of training in some other recognized training school for nurses (Board of Nursing. Minutes, 1922, p. 84)

Apparently such drastic and immediate action by the Iowa Board of Nurse Examiners had an effect upon the Board of Trustees of the training school in question, the school is listed on the list of approved schools.
Hospital Size

The small rural hospital schools of nursing were not able to provide all of the clinical experiences deemed necessary for student nurses.

The question of whether or not small rural hospitals should conduct schools of nursing was answered by Dr. F. E. Sampson, Creston, Iowa in an article published in the September, 1919, issue of The Modern Hospital.

The rural hospital . . . can and should conduct a nurses' training school . . . . The nurse thus trained is able to handle successfully many an urgent situation in which the standardized type of nurse would be helpless in the absence of a complete outfit of standard things. The senior pupil nurse who could not go into the average country home and there find the essential things, and prepare said things to efficiently fulfill the essential requirements for an ordinary surgical procedure, would not be considered fit for graduation from this training school.

The ability to give a gastric lavage and do it right, and not a few other procedures that some schools might deem invasion of the doctor's domain, are essential for nurses working in rural communities (p. 176).

Sampson (1919) pointed to the rules of his hospital, the Greater Community Hospital, Creston, Iowa. Rule 9 stated that physicians on the hospital staff must serve as training school faculty and must render "gratuitous and faithful service in such lines as to such extent as may be arranged by those in authority" (p. 175).

Olive Lonnecker, Creston, a 1930 graduate wrote of the training, "We were taught by local M.D.s and one R.N. Perhaps the R.N. was salaried but I'm sure the M.D.s donated their time and talent . . . actual bedside training excelled larger training schools. Our classes
were small, from five to eight in each class . . . except for one R.N. at night, the nursing staff was made up of student nurses" (Lon- necker, Note 3, July 11, 1979).

Sister Mary Visitation, the Director of Nursing in Anamosa from 1920 until 1926, wrote about the school of nursing at Mercy Hospital in Anamosa.

In 1918 as more patients came from the surrounding area it was decided to start a School of Nursing, 3 year course with 6 to 9 months at Mercy Hospital Cedar Rapids. Not for surgical nursing, Anamosa hospital had a heavy surgical load, but obstetrics and medicine . . . . Dr. H. Dolan taught surgery . . . Dr. J. Paul, medicine, obstetrics, etc., others gave occasional lecturers. With this poor instruction, many of those 1st graduates went on to advanced education (Visitation, Note 4, August 21, 1979).

University Schools of Nursing

In a paper entitled "Notes on the Supply and Distribution of Nurses in the United States, May, 1922" Nutting (1922) states:

180 Schools are reported as affiliated with colleges or Universities, but this fact has little if any significance in the majority of instances. The schools of nursing usually do not benefit in any particular by the relationship, since the educational resources and facilities of the University are not open to them (p. 3).

Means (1951) states the experimental 12 week preparatory course conducted in the summer of 1918 and modeled after the course conducted by the American Red Cross at Vassar College was the basis of pre-nursing courses at the University of Iowa. The pre-nursing courses were not the same as the preliminary course allowed before the student began clinical experience. The preliminary course had been a part of the nursing program since September, 1916. The pre-nursing course began as a three
months course period and soon extended to four. Studies included were the "fundamentals of natural science essential for the trained nurse" (p. 7).

The University of Iowa Service Bulletin, May 10, 1919, stated the applicants were required to meet the educational prerequisites of completion of a regular high school or its equivalent. In addition, every applicant had to present a certificate from a reputable physician to the effect that she was in good health. Character references were also required (U of I Service Bulletin, 1919).

Those accepted as probationers were provided with room, board, and laundry free of charge. At the end of the probation period, which varied depending upon the ability and aptitude of the probationer, she progressed into uniform and was paid five dollars a month. The course was 36 months including the pre-nursing course. College graduates were allowed a maximum reduction of nine months, and for those with two years of college, not more than six months could be applied to the thirty-six.

In the fall of 1919, a new combined course of liberal arts and nursing was initiated. Nurses completing the course were granted the degrees of Bachelor of Science and Graduate Nurse at the end of five years. The first three years were devoted to preparatory work, the last two years were professional and practical work. The candidate could utilize the two complete summer sessions and complete the combined course in four calendar years (Means, 1951, p. 5).

According to Means (1951), nursing students were required to pay tuition for the first time in 1930. The tuition was $50.00 for each semester of the freshman year (p. 8).
Legislative Activity

The June, 1919 American Journal of Nursing, printed an account of the I.S.A.R.N.s struggle to strengthen the control of the practice of nursing and nursing education in Iowa.

In order to secure the much needed Educational Director or Inspector of Training Schools, an amendment to the present law regulating the practice of nursing was prepared which extended the duties of the nurse members of the Nurses' Examining Committee of the State Board of Health. While the provisions of the bill were not what the nurses of the state desired, it was at least a step in the right direction. After the bill was placed on the calendar and was about to come up for a vote, it was learned that an amendment would be offered which would take from the State Board of Health the right to determine when a training school is giving an accredited training and would allow any woman to become a registered nurse if she passed the state examination whether she "received her training in a hospital or a corn-field." Owing to a general feeling of opposition to the State Board of Health in both the House and Senate because of other health legislation, it appeared reasonably certain that this amendment would pass rather than the bill prepared. It was therefore withdrawn. A second bill, endorsed by the State Nurses' Association, was introduced and provided for the annual reporting of all registered nurses within the State with an annual fee of $1.00. This would help to increase the nurses' fund and in that way help to pay for the inspection of training schools, besides giving an accurate knowledge of the total number and addresses of all nurses within the State. The need for this has been felt when the nursing surveys were asked for. This bill was also withdrawn because without the right to have the inspector there was no need for additional funds. It is necessary for the nurses of the state to begin now to plan what is the best method to secure this much needed legislation. It is evident that nurses themselves are not aware of the attitude of many people toward the nursing profession standards. They are constantly in danger of having repealed what little the present law does offer. Nurses must discuss this subject at every meeting and get in touch with influential people in their communities because much education is necessary among nurses and lay people as well, if they hope to raise their standards at a future session of the Legislature (pp. 724-725).
The burden of having to struggle for effective legislation for the control of nursing practice from a position of weakness was to be altered soon. By proclamation of Governor Harding, the Iowa Legislature was convened in special session July 2, 1919, to decide so far as Iowa was concerned, whether or not all citizens regardless of sex, would have the right to vote.

The special session of the two Houses quickly passed the resolution for the adoption of the nineteenth amendment to the Federal constitution (Harlan, 1931, pp. 316-317). Women had won the right to vote.

Conditions for nursing in Iowa did not improve. Instead, with the rapid increase in the number of nurses' training schools in Iowa, the need for an educational director, on the state level, became more apparent.

The report of the State Board of Nurse Examiners, given by Hefner of Sioux City, at the I.S.A.R.N. Annual Meeting in Des Moines, November 17 through 20, 1924, stated, "the papers written by nurses from some schools showed too low entrance requirements both in teachers and students . . . inadequate equipment, no resources for materials, lack of time for preparation of lessons and too long hours on duty. We need an educational director" (A.J.N., January, 1925, pp. 361-362).

On October 28, 1924, the State Board of Health became a State Department of Health and each professional Board became its own controlling agent under the State Department of Health. This re-codification of the law made it impossible for anyone connected with a school of nursing to serve on the examining board.
According to a report prepared by Frances Hutchinson, and dated January 13-14, 1928, at the time of the re-codification the nurses submitted to the governor several names of nurses who were not connected with a school of nursing. The Governor appointed three of these nurses to act as a Board of Nurse Examiners for one, two, and three years, one new nurse to be appointed or one to be re-appointed each year to serve for three years. This nurse was selected from six names submitted annually by the State Nurses Association (Hutchinson, 1928, p. 1).

The Board of Nurse Examiners was still without a headquarters. Its work was done by correspondence. The meetings and examinations "have been held in every quarter in Des Moines; the Board has the use of the House of Representatives when Legislature is not in session" (pp. 1-2).

The Board members were allowed their actual expenses for the two or three days necessary for the examinations and Board meeting. The pay was at the rate of $10.00 per day for the purpose of preparing examination questions. Examinations were corrected at the rate of 400 answers per day, regardless of length of answers.

Included in the duties of the Board of Nurse Examiners were tasks such as to recommend and approve all schools of nursing accredited by the State Department of Health. The Board of Nurse Examiners also had to conduct examinations for licensure of nurses. Another duty of the Board of Nurse Examiners was to police the profession by reporting "to the Department of Health the name of every person without a license that she has reason to believe is engaged in the practice of nursing" and "furnish such evidence as she may have relative to any alleged violation which is being investigated" (pp. 3-4).
All student transfers, affiliations, curriculum changes, faculty numbers and changes were also approved by the Board of Nurse Examiners. "On and after September 1, 1926 only students . . . whose credentials and application have been approved by the State Department of Health" were to be admitted to schools of nursing (Hutchinson, 1928, p. 5).

The State Association, not wishing to wait until action could be taken by the Legislature, determined to assume the responsibility of financing the work of training school inspection in 1926. Its hope was that this demonstration would influence the legislatures by furnishing proof of the need for an educational division (Twenty-third Biennial Report Iowa State Dept. of Health, 1928, 1929, pp. 116-119). I.S.A.R.N. 25th Annual Convention minutes reveal that in addition to influencing the legislature by example, the Association felt the paying something toward the Educational Director's salary would keep "a little string on that office" for the Association. The nurses felt that the Governor would not appoint a Director not approved of by the Association, as long as the association was paying a part of the salary (I.S.A.R.N. Minutes, 1928, p. 270).

In January, 1927, the Division of Nursing Education was created by an act of the Forty-second General Assembly. The nurses' state association continued to finance the work of the division until the appropriation was available, July 1, 1927. Two acting directors served from October 1, 1926, to January 1, 1927, and from January 1, 1927 to July 1, 1927, respectively. From July 1, 1927 to January 1, 1928, there was no division head.
The 23rd Biennial Report of the Iowa State Department of Health, 1928 (1929), reports the activities of the Division of Nursing Education and the director from October, 1926, to July 1, 1928:

The credentials of all applicants for training in all schools have been reviewed by the director and approval given if all entrance requirements were met. A card file of all students in training October 1, 1926, and all students since admitted, giving a resume of their credentials, has been maintained in the division.

There is no shortage of students in the schools of nursing of Iowa . . . . An effort was made to make a preliminary survey during 1927 to ascertain the number of schools that were actually meeting requirements for accredited schools as formulated by the Board of Nurse Examiners.

After this survey the accredited list was changed by the removal of five schools; two closed voluntarily, two were removed by the board and one closed by mutual consent.

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According to the report there were 2,044 students in training in 1928.

A report of the salary schedule in various hospitals was published in the 1928 biennial report: The monthly salary rates were:

The division of Nurse Examiners functioned under the State Department of Health. An advisory committee was formed. The committee was composed of the State Health Commissioner, the three members of the Board.
of Nurse Examiners, the president of the State League of Nursing Educa-
tion, two superintendents of nurses, the president of the I.S.A.R.N. and
the director of nursing education.

The Advisory Committee pointed to the frequent changes in super-
tendents of nurses, noting that there "have been sixteen changes
between January 1, 1928 and July 1, 1928. In three instances more than
one change has occurred in the same hospital during this period" (23rd
Biennial Report Iowa State Dept. of Health, 1928, 1929, p. 118). The
Committee noted that there were obvious reasons for some of the changes;
with the fault lying with the superintendent of nurses and management of
the hospital in about equal proportions. The Committee recommended a
more careful selection of persons for the position of superintendent and
a better understanding of the position by boards of directors and mother
houses in the case of the Catholic hospitals.

The 1918 list of approved schools of nursing in Iowa had reached
the number of 54 and is represented in Table 3 (U.S. Commissioner of
Education, 1918, pp. 62, 63). The report prepared by Frances Hutchinson
(1928) stated "we now have 48 accredited schools of nursing" (p. 8).

The Advisory Committee on Nursing Education made a very significant sug-
gestion when it concluded that the division on nursing education should
"educate hospital boards and superintendents with regard to training
school requirements and the advisability of discontinuing some of the
smaller schools: (23rd Biennial Report of the Iowa State Department of
Health, 1928, 1929, p. 119).
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<td>20</td>
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<td>Type</td>
<td>Beds</td>
<td>Affiliation</td>
<td>Managed By</td>
<td>Founded Year</td>
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<td>Creston, 8,034</td>
<td>Union</td>
<td>Greater Community Hosp.</td>
<td>Gen.</td>
<td>50</td>
<td>Independ.</td>
<td>Yes</td>
<td>Lay</td>
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<td>Davenport, 56,727</td>
<td>Scott</td>
<td>Mercy Hospital</td>
<td>Gen.</td>
<td>125</td>
<td>Church</td>
<td>No</td>
<td>Lay</td>
<td>1869</td>
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<td>Des Moines, 126,468</td>
<td>Polk</td>
<td>St. Luke's Hospital</td>
<td>Gen.</td>
<td>75</td>
<td>Church</td>
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<td>R.N.</td>
<td>1895</td>
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<td>Broadlawns Polk County Public Hospital</td>
<td>Gen.</td>
<td>100</td>
<td>County</td>
<td>No</td>
<td>M.D.</td>
<td>1921</td>
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<td></td>
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<td>Iowa Lutheran Hospital</td>
<td>Gen.</td>
<td>150</td>
<td>Church</td>
<td>No</td>
<td>Lay</td>
<td>1914</td>
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<td></td>
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<td>Iowa Methodist Hospital</td>
<td>Gen.</td>
<td>239</td>
<td>Church</td>
<td>No</td>
<td>Lay</td>
<td>1901</td>
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<td></td>
<td>Mercy Hospital</td>
<td>Gen.</td>
<td>148</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1893</td>
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<td>Dubuque, 40,996</td>
<td>Dubuque</td>
<td>Finley's Hospital</td>
<td>Gen.</td>
<td>90</td>
<td>Independ.</td>
<td>No</td>
<td>Lay</td>
<td>1890</td>
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<td></td>
<td></td>
<td>St. Joseph's Mercy Hosp.</td>
<td>Gen.</td>
<td>100</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1879</td>
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<tr>
<td>Estherville, 4,699</td>
<td>Emmet</td>
<td>Coleman Hospital</td>
<td>Gen.</td>
<td>50</td>
<td>Independ.</td>
<td>Yes</td>
<td>R.N.</td>
<td>1916</td>
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<td>Fairfield, 5,948</td>
<td>Jefferson</td>
<td>Jefferson County Hosp.</td>
<td>Gen.</td>
<td>29</td>
<td>County</td>
<td>Yes</td>
<td>R.N.</td>
<td>1912</td>
<td></td>
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<td>Fort Dodge, 19,347</td>
<td>Webster</td>
<td>St. Joseph's Mercy Hosp.</td>
<td>Gen.</td>
<td>112</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1908</td>
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<td>Hampton, 3,551</td>
<td>Franklin</td>
<td>Lutheran Hospital</td>
<td>Gen.</td>
<td>50</td>
<td>Church</td>
<td>Yes</td>
<td>R.N.</td>
<td>1914</td>
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<td>Iowa City, 11,267</td>
<td>Johnson</td>
<td>Mercy Hospital</td>
<td>Gen.</td>
<td>100</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1878</td>
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<tr>
<td></td>
<td></td>
<td>University Hospital</td>
<td>Gen.</td>
<td>683</td>
<td>State</td>
<td>No</td>
<td>M.D.</td>
<td>1870</td>
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<td>Keokuk, 14,423</td>
<td>Lee</td>
<td>Graham Protestant Hosp.</td>
<td>Gen.</td>
<td>40</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1901</td>
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<td></td>
<td></td>
<td>St. Joseph's Hospital</td>
<td>Gen.</td>
<td>90</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1882</td>
<td></td>
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<td>LeMars, 4,683</td>
<td>Plymouth</td>
<td>Sacred Heart Hospital</td>
<td>Gen.</td>
<td>50</td>
<td>Church</td>
<td>No</td>
<td>Lay</td>
<td>1917</td>
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<td>Marshalltown, 15,731</td>
<td>Marshall</td>
<td>Evangelical Deaconess Home and Hospital</td>
<td>Gen.</td>
<td>125</td>
<td>Church</td>
<td>No</td>
<td>Lay</td>
<td>1913</td>
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<tr>
<td></td>
<td></td>
<td>Mercy Hospital</td>
<td>Gen.</td>
<td>60</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1902</td>
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<td>City, Population, County and Hospital</td>
<td>Type of Service</td>
<td>Beds</td>
<td>Aver. Pts.</td>
<td>Control</td>
<td>Sch.</td>
<td>Supt. M.D.</td>
<td>Supt. R.N.</td>
<td>Lay</td>
<td>Year Est.</td>
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<td>Mason City, 22,682—Cerro Gordo Park Hospital</td>
<td>Gen.</td>
<td>50</td>
<td>37</td>
<td>Indep.</td>
<td>No</td>
<td>R.N.</td>
<td>1910</td>
<td></td>
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<td>Muscatine, 16,068—Muscatine Benjamin Hershey Memorial Hospital</td>
<td>Gen.</td>
<td>50</td>
<td>21</td>
<td>Indep.</td>
<td>Yes</td>
<td>R.N.</td>
<td>1902</td>
<td></td>
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<tr>
<td>Nevada, 2,811—Story Iowa Sanatorium and Hospital</td>
<td>Gen.</td>
<td>35</td>
<td>27</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1927</td>
<td></td>
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<td>Oskaloosa, 9,427—Mahaska Mahaska County Hosp.</td>
<td>Gen.</td>
<td>30</td>
<td>24.18</td>
<td>County</td>
<td>Yes</td>
<td>R.N.</td>
<td>1907</td>
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<tr>
<td>Mercy Hospital</td>
<td>Gen.</td>
<td>35</td>
<td>14</td>
<td>Part</td>
<td>Yes</td>
<td>Lay</td>
<td>1909</td>
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<td>Ottumwa, 23,003—Wapello Ottumwa Hospital St. Joseph Hospital</td>
<td>Gen.</td>
<td>54</td>
<td>42</td>
<td>Indep.</td>
<td>No</td>
<td>Lay</td>
<td>1894</td>
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<td></td>
<td>Gen.</td>
<td>76</td>
<td>40</td>
<td>Church</td>
<td>No</td>
<td>Lay</td>
<td>1914</td>
<td></td>
<td></td>
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<tr>
<td>Sioux City, 71,227—Woodbury Lutheran Hospital Methodist Hospital St. Joseph's Mercy Hosp. St. Vincent's Hospital</td>
<td>Gen.</td>
<td>76</td>
<td>48</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1902</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Gen.</td>
<td>110</td>
<td>73</td>
<td>Church</td>
<td>No</td>
<td>Lay</td>
<td>1920</td>
<td></td>
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<tr>
<td></td>
<td>Gen.</td>
<td>175</td>
<td>100</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1890</td>
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<td></td>
<td>Gen.</td>
<td>125</td>
<td>58</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1907</td>
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<td>Location</td>
<td>Hospital</td>
<td>Type</td>
<td>Beds</td>
<td>Patient</td>
<td>Church</td>
<td>Staff</td>
<td>Year</td>
<td></td>
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<td>Waterloo, 26,771</td>
<td>Allen Memorial Hospital</td>
<td>Gen.</td>
<td>47</td>
<td>31</td>
<td>Church</td>
<td>No</td>
<td>Lay</td>
<td>1925</td>
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<td></td>
<td>Presbyterian Hospital</td>
<td>Gen.</td>
<td>50</td>
<td>28</td>
<td>Church</td>
<td>No</td>
<td>R.N.</td>
<td>1904</td>
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<td>Waverly, 3,352</td>
<td>St. Joseph's Hospital</td>
<td>Gen.</td>
<td>50</td>
<td>25</td>
<td>Church</td>
<td>No</td>
<td>Lay</td>
<td>1904</td>
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Iowa did not differ markedly from the remainder of the United States in respect to nursing schools. Once the war had terminated, and the influenza pandemic subsided, the country could examine its resources. The greatly increased demand for nursing students during the war and afterward had resulted in many schools lowering their admission requirements to attract more students. Many more poorly qualified schools opened. There was no control, except for the requirement that the hospital wishing to conduct a school of nursing file a copy of the proposed curriculum with the Nurse Examiner Board.

The Goldmark report validated the deteriorating standards of education in schools of nursing. There were startling revelations about nursing education reported by Goldmark. The revelations were accompanied by strong recommendations and slow results as the impact of this study gradually was felt in the field of nursing.

One interesting fact was that the results of this study were not shared with the public in the same manner as the Flexner study of medicine and medical education had been. Nursing's experience with deteriorating standards was not unique. Medical schools in America had passed through a very poor period. However, the public was made aware of the problems in medical education, and conditions changed remarkably quickly. Nursing school problems were not shared with the public.

Although the immediate results of the study may not have been as striking as they would have been if shared with the public, reforms of various kinds slowly developed. The apprenticeship system was altered to include instructors hired to teach, the amount of nonnursing service
was reduced, and the cost of the nursing education programs started to increase.

The increase in the cost of nursing education programs caused many hospital administrators to wonder whether or not there was an economic advantage to conducting a nursing program. The Iowa Board of Nurse Examiners gradually increased the requirements of the schools in regard to qualifications of students. Minimum age of students entering nursing was increased, as was preliminary education for students. Hospitals were required to be of a minimum bed size in order to conduct a nurses' training program. These changes resulted in a slow decrease in the numbers of hospitals in Iowa conducting nurses' training programs. However, Iowa was flooded with women calling themselves graduate or registered nurses and jobs for nurses were scarce.

The Era of Hospital Schools: A Summary

How did economic factors influence the development of professional education? During the war effort, the nation's resources were directed toward successful completion of the war. Indirectly the war had a long lasting effect upon nursing care and nursing education.

Wars have always had the effect of emphasizing the necessity of better nursing care. The war efforts generally cause a serious drain on the number of civilian nurses available. In addition, changes in the type of warfare results in different types of battle wounds. The different types of wounds caused the nursing care to be altered. The result of changes in nursing care resulted in an alteration of the school's
curricula.

One of the nation's resources was its nurse manpower. World War I challenged nurses to provide nurse manpower for both the military and the civilian populations. Schools of nursing were encouraged to increase the number of students entering nursing. The schools responded to this request in several ways. One effort to increase the number of students entering nursing was an appeal to college educated women to enter nursing. Another method of increasing the number of students entering nursing was to lower the admission requirements of the hospital schools. The effects of these efforts to recruit students into nursing were successful. Admissions to schools of nursing during the years 1917-1918 increased by about 25 percent.

One very successful experimental program, the Vassar Training Camp, enrolled female college graduates in an intensive preparatory course. A result of this successful program was an increased interest in the field of nursing. Colleges and universities throughout the country became interested in providing preparatory courses for nurses. Unfortunately, the colleges and universities did not attempt to provide professional education. The colleges and universities provided only the preparatory courses, the students received the professional part of their education in a regular hospital school of nursing. Apparently college and university officials did not take the responsibility to examine the type and content of professional education received by the nurses. Perhaps because the physicians and hospital administrators seemed satisfied with the type of education given nurses in hospitals
the officials of the higher education institutions did not interfere. Instead, they apparently granted degrees in nursing without knowing what was taught about nursing.

This era marks the beginning of the heterogeneity of persons labeled "nurse." It was probably the influence of current societal expectations of the role of the nurse which led to most colleges admitting students into the preparatory courses for nurses without requiring previous college graduation. The students were allowed to enroll in preparatory courses directly from high school graduation. To make matters worse, many schools of nursing lowered their admission requirements. The admission standards were lowered in an attempt to attract more individuals into nursing. Thus, by 1920, there was a marked diversity of educational preparation required for individuals entering schools of nursing. A student could enter a hospital school of nursing as a high school graduate with a three month college preparatory course, a college graduate with a three month preparatory course, or as an individual with only a grammar school background.

The diversity of the educational base for the profession has been one factor which has deterred the professional development of nursing. There has not been an intellectual base from which colleague interactions could and should take place. Without a uniform educational base, common value systems could not be developed. Value systems color communication. Certainly, misunderstandings from the lack of a common value system occur in any communications reflecting the individual's knowledge base. Additionally, there were no incentives to encourage
theoretical dialogue among nurses. The reward system prized the nurse who followed the physician's orders.

The dominance of medical education over nursing education in the hospital received official sanction in the 1920s when the Council on Medical Education of the American Medical Association officially became the Council on Medical Education and Hospitals. This change in the title of the organization indicates the change of focus of the organization. The change was due to the fact that leading members of the association thought it desirable for medicine to give closer attention to the manner in which hospitals could be used to the advantage of physicians.

With the formation of this new council the American Medical Association automatically assumed it had the right to make decisions about nursing and nursing education. After all, nursing schools were located in hospitals and the chief product of the hospital was nursing service.

To be sure, not all physicians assumed a paternalistic attitude toward nursing and nursing education. A notable exception was Richard Olding Beard, who first proposed the idea of a university-affiliated school of nursing.

During this period of time, the religious influence on nursing education was largely in the control of student behavior. Students were to be subjected to strict discipline. Student dress, manner of speech, table manners, and social activities were all subject to approval. Graduate nurses were no doubt pleased to be free from the control of the
A major consequence of the situation in which poorly trained nurses flooded the occupation was the damage to the image of nursing. With admission standards to schools so low, and discipline unreasonably strict, little could be done to improve the image of the nurse in the eye of the public. Consequently, many capable and qualified individuals did not enter nursing.

The heterogeneous educational standards for nurses resulted in such confusion that it was necessary to record and analyze the situation before attempting reform. Fortunately, the Rockefeller Foundation was interested in the area of public health and preventive medicine. The Rockefeller Foundation agreed to finance the Committee for the Study of Nursing Education. The committee, sometimes called the Goldmark committee after the secretary of the committee, conducted a detailed study of the conditions in nursing.

Although the committees' results were not shared with the public in the same manner as the study of medical schools, there were results. Slowly, over a period of about ten years, schools of nursing improved. Educational standards were raised. Entrance requirements for schools of nursing were made uniform. Some inferior schools were eliminated and there was a decrease in the number of students admitted to schools of nursing.
Chapter Five: From Depression to W.W. II, 1930-1945

This chapter discusses the economic influence of the depression on the development of professional nursing education. The economic exploitation of women, as nurses, was intensified during the depression. During the depression years, the unemployment problems in nursing became more obvious. Hospitals continued to use student nurses to provide the majority of nursing care. Graduate nurses wanted to work for room, board, and laundry. Some hospital administrators allowed graduates to work under such circumstances, others did not think such concessions were worth the expenses involved.

The Social Security Act of 1935 authorized the use of federal funds for the training of nurses employed by health departments. Many formerly unemployed nurses received public health training through the use of these funds.

Another economic factor was the introduction of hospital insurance. Hospital insurance is sometimes called "health" insurance. This misnomer is indicative of the national focus of health care. Hospital insurance is probably more correctly called "sickness" insurance. The pay-off is for sickness not for health. The introduction of hospital insurance resulted in increased numbers of hospitalized patients.

The poor quality of education received by the average student nurse and the lack of professional status of graduate nurses held back the development of professional nursing education. Medical domination of nurses education probably restricted the focus of care. Medicine has focused on disease and treatment. Nursing has attempted to focus on
Nurses were criticized for their lack of culture and social graces. Changes in the nursing education programs and the growth of general education are discussed to point to the attempts at change. Nurses were taught in an apprenticeship system of education, a system not designed to impart either social graces or general education. Still, nurses were criticized for not acquiring these attributes.

The Woman's Movement, while not recognized by that name, might have been responsible for the shortage of nurses immediately after the war. Women had, no doubt, grown somewhat wiser about the social discrimination faced by a women's profession. Therefore, many women would not consider nursing as a career. Many, already in the field of nursing, left for marriage or for better working conditions elsewhere.

The same research questions are discussed in relation to the conditions in Iowa. Iowa was not immune from the social problems of the time. The economic factors experienced throughout the nation were experienced in Iowa.

Perhaps Iowa hospital schools of nursing responded more rapidly than did the schools throughout the nation. Schools of nursing in Iowa began closing in the late 1920s.

Evidence to this time indicates that the Iowa schools of nursing were developed, or closed, as a reaction. There was no evidence of state wide planning for nursing education. Each local area was free to respond to its own need for nursing service. There was no evidence of consideration for the needs of the graduate nurses.
Unemployed Nurses

The Great Depression did not signal the onset of an unemployment problem in nursing. Even before the depression, unemployment among nurses was extensive. It had been a problem since the 1890s. Beginning after the initial proliferation of training schools, nurses were forced to deal with the constant out-pouring of new graduates and with the competition from students (Medical Care, 1932, pp. 141-142). The Depression served only to make the problem more obvious. An estimated 8,000 to 10,000 graduate nurses were out of work (Geister, 1930, p. 320).

Announcements such as the following were common in the American Journal of Nursing:

Will you please publish a warning to nurses contemplating coming to Colorado Springs, Colorado? We do not wish to appear inhospital, but it might save much time and money to know there is not enough work for nurses who are already here. M.A.P (A.J.N., March, 1930b, p. 344).

Nurses who are contemplating coming to Binghamton, New York, to work, are advised not to do so as there is not enough work for nurses already here. Secretary, Alumnae Association, Binghamton Training School.

District I (Birmingham) of the Alabama State Nurses' Association does not wish to be inhospitable but advises nurses planning to come here to do private duty, that unemployment is a serious problem in that branch of nursing here, many local nurses not making enough to live. Catherine A. Moultis (A.J.N., January, 1930a, p.97).

Nurses most affected by the depression in its early stage were the nurses that did private duty. According to Roberts (1961):

Private duty nurses are extremely vulnerable to changes in either the economic status or the health of a community. News of the stock market crash was not many hours old when registrars began receiving messages from hospitals canceling previous requests for special duty nurses. Annual visitations of influenza following the epidemic of 1918 had subjected them to seasonal cries of "shortage"
of nurses. But the public, mercifully spared an epidemic in 1929, gave no thought to the plight of the nurses who, on the basis of past community needs, and anticipated a period of assured employment. Unlike firemen, private duty nurses are not salaried to ensure their availability when needed. As the depression deepened, clinics became over-crowded and public tax-supported hospitals overflowed with patients. Public health nursing agencies were under heart-breaking pressure to provide care for more and more patients who had less and less food and fuel in their homes. But the occupancy of voluntary hospitals whose patients in normal times employed considerable numbers of special duty nurses fell off abruptly . . . . A job-finding program noted that a surprising number of nurses who were frantically searching for employment had one or more dependents. When employment was found, it was necessary to equip many of them with shoes and uniforms before they could go on duty (p. 223).

In 1932 a campaign to promote the hiring of graduate nurses in hospitals, together with the discontinuation of training schools and the provision for an eight hour day, was launched by the American Nurses' Association.

The campaign met with considerable resistance. The President of the American Hospital Association, Paul H. Fesler (1932), speaking to the convention of the two national nursing organizations in 1932, stated that "business matters" in the hospitals did not warrant the encouragement of "new projects" such as the employment of graduate nurses. Fesler told the nurses that physicians and hospital administrators would not support the nurses efforts for improvement of educational standards. He concluded that "each hospital has its own service problem" and plans for change were destined to fail "when they meet financial barriers" in individual hospitals (p. 638).
The financial burden was addressed by J. A. Diekmann, Superintendent of the Bethesda Hospital in Cincinnati in an article published in the March, 1934, issue of Hospital Management:

There are today 68 Bethesda graduates in this city, victims of unemployment. To remedy this movement the national and state nurse organizations are forcing an issue that looks toward eliminating nurse schools from a large percentage of hospitals, and to employing only graduates for all hospital nursing work.

But what would that mean in point of expense? We have made a careful study of what it would mean to Bethesda. The maintenance of our 112 students costs us $95,036 a year, or $848.53 a student. To do our nursing work through graduate nurses would cost us $132,107, or $37,071 more than student nursing. If we are compelled to give up our nurse school, where would we get that additional $37,071? Hospital rates cannot be raised. There is universal complaint of their being exorbitant now. Will the friends of the hospitals defray that additional large expense by more liberal contributions? The above movement would solve the nurse problem only to create an additional financial problem for the hospitals, most of whom now are in financial desperation (pp. 29-30).

The unconditional acceptance of hospital apprenticeship nurse education derived from the economy of the plan. Few spoke of the value of the system in educational or professional terms. Effie J. Taylor, representing the nursing profession on a panel discussion sponsored by the Council on Medical Education and Hospitals and the American Conference on Hospital Service in 1933, spoke to the exploitation rather than the educational features of the system. Taylor said:

The first objective of any professional school should be the education of the student for her vocation, and the service she may give should be incidental to her education for her profession. The fundamental objective of the nursing service of the hospital is the daily and immediate care of the patients, and all other functions should be secondary. But the primary function of the schools of nursing is in the hospital inevitably evaded . . . . In
nursing schools even the apprenticeship system is exploited, since the major time of the student is spent in service with the minimum of supervision and instruction (Report on Joint Session, 1933, p. 1179).

On the panel with Taylor was C. Rufus Rorem, a Chicago physician and a member of the research staff of the Committee on the Costs of Medical Care. He admitted that the superior status accorded student nurses in hospitals was questionable. He stated:

Hospital directors should not maintain too stoutly that a student is "as good" as a graduate, or even "nearly as good"; for, if the average technical and economic value of students approaches that of graduates one is forced to question the quality of education in the nursing school (Report on Joint Session, 1933, p. 1180).

Rorem identified the inconsistencies in the thinking of hospital authorities and their nurse supporters in relation to the problem of nursing service and discriminatory practices directed toward graduate nurses (Rorem, 1933).

Malcolm MacEachern (1932), a physician and Associate Director of the American College of Surgeons, considered the total problem of graduate or student service in the June, 1932, Modern Hospital. MacEachern maintained that "it is not sufficient simply to decide which is the more economical," provided nursing service did not necessitate raising hospital charges which would not "be in the best interests of the patient" (MacEachern, 1932, p. 97).

In discussing the objections to the graduate nurse, MacEachern (1932) pointed to the complaints of hospitals that the graduate "objects to discipline. She is not nearly so docile as the student nurse and does not always respond with alacrity to orders from head nurses and supervisors" (p. 98). In addition, MacEachern stated:
Strange to say, one of the most frequent objections one hears to the graduate nurse is that she herself does not like general duty. She is dissatisfied with her job and shows it in her attitude toward patients and personnel; she is indifferent toward her work and is likely to infect others with the germ of indifference . . . . She more often complains about the food, the housing and the hospital rules. She resents criticism . . . . Finally, there is the fact that the graduate must be paid a salary; in other words, that her services are more expensive than those of the student nurse (p. 98).

As to which is actually more economical, graduate or student service, hospital authorities of the time did not know. The Committee on Grading of Nursing Schools ascertained that as many as 42 per cent of the 1,395 hospital superintendents did not know the costs of their schools, and 34 per cent could give only an estimate (Burgess, 1928, pp. 288-400). MacEachern (1932) indicated that when the school attempts genuinely to educate the nurse the cost of nursing care increased. "Though not many 'controlled' studies are available to prove the point, there is a growing opinion that the graduate nurse is more proficient than the student." This was not a reflection on the student, but to be expected that the individual still in training is less adept than the one who has had a full academic and practical course. "What would the hospital and the lay world say if we were to decide that the intern or the medical student were better suited to treat the sick than is the fullfledged doctor" (p. 102).

MacEachern (1932) pointed to the hospital as responsible for the poor spirit of the graduate nurse. The majority of hospitals still required that graduates live in dormitories. Executive positions and salary increases were not filled from the ranks of general duty nursing.
According to MacEachern, not taking orders as submissively as would the student, a major complaint against graduates, could be handled by courteous treatment (p. 104).

Some nurses approached hospital administrators asking to be allowed to work for their board, room, and laundry. How to handle this request became the question of the month for January, 1933, Modern Hospital publication. The question "Should hospitals take them in?" was asked of selected hospital administrators in different geographical locations throughout the United States. The replies were diverse and of interest. Dr. Donald C. Smelzer, Director of the Graduate Hospital of the University of Pennsylvania, expressed his opinion that the hospital should not exploit the misfortune of the graduate nurse. If the nurse voluntarily applied for work under such conditions, the hospital was justified in accepting her services. The period of service should be treated as postgraduate work. The hospital would be rendering a generous act, the room and board would be equivalent to the value of the service rendered to the hospital.

Dr. Maurice H. Rees, Director of the Colorado General Hospital in Denver, expressed his opinion that nurses working only for board and room were not likely to be first class nurses. He was not sure that the hospital could stand the expense of an unfair exchange: food and lodging for inferior service.

Grace Craft, Superintendent of Madison (Wisconsin) General Hospital, offered her opinion that to accept a full day's work in exchange for room, board and laundry was to take unfair advantage of the graduate
Harlan Hoyt Horner, then assistant commissioner for higher education in New York State Department of Education, published a study of conditions in nursing in 1934. Horner's report charged that it was the attitude of the hospital managers who maintained "that profit may or ought to be made out of a training school for nurses worthy of the name" that was at the bottom of the problem (Horner, 1934, p. 5).

Horner (1934) found the image of nurses very low. In conducting the study, Horner and his staff interviewed hundreds of patients and families to determine their views on the type of nursing care they received from nurses. Public attitude about nurses was deplorable. Most condemned was the nurses' lack of culture, general education and social poise, and undesirable personality. In addition, the average nurse was unable to "teach the patient how to care for himself," she also lacked a "preventive point of view," and a "feeling of responsibility for teaching positive health". Sadly, when the nurses were asked to evaluate themselves "their replies followed the same lines as those of the other groups approached" (pp. 7-38).

The condemnation of the nurses for lack of culture and the social graces must be considered in relation to the apprenticeship system of education. Apprenticeship systems of education, in any society, have not been designed to impart either the social graces or general education. A liberal education system has had the task of imparting "culture" and a broader base of knowledge. For this reason the professional groups, other than nursing, have established themselves in
colleges and universities. The nursing profession has made an attempt to establish a place in the university for nursing, but progress has been slow.

Apprenticeship education did not and could not provide a liberal education for nurses. The responsibilities of citizenship or professional commitment were ignored or sacrificed for the good of the institution. The poor quality of education received by the average student nurse and the lack of social and professional status of graduate nurses prevented them from functioning as effectively as possible. As a group, nurses often did not know how to help themselves. In speaking to her colleagues in the National League of Nursing Education in 1932, Elizabeth C. Burgess told the nurses that they themselves "held back progress through their apathy, their lack of understanding, and because of their long domination by hospital interests" (Burgess, 1933, pp. 49-50).

**Greater Access to Health Care**

Health care delivery was inadequate, especially for the poor. Attempts at health care reform were being pushed. In 1927 a Committee on the Cost of Medical Care was formed to investigate many of the complex problems of medical care. The Committee was composed of a group of representative physicians, public health officer, social scientists, dentists, nurses, and public representatives. Dr. Ray Lynman Wilbur, president of Sanford University and former president of the American Medical Association, was chairman of the Committee.

Results of the study were published in December, 1932. Davis (1932) revealed that approximately $3.5 billion was spent annually for medical
care. Of this amount, physicians received 30 percent, hospitals 24 percent, dentists 12 percent, medication accounted for 19 percent, private duty nurses accounted for 5 percent, public health work received 3 percent, and all other purposes accounted for 7 percent. Each family spent about $108 for medical care, an average of $24 per person (pp. 41-46).

One significant difficulty in health care delivery, exposed by the Committee is that the individual family could not budget medical costs because of the unpredictability of sickness. To meet this difficulty the Committee proposed a variety of experiments in organized medical services. These included low-rate hospital services, pay clinics, public health nursing, organized services by trained nurse midwives, government hospitals, tax-supported physicians in rural areas, state aid for local medical services, university medical services, and installment payment plans for medical care.

The basic recommendations of the Committee on the Cost of Medical Care were condensed as follows:

That medical care be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel, centered around a hospital, and rendering home, office, and hospital care.

That all the basic public health services be extended until they are available to the entire population, according to its needs.

That the cost of medical care be placed on a group payment basis through the use of insurance, taxation, or both methods, without precluding the continuation of the individual fee basis for those who prefer it.

That a specific organization be formed in every community or state for the "study, evaluation, and coordination of medical services."

That the professional education of physicians, dentists, pharmacists, and nurses be reoriented to accord more closely with present needs, and that educational facilities be provided to train three new types of workers in the fields
The Recommendations of the Committee on the Cost of Medical Care were not extensively well received. Lucius R. Wilson (1930), M.D., Superintendent of John Sealy Hospital, Galveston, Texas, suggested "while the idea of paying for things on the installment plan may be repulsive to some of us, yet if it is universally used for all luxuries and necessities of life, can it not be employed by the hospital as a means of paying for that most essential . . . life and health?" (p. 70). Wilson might have been pleased with the recommendations of the Committee. The American Medical Association was not pleased.

R. C. Leland (1933), M.D., Director of the Bureau of Medical Economics of the American Medical Association, stated that the recommendations proposed were "tactics of desperation" in which hard-pressed hospitals sought "any port in a storm." He warned that all such plans tended to lessen the control of the county medical societies over medical practice and thus to decrease the effectiveness of the most important form of professional control of standards and ethics, while at the same time they increased the influence of lay commercial interests.

Leland (1933) warned of increased hospitalization because of a group hospital-insurance plan. The broad effect of the plan would be to shift the burden of hospital support from philanthropy and good will to taxation of low-paid workers. Dr. Leland (1933) asked: "Does the public need at the present time an increased amount of hospital care, or will it benefit more from a greater amount of medical care in the home" (pp. 25-26).
Dr. Morris Fishbein (1932), the editor of the *Journal of the American Medical Association*, wrote against the report of the Committee. He declared the recommendations to be "socialism and communism - inciting to revolution" (pp. 1950-1952).

The committees description of nursing education and the recommendations for reform caused no outcry from the nurses, the report rang true as it stated:

An oversupply of personnel, much of which is not of a professional quality, has created serious economic problems for nurses. The Committee on the Grading of Nursing Schools has shown that the present unrestricted development of hospital training schools is flooding the market with nurses. Although many persons who need nursing forego it because of the cost, the growth in the number of nurses threatens to outstrip the needs of the people as it long ago outstripped their effective demands. Even before the current depression, unemployment among this group was extensive; yet the supply of new graduates continues to be poured out as the result of a hospital policy which ignores the needs of the student and of the public in the interest of obtaining inexpensive hospital help. Moreover, the quality of instruction offered in many of these schools is too low to produce competent nurses, while the requirements for licensure in some states are so low that incompetent nurses are able to practice as though fully qualified.

There should be a rearrangement of curricula and a revision of the fundamental purposes of many nursing schools, so that they will produce socially-minded nurses with a preparation basic to all types of nursing service. The care of hospital patients is not, in and of itself, sufficient preparation for professional nursing. Nurses should be prepared not only for the practice of a profession but for life and its manifold home and community duties as well ("Medical Care," 1932, pp. 141-142).

The Hospital Insurance

Hospital insurance plans in the United States are not recent. As early as 1880, hospital service insurance plans were in operation in
northern Minnesota for the benefit of lumbermen (Kalisch & Kalisch, 1978, p. 420). In 1912, the Rockford Association was organized in Rockford, Illinois. In 1921, the community hospital in Grinnell, Iowa, developed a plan covering the costs of room, board, and nursing care, laundry, surgical dressings for the students of Grinnell College. The cost of the insurance was $5 per year or $3 for a semester. As a point of interest, this 45 bed hospital opened a school of nursing "in the early part of the first year" of the hospital's existence. The first class graduated in 1922, a class of only two (Larsen, 1922, pp. 394-397).

The hospital insurance plan was salvation for the hospitals. The occupancy rate had been about 50 percent. People were not going to the hospital for fear of personal bankruptcy. Kimball (1933) urged hospitals to undertake insurance plans without waiting for regulatory decisions on specific insurance aspects from state attorneys general. He pointed to the fact that the patient would have his hospital bills paid, and money enough left to pay the physician (pp. 345-352).

The Committee on the Cost of Medical Care had recommended prepayment plans for individual hospitals. These plans constituted a form of social insurance in which individuals or groups made equal and regular payments into a fund to be used at a given hospital when required by one of the members. By the end of 1934, nonprofit community hospital service plans had begun to be established so rapidly that they were termed a national movement (Kalisch & Kalisch, 1978, pp. 420-421).
The American Hospital Association provided leadership in the development and coordination of hospital insurance plans. Approved plans were allowed to use the name "Blue Cross." The plans were sponsored locally by hospitals, the medical profession, and the general public. A Blue Cross plan was a nonprofit corporation organized under community and professional sponsorship and approved by the American Hospital Association for the purpose of assisting the individual to defray the cost of hospital service.

During the late 1930s, the annual cost of membership in Blue Cross plans ranged from $5 to $12 per subscriber, depending upon the cost level of the area and the type of illness covered (Kalisch & Kalisch, 1978, pp. 422-423).

Social Security Act of 1935

In 1935, Congress passed the Social Security Act to deal with the problem of economic insecurity. The Act was one of the New Deal measures that had been tried first in Europe.

The Social Security Act provided for (1) federal old-age benefits; (2) grants to the states for old-age assistance, vocational rehabilitation, and unemployment compensation administration; (3) aid to dependent and/or crippled children, aid to the blind, and maternal and child welfare; (4) public health work, including the authorization of grants to states for aid in the development and maintenance of state and local health services; and (5) an annual appropriation to the Public Health Service for additional research and training activities.
The Title VI of the Social Security Act, which authorized use of federal funds for the training of public health personnel, was especially appreciated by nurses. During the first year of the Social Security program, about 1000 nurses received scholarship stipends through Social Security funds for study at universities offering public health nursing programs. The programs had to be approved by the National Organization for Public Health Nursing. Within two years after implementation of the Social Security Act, 2,304 nurses received some postgraduate training at approved schools on training stipends. Almost 15 percent of those receiving training stipends attended school for a full academic year or more (Kalisch & Kalisch, 1978, pp. 432-433).

Nursing Education Changes

The first study of schools of nursing was made by the Committee on the Grading of Nursing Schools in 1929, followed by a second study in 1932. These two studies are known as the First and Second Grading. The second grading convinced the committee that where the schools could be helped to study what they were doing, and discover what they ought to be doing, changes would follow. A decided improvement in many schools was shown in the second grading.

In 1929, there were over 2,286 hospital schools of nursing; by 1932 the number had decreased to 1,781; in 1935, the number had dropped to 1,472, a decrease of 814 schools, or 35 percent, in six years.

This attrition was attributed to the evaluation studies of the 1920s and the national economic depression. Private patients became scarce and hospitals permitted their graduates to remain at work.
Claribel A. Wheeler, Executive Secretary of the National League of Nursing Education discussed the typical school of nursing in the January, 1936 issue of Modern Hospital as follows:

There are 17,000 fewer students in the accredited schools now than there were in 1932. On January 1, 1935, 67,533 students were enrolled; this is 20 percent fewer than at the time of the second grading. In 1934, 22,000 students were graduated. Three years before more than 25,000 entered the profession . . . . The typical school of nursing today is in a slightly larger hospital than it was at the time of the second grading. At that time, in 1932, the median school was connected with a hospital having a daily average of 75 patients. Now it is located in a hospital with 80 patients. In 1932, 30 percent of the schools were in hospitals with less than 50 patients; this year, 26 percent of the schools are in hospitals of this size. Although the daily average number of patients in a hospital does not necessarily determine the character of a school, those connected with very small hospitals are less likely to provide . . . clinical experience necessary for . . . nurses (Wheeler, 1936, p. 47).

The number of schools employing at least one full time instructor increased from 58 percent in 1929 to 89 percent in 1935. The number of states in which every school had at least one instructor increased from three states in 1929 to 14 states in 1935.

Student health services had improved. In 1929, only 2 percent of all schools had given a complete health examination to all of their students. In 1935, 73 percent of the schools reported they had provided a complete health examination for all of their students each year that they were in training.

There was a growing trend for schools to give up paying allowances to their student nurses and to charge tuition instead. In 1932, 78 percent of the schools paid allowances and did not charge tuition to their
student nurses. In 1935, 43 percent of the schools paid allowances and did not charge tuition, and 22 percent of the schools did not pay allowances and charged tuition. Ten percent of the schools both charged tuition and paid an allowance, and 25 percent of the schools did neither.

According to Wheeler (1936), discontinuing the payment of a monthly allowance was a progressive sign, provided the schools were using the money to give the students a better education.

If nothing is being done to improve the teaching, supervision and clinical experience of the student, then it is not a hopeful indication. Some of the schools charge tuition for the preclinical course only, while in other schools tuition is charged for each term of the student's course (p. 48).

By 1936, eight hours, exclusive of time spent in class, study or at meals, was the prevailing length of day duty time. The length of night duty remained more than eight hours in half of the schools. The number of hours per week of duty time for students ranged from 56 to 70 or more. More than half of the schools were on the 56 hours per week schedule. Wheeler (1936) reported that the National League of Nursing Education suggested that nursing schools make the 44 hour week, including regular class work, their objective, as student nurses were expected to spend about 10 hours a week in study. "Is it reasonable to ask them to spend more than 54 hours each week in work and study?" (p. 49).

The National League for Nursing Education published the Curriculum Guide for Schools of Nursing in 1937. The guide was the product of literally thousands of nurses all over the country who were involved in either creation or revision.
According to Christy (1969), it was "the process by which this study was accomplished, rather than the book which was later published, that had the most far-reaching effects" (p. 92). Isabel Stewart and her students at Teachers College gathered all of the curriculum proposals, outlined the meaning of the proposals, and raised questions for discussion. These materials were sent to the Committees of the State Leagues, to the state subcommittees, and finally to the local committees. In this way "People who knew little or nothing about a curriculum were now actively involved in constructing one." It was a "masterly job" of teaching the "mass of nursing educators across the country" something about "not only what a curriculum was, but how to share in the development of a curriculum" (pp. 92-93).

The guide contained two assumptions. One was that the primary function of the school of nursing should be education of the nurse. This was a change from the earlier assumption that the function of the school was to provide nursing service for hospital patients. This assumption did not reject the responsibility for patient care, rather pointed to the long term goal of preparing nurses to care for future patients. The second assumption was the community concept of nursing. Rather than caring only for hospitalized patients, the concept of prevention, public health nursing, mental health nursing, and economic aspects of health care were stressed.

The curriculum guide was designed to cover a two and one-half to three year period. The plan suggested a five and one-half day week, or 44-48 hours, with one and one-half day off per week. The proposed
course called for 1,200 to 1,300 hours of class and laboratory work and about 4,800 hours of nursing practice. This was an increase of approximately 275 classroom hours, and a decrease of approximately 1,200 hours of nursing practice compared to the 1927 curriculum guide.

The Growth of General Education in Nursing

Because there was a paucity of collegiate schools of nursing prior to the 1930s, the development of these educational programs for nurses will be discussed in this section. It is significant to recognize that the genius of a truly liberally educated woman, Florence Nightingale, gave impetus to the evolution of professional nursing. Even while nursing schools in America were regressing from the standards set by Florence Nightingale, the voices of the vanguard of collegiate nursing could be heard. As early as 1901 Ethel Bedford Fenwick made a plea for the foundation of endowed colleges of nursing. In a statement that is timeless in concept, she said:

A nurse cannot live by learning alone. We must consider also her Fantasy and her Heart . . . . To this end we would have nurses come into touch with all that is purest, wisest, and most potent for good in this beautiful world, to do which they must take part in the civil and social movements of the time, realize the obligations of citizenship, and appreciate at their true value national and international events. They must live with others, not altogether for them (p. 7).

Other supporters of a liberal education for nurses were Isabel Hampton Robb, M. A. Nutting, and Annie W. Goodrich, to name a few. Among the many problems accompanying the development of collegiate schools of nursing was the crucial one of identifying the specific meaning of "collegiate school of nursing." Many schools had such
tenuous connections will colleges or universities that their claims to
the "collegiate" designation were spurious.

The necessity for placing some limitations on the meaning of col­
legiate education for nurses was recognized in 1921 in a report of a
committee of the National League of Nursing Education. In a report,
the committee declared:

While the Committee is anxious to encourage in every
possible way the experiment which promises a sounder
and broader system of nursing education, it believes
that nothing could be more unfortunate for the future
of nursing than the too prevalent idea that almost any
kind of connection between a nursing school and a
university is acceptable or advisable (Department of
Nursing Education, 1921, p. 620).

The committee then went on record favoring the "five-year" schools
to exemplify collegiate nursing education. It delineated six major
arguments favoring the establishment of schools of nursing in univer-
sities. First, educational opportunities were superior. Second, since
the modern nurse was a public servant, it was in the public's interest
to see that her education was on the soundest possible basis. Third,
unlike hospital schools, the collegiate schools had independent financial
resources. Fourth, both hospitals and universities would benefit from
the affiliation. Fifth, the social and scientific subjects basic to
nursing were already well established in universities. Finally, cultural
backgrounds, as well as scientific and professional subjects, were needed
by nurses as essentials of an "all-around college education" (Dept.
Nursing Education, 1921, p. 620). The same report stated that the
academic subjects which the committee deemed essential were: modern
language, English, history, chemistry, physics, general biology or
zoology, anatomy and physiology, bacteriology, hygiene and sanitation, psychology, sociology or economics, and physical education (p. 714).

The five-year nursing programs were not integrated units. They were two separate programs, one superimposed upon another, leading to a baccalaureate degree. The professional phase of the programs followed the traditional pattern of hospital diploma programs.

During the 1920s and 1930s, the number of collegiate nursing programs increased slowly. At the same time, the confusion of aims for collegiate nursing education was manifest in the pronouncements of nursing leaders and friends of nursing. At the Forty-first Annual Convention of the National League of Nursing Education, Edna S. Newman (1935), Director of Cook County School of Nursing, said:

Trends in nursing education are influenced and determined by those of general education . . . . The program of nursing education must be consistent with the plan of general education to be successful (p. 236).

A different view was expressed by Anne N. Austin (1935) at the same convention:

It cannot be too strongly stressed with relation to . . . sociological principles that only those concepts should be included which will find a definite use in the life and work of the nurse . . . (p. 245).

The controversy continued and by the mid-thirties it seemed evident that the time had come for stocktaking of the purposes and direction of collegiate education for nurses. Petry (1937) reported the results of a survey on nursing curricula leading to a degree. There was such heterogeneity with reference to the purpose for which programs were established as to make classification impossible. Some frequently stated purposes
were: to improve the education of the nurse; to prepare teachers of
nursing; to prepare public health nurses; to secure better students in
the school; to raise standards of nursing in the hospital to add
prestige to the course; and to procure more mature persons (pp. 287-97).
Petry (1937) commented:

In all too few instances did there seem to be conscious
effort to prepare nurses with wide cultural and social
insight . . . . The possibility of helping the nurse to
develop more fully her potentialities as an individual
was scarcely mentioned (p. 295).

Brown (1936) reports the formation of the Association of Collegiate
Schools of Nursing in May, 1935, at Western Reserve University. 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 was restricted to schools or departments of nursing that have
a definite commitment to the task of developing collegiate and profes-
sional curricula (pp. 70-73).

In an article published in the American Journal of Nursing, Isabel
M. Stewart (1936) discussed the Associations goals:

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 (pp. 45-46).

The years preceding World War II brought increasing interest in collegiate nursing education, but no major changes in its character. The programs remained, essentially, two discrete educational units leading to a diploma and a baccalaureate degree.

In 1939, Earl J. McGrath, an educator interested in nursing education, expressed support for nursing's cause of public support for nursing education. McGrath (1939) outlined the responsibilities of the profession to warrant such support. Among the changes which he lists as expectations of the public were: (1) the separation of education from service; (2) the affiliation with institutions of higher learning; and (3) ample provision for general education, and the integration of general education and professional education (pp. 122-127).

Although lack of integration may have been one educational deficiency easily recognized by allied professional groups, more serious violations of educational principles were disturbing nursing educators. In most instances, the universities had little or no control over the professional aspects of the programs for which they were granting degrees. Many of the deficiencies inherent in hospital diploma programs were being perpetuated in the professional phase of the collegiate program. These deficiencies were the long hours of student service, the primacy of service over educational experiences, and the ill-prepared faculty with dual responsibilities over service and education. In 1941 Lucile Petry spoke out against collegiate education as it then existed. She placed a share of the burden on college administration:
The administrators of the colleges assume that, since the director of the school of nursing is a worthy person and since reputable physicians are satisfied with the care given their patients in the hospital, educational standards are being maintained. The fallacy in such an assumption is revealed by consideration of the development of nursing education and the economics of the present complicated situation (p. 403).

World War II - The Beginning

By 1939, the reduction of working hours for student nurses, and for graduate nurses in hospitals had resulted in an increase in nursing school enrollments from 67,000 students in 1935 to over 82,000. Patients in American hospitals were receiving over 60 million more days of care than in 1934. The number of hospital beds had increased by 14 percent (Washburn, 1940, pp. 13-17).

The international relations in Europe were steadily deteriorating. Nursing leaders were aware of what another war would mean to nursing. The May, 1939, issue of the American Journal of Nursing carried the following editorial which alluded to the future:

We salute you, the graduates of '39. We wish you well. The world has need for more nursing.

If such a thing were possible, and all the graduates of '39 could be massed in one great stadium, what a heart stirring sight it would be.

We don't know what our hypothetical speaker would say to you, you thousands of young and eager American nurses on so great an occasion. Probably he (or she) would begin with some description of the shattering fears of the world we live in, of the undeclared wars, of changing national boundaries, of problems, of migration, and of the health problems created by all of them.

Nurses of '39, the world has need of you. If war should come, we have faith to believe that you will fulfill the traditional role of the nurse ("To the Graduate," 1939, pp. 529-530).
The international crisis persisted, and February, 1940, the editor of the *American Journal of Nursing*, wrote:

Congress, as this is written, has been in session only ten days. The very air is supercharged with tragedy. The wars of other countries are profoundly influencing life in our own, and the Congress is concerned with such matters as neutrality, reciprocal trade agreements, and armaments for defense ("Federal Legislation," 1940, p. 176).

The theme for convention of the American Nurses' Association held May, 1940, was "Nursing in a Democracy." During one of the sessions of the convention the radio carried President Roosevelt's announcement of national preparedness. Although no general plans had yet been formulated, a resolution endorsed by the National League of Nursing Education and the American Nurses' Association was passed, offering President Roosevelt "the support and strength of our organizations in any nursing activity in which we can be of service to the country" (Philadelphia Biennial, p. 673).

In order to insure an adequate supply of well trained nurses for both civilian and military nursing services, Congress passed the Labor-Federal Security Appropriation Act. The Act, signed by President Roosevelt on July 1, 1941, included an appropriation of $1,200,000 for nursing education. This was the first federal funds ever granted to undergraduate nursing students and schools. The promptness and the procedures in utilizing these funds may be illustrated by an announcement which appeared in the August, 1941, *American Journal of Nursing* under title "Federal Funds to Increase the Nurse Power of the Nation":

Funds were provided for use in connection with the basic course, for postgraduate work including midwifery for nurses, and for refresher courses. Before this magazine is in the mails, letters will have been received by the
nurses in charge of the basic courses in hospitals having a daily average of 100 or more patients and of postgraduate courses in clinical specialties and for the preparation of teachers and administrators. The letters will request from each the information about existing facilities . . . . The assistance of State Boards of Nurse Examiners will be sought. The national and state organizations will be informed of each step in the procedure (pp. 931-932).

In August, 1941, the Mayor of New York City, Fiorello H. LaGuardia, director of civilian defense, invited 800 schools of nursing to participate in a nationwide program to augment the nursing services of hospitals, clinics, and public health agencies by training nurses' aides. Mayor LaGuardia encouraged the schools of nursing to cooperate with the American Red Cross and the Office of Civilian Defense in training 100,000 volunteer nurses' aides so that each hospital nurse might have at least one trained aide to help her extend her services to many more patients. He predicted "the deficiency in nursing personnel will be overwhelmingly accentuated if this country becomes actively involved in defensive combat" ("Training Program," 1941, pp. 44-45).

In 1942, an appropriation of $3,500,000 was made available for nursing education by the federal government. These funds were to be used for salaries of instructors and other personnel, scholarships of tuition and entrance fees, subsistence, the establishment or expansion of affiliations, and a limited amount of classroom facilities.

On June 17, 1942, the President signed the "Pay Readjustment Act." Among other provisions, this measure raised the base pay of Army and Navy nurses from seventy to ninety dollars per month. Even this increase left the nurse ensign with a base pay of $90 a month, compared to $150 for a male ensign. The situation was adjusted when on June 22, 1944,
Congress enacted a law providing members of the Army Nurse Corps and the Navy Nurse Corps with temporary officer's rank. For the duration of the war and for six months thereafter they were entitled to the same initial pay, allowances, rights, benefits, and privileges as prescribed by law for commissioned officers.

The Bolton Act, sponsored by Mrs. Frances Payne Bolton, congresswoman from Ohio, was passed by Congress in June 1943. The act differed from the previous aids to nursing education in many respects. Under its program the students of nursing might join the United States Cadet Nurses Corps. Every qualified individual was given free professional training in return for a pledge to remain in essential nursing, military or civilian, for the duration of the war. Approved schools of nursing agreed to give all of the required theory and practice in a maximum of thirty months. Tuition, textbooks, uniforms, and other materials, as well as maintenance for the first nine months of each student's training period were paid for by the government. A stipend increasing progressively from fifteen to twenty dollars was paid to each student by the government during a maximum of thirty months. During the last six months, the senior cadet period, the student received thirty dollars a month paid by the hospital. Students could elect to spend the senior cadet period in one of the federal nursing services. In 1945, the federal nursing services included Army, Navy, Veteran Administration, United States Public Health Service, Marine, and Indian Service hospitals. Nurses accepted into these hospitals received stipends of sixty dollars per month with full maintenance (Sellew & Nuesse, 1946).
By the end of the war, in August, 1945, almost half of the 240,000 active registered nurses in the United States had volunteered for military service and some 76,000 had served. Nationwide student enrollment had increased by 30 percent since 1943 (U.S. Cadet, 1949, pp. 78-82).

As a result of the federal aid programs for nursing education, hospital schools of nursing obtained more students and better qualified instructors and head nurses. In addition, over $17 million of Lanham Act building funds were allotted to schools in the Cadet Nurse program for the construction of instructional facilities and nurses' residents.

**Iowa in the Great Depression**

According to Bjornstad (1952), the depression hit Iowa hard, and early. As a result of the collapse in farm prices, farm income, and land values, many farmers from 1932-1935 were faced with foreclosures. Misfortunes grew worse - agriculture continued to maintain a high level of production, but unemployment on a vast scale resulted in low purchasing power for the farm, as well as other products. The disparity in the prices of farm products and the goods and services purchased by farmers together with the heavy mortgage indebtedness resulted in the ruin of many farmers (p. 104).

The hospitals, in a state dependent on farm income, suffered as Iowa suffered.

One of the first results of the crash of the stock market, was an almost immediate decrease in the number of patients in hospitals. Iowa Methodist Hospital, Des Moines reported a drop from 6,390 in 1930, to 6,303 in 1931, 5,620 in 1932, and 5,416 in 1933. The following year the trend changed from a steadily decreasing to a steadily increasing number of hospitalized persons (Bjornstad, 1952, p. 105).
As the decreased number of hospitalized patients would indicate, the years of 1933 and 1934 were the worst of the depression in their effect on Iowa Methodist Hospital. An indication of the financial difficulty experienced by the Iowa Methodist Hospital is in the words of Bjornstad (1952):

The hospital reluctantly refused a gift of a plot of South Dakota land because no rental income could be expected, and there was no income to pay the annual taxes of $39.19. . . . In September, 1931, after a comparative study of payrolls of ten other Midwest hospitals, the hospital curtailed expenses by a ten per cent payroll reduction. Hospital bed rates at that time were $3. per day for four-bed wards, $3.50 for semi-private rooms, and from $4 to $8 for private rooms, most of such rooms being available at $4 or $5 (p. 106).

Iowa Health Practice and Programs

For the biennium ending June 30, 1930, there were 4,942 cases of smallpox reported in Iowa. This was an increase of 86 percent over the previous biennium. The Twenty-fourth Biennial Report of the Iowa State Department of Health (1931), stated "it has been said that community conscience may be measured by the amount of smallpox present. It is a fact that a town or city may or may not have smallpox as it wishes" (p. 31).

The Twenty-fifth Biennial Report of the Iowa State Department of Health, 1932 (1933), was more direct in its sentiment concerning the smallpox outbreaks. The report states, "the amount of smallpox present in Iowa at all times is a sad commentary upon the reputed intelligence of our people, for with an illiteracy of less than 1%, every responsible person should know that vaccination will prevent smallpox." The re-
port noted that there did not seem to be active opposition to vaccination but only a general apathy, a sort of "laissez-faire," or "let-sleeping-dogs lie" attitude (pp. 31-32).

According to the Iowa Health Bulletin, for the first quarter of 1934, fewer babies were born in Iowa during 1933 than at any time since the beginning of the twentieth century. The largest number of babies born in the period between 1923-1932 was 51,305 in 1923. There were 38,600 babies born in 1933 (Iowa Health Bulletin, 1934, p. 4).

The University Hospital Administrator, Mr. Robert E. Neff, reported that the University Hospital, Iowa City, had treated 547 cancer patients. The patients were treated at an expense of $79,370.98 or an average of $143.27 for each patient. This number of patients represented about 6.9 percent of the probable number of cancer patients in Iowa in 1931 (Iowa Health Bulletin, 1933, p. 27).

Public sentiment was growing in favor of public health nursing; the Division of Nursing Education recommended that, if at all possible, senior nursing students should be provided a clinical experience in public health nursing (Twenty-fourth Biennial Report, 1931, pp. 69-71).

During the 1930s, Iowa citizens and health care practitioners seemed to develop a greater awareness of the concept of prevention of diseases and control of social problems. The extent to which some Iowans desired prevention of social problems might be traced through one Iowa law.

By 1936, Iowa had experienced four laws on sterilization on the statute books, but it was the one passed by the 43rd General Assembly that was the only one under which sterilization operations were
successfully effected. The sterilization law was for use of those persons desirous of making application for sterilization either for themselves or others in which they were interested (Twenty-seventh Biennial Report, 1937, p. 238).

By the time the Board of Eugenics functioned for two years there had been 98 applications for sterilizations and 90 orders for the procedure were issued (Twenty-eighth Biennial Report, 1939, p. 174). The Thirtieth Biennial Report of the Iowa State Department of Health, 1942, (1943), contains the following information concerning the eugenic law:

During the period July 1, 1940 to June 30, 1942 one hundred and fifty applications for sterilization were received and presented to the Board for its consideration at quarterly meetings . . . . It was shortly after Doctor Bierring became commissioner that he organized the Board and since that time three hundred and eighty cases have been ordered sterilized following due notice and hearing. Although the present eugenic law provides for compulsory sterilization, the Board has to date had accepted only those cases wherein consent has been secured from the proper parties (p. 164).

The Thirty-third Biennial Report of the Iowa State Department of Health, 1948, (1949), gives information as to the "sterilization of the unfit" in relation to whether more men or women were sterilized.

Since that time [1933] orders for sterilization issued by the Board number 768, of whom 574 are female and 194 male . . . . During the biennium [ending 1948] the inspector has cooperated with and prepared 168 cases for presentment to the Board of Eugenics, 130 of which were female and 33 male (p. 149).

There is no further mention of the Board of Eugenics and its work in the Reports to the Iowa State Department of Health. Perhaps the concept of eugenics received the type of publicity at the Nuremberg Trials which caused Iowans to reconsider their actions.
Unemployed Nurses

The nursing staffs of hospitals and training schools in Iowa were affected by the economic depression. There were 2,260 student nurses in training schools in Iowa during 1929, this number decreased slightly in 1930 to 2,247. The number was reduced to 1,735 by 1932 (Iowa State Association of Registered Nurses, Minutes, 1933, p. 59).

According to Bjornstad (1952), there were 138 students in the Iowa Methodist Hospital School of nursing in 1931. "Beginning in September of that year, students paid an enrollment fee of $75, instead of the previous $25. Monthly allowances were discontinued. No class was admitted in January, 1932" (p. 107). Despite these changes, the number of applicants to schools of nursing far exceeded those of previous years.

In 1932 there seemed to be too many nurses. In that year forty percent more nurses were admitted by examination in Iowa than the previous year. According to Bjornstad (1952) Des Moines private duty nurses were faced with waiting, on the average, from six to eight weeks between patients and employment. This long wait between periods of employment made it impossible to meet expenses.

The training school management had to decide whether to continue graduating large groups of nurses and add to the oversupply, or to admit smaller groups and employ graduate nurses to help care for patients. The employment of graduate nurses would relieve the students for additional class room work, and the graduate nurse could supply more skilled care.
At Iowa Methodist Hospital, Des Moines, the solution was to reduce the classes and to employ graduate alumnae by giving board and laundry in return for four hours nursing service daily, and room, board, and laundry for six hours service. The nurses thus employed retained their places on the registry and were free to accept private duty calls at any time (Bjornstad, 1952, p. 107).

The Division of Nursing Education's effort to influence the schools to admit only one class a year met with some measure of success. This fact was especially important since a decrease in the number of students seemed imperative owing to the great oversupply of graduate nurses, and consequent unemployment. The 1930 Census in the state of Iowa revealed that one in every 18 women gainfully employed in Iowa was a nurse (U.S. Dept. Commerce, Bureau of the Census, 1930, pp. 7-9).

According to the History of Broadlawns School of Nursing prepared and published by the school, (circa 1970) Broadlawns hospital helped the unemployed nurses. In 1933, a class of nineteen graduated from Broadlawns School of nursing; the majority of them stayed to work at the hospital for some time after graduation. They were employed at $50 per month plus maintenance (Note 1, p. 2).

The hospitals lacked information about how much it would cost to operate a hospital without a training school. Further, they did not know how many patients a graduate nurse could care for in one day. The studies reported in various publications usually were in relation to large city hospitals.
The 1930 Division of Nursing Education report, published in the

Twenty-fifth Biennial Report of the Iowa State Department of Health

(1933), reveals the following information:

Personal visits to fifteen hospitals operating without schools of nursing were made to gain first hand information concerning operating costs, with special reference to salaries of graduate nurses, organization, etc., and in an effort to secure a wider knowledge of the actual experience of hospitals maintaining complete staffs of graduate nurses.

The survey revealed:

The average [monthly] salary for graduate nurses on general floor duty; $90.00

The average number hours on day duty; 9

The average number hours on nights; 10

The average number patients cared for by one graduate nurse; 4 plus . . . (pp. 66-67).

In January, 1930, the Board of Nurse Examiners increased the daily patient average required of hospitals wishing to have accredited schools of nursing. The increase was from 20 to 25 patients. The increase in daily patient census was responsible for several hospitals making plans to discontinue their schools rather than maintain nonaccredited schools. Other hospitals undertook building projects to increase their bed capacity.

The change from student staff to graduate staff for care of patients caused some discontent among few groups of hospital managers. The Division of Nursing Education worked with the groups to help them recognize the rational for change.

The Minutes of the Division of Nursing Education, Board of Nursing, for November 1, 1930, reveals some of the content of a meeting of county hospital groups with the Division relative to the new standards of schools of nursing:
Miss Stoddard: ... We get apart in all of our discussion because you go back to the hospital and infer that the hospital cannot go on existing after the school ceases to exist, and of course, as I say we are looking at it from the viewpoint of the education of the nurse. If you would give it much thought, I am sure you would agree that our system of nursing education is wrong. We have grown into it. It was in the first place cheap labor, and the hospital started the school because of the cheap labor, and because we are trying to give our nurses better education, it isn't cheap labor, because we are giving those nurses something better in education. But when the community goes into a hospital and pays you whatever your rates may be, the man who pays the bill is the man who happens to be sick. He is paying for the education of the nurse. Surely no other profession is educated in that way (Board of Nursing. Minutes, November 1, 1930).

School Closings

A report of the education division was given at the 30th Annual Convention of the I.S.A.R.N. held October, 1933, in Sioux City. Maude E. Sutton reported as follows:

As you who read your Journals know, Iowa has established something of a record in the matter of discontinuing schools and in reduction in the number of students.

Before proceeding, I wish to speak briefly of the figures given out recently in publicity from the Grading Committee and copied quite generally over the state. The figures (and this the article failed to mention) were two or three years old. Iowa has continued to progress in these two or three years, so the figures as given are scarcely applicable today.

In order to refresh your memories, permit me to recall figures of a few years ago. When the Division of Nursing Education was established, there were fifty-four schools. During Miss Ankeny's tenure of office, a period of six months, two schools closed voluntarily when the first notice of an intended visit by the director was received; two more were closed because they failed after three months to arrange for necessary affiliation. During this period two new schools were accredited, both of which have since discontinued.

You probably all remember that from July 1, 1927 to January 1, 1928, there was no director in the Division.
On January 1, 1928, when the present director assumed her duties, there were 52 accredited schools. Of these, 11 were in hospitals of 35 to 50 beds, 19 in hospitals of 50 to 100 beds, 21 in hospitals of 100 to 300 beds, and one, the University School, is the only hospital with more than 300 beds.

Since January 1, 1928, nineteen schools have discontinued, three during the past year, making a total of twenty-three discontinued since the Division was established. This is slightly more than forty-one per cent of the original fifty-six.

Of the remaining thirty-three schools, nine, only, are in hospitals of less than 100 beds, and none are in hospitals of less than 50 beds.

Of the nine schools above mentioned, three are in hospitals of 50 to 75 beds, and six in hospitals of 75 and 100 beds.

Fifteen of the other schools are in hospitals of 100 to 150 beds, six in hospitals of 150 to 200 beds, two in hospitals of 200 to 300 beds, and one, the University, in a hospital of 700 beds.

Last year I gave you figures on student personnel gathered each year on November 1. Through the splendid cooperation of the superintendents of nurses, I have secured figures for November 1 this year, two weeks in advance of the actual date. These figures may be accepted as reasonably accurate, and if there is a discrepancy it will be because one cannot definitely anticipate whether or not preliminary students will leave during the coming two weeks. If any do leave, our record of decreases will be just that much better.

The decrease in student personnel for the year ending November 1, 1933, is 226, making a total decrease in three years of 738.

Perhaps you would like to have the figures again for the past six years for the sake of comparison:

<table>
<thead>
<tr>
<th>Date</th>
<th>1928</th>
<th>1929</th>
<th>1930</th>
<th>1931</th>
<th>1932</th>
<th>1933</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 1</td>
<td>2106</td>
<td>2260</td>
<td>2247</td>
<td>2059</td>
<td>1735</td>
<td>1509</td>
</tr>
</tbody>
</table>

I think Iowa may well be proud of these records. Hospital superintendents and superintendents of nurses, almost without exception, have cooperated in bringing about this splendid reduction in number of students.

While the number of applications on file for next week's examination is larger than usual there are legitimate reasons for it. The large classes admitted three years ago this fall are just completing their training . . . (I.S.A.R.N. Minutes, 1933, pp. 57-59).
The Division of Nursing Education maintained records on reasons students in training schools withdrew from the school. In 1930, the most frequent reason given for leaving school was the inability to grasp the work or unfitness for the work. The second most frequent reason for withdrawing from the school was not liking the work, followed by ill health and lastly marriage. In 1930, students who were married were not permitted to train as nurses (Twenty-fourth Biennial, 1930, 1931, p. 67).

In January, 1930, the entrance requirements with regard to minimum preliminary education of students were raised from two to four years of high school. The new requirement became effective for all applicants considered for Iowa schools of nursing after April 15, 1930. A result of requiring four years of high school was an increase in the age of the students.

The turnover rate of instructors and supervisors was a severe problem in Iowa. Reports of changes in nursing personnel were received monthly by the Division of Nursing Education from all accredited schools.

These reports emphasize the fact that changes in training school executive positions occurred far too frequently, one small hospital reported fifteen changes of supervisors in one year. Another reported as many as four changes in superintendents of nurses within one year (Twenty-fourth Biennial, 1930, 1931, pp. 66-67).

The August, 1933, issue of the American Journal of Nursing revealed the method by which the Iowa State Board of Nurse Examiners encouraged schools to close. Maude E. Sutton, Educational Director of the Iowa Board of Nurse Examiners reported that 40 percent of Iowa's 56 schools had been discontinued.
average number of patients recorded on annual reports each year shows a gradual drop in percent of bed occupancy.

**TABLE 4**

Percent of Bed Occupancy in 32 Hospitals

Now Maintaining Schools

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>90%</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>80%</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>70-80%</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>60-70%</td>
<td>6</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>50-60%</td>
<td>13</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>40-50%</td>
<td>9</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>30-40%</td>
<td>2</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>20-30%</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

(22nd Biennial, 1934, 1935, p. 207)

There were 37 approved schools of nursing in 1932. By 1934 this number decreased to 32 approved schools. The majority of the hospital schools are maintained by hospitals having 100 to 200 bed capacity. Only seven hospitals were less than 100 bed capacity.

The Division of Nursing Education reported that there was an increased employment of graduate nurses for general care of patients,
She urged state boards to move slowly, being careful not to arouse antagonism in this matter. Greatest success seems to come when one person can give most of her time to helping the superintendents to make the school board and medical staff "school conscious." The plan pursued in Iowa has been to study, by personal visit, the small hospitals operating with graduate nursing staff, finding out the daily average number of patients, staff, and salaries (including the nonprofessional staff), and on the basis of the findings to work out plans for the nursing in each individual hospital which is considering closing its school . . . (A.J.N., August, 1933, p. 811).

One of these hospitals might have been the John McDonald Hospital at Monticello, Iowa. The November 5, 1931, issue of the Monticello Express carried the following item:

The hospital now has an alumni of 34 nurses, with 4 more eligible as soon as they pass the state board requirements. Five nurses, who are the class of the training school, were graduated June 19th. Soon after that time the training school was changed to a staff of graduate nurses, with the exception of one student whose term expires in December on account of previous illness (p. 8).

Jessie Joyce, Superintendent, gave 1928 as the final disbanding date.

A report of another school closing was published in They Have Taken Root, a history of the Sisters of the 3rd Order of St. Francis of the Holy Family. The account concerns the Sacred Heart Hospital at LeMars which "conducted a fully accredited School of Nursing Education from 1923 to 1938. During this period, sixty-four nurses were graduated . . . [the school] closed because the Hospital, being small, could not offer sufficient clinical experience to meet the State requirements made a short time before" (Mousel, 1954, p. 289).

According to the Twenty-sixth Biennial Report of the State Department of Health, 1934, the Division of Nursing Education gathered and tabulated information on the approved schools of nursing. There was
an increase in the number of graduate nurses employed by the hospital. "This assures patients adequate care while students are in class or on hours off, and releases students for assignment where their experience will prove of distinct educational value." Most schools were admitting only one class a year and at the time of regular class admission. The Division recognized that hospital administrators were developing a "keener realization" that, if a school is maintained, "the hospital is responsible for providing adequate supervision and opportunity for experience as well as satisfactory theoretical instruction" (Twenty-sixth Biennial, 1934, 1935, pp. 224-225).

Conditions in Iowa Schools of Nursing

The Division of Nursing Education conducted a study of nursing programs on March 8, 1937. Questionnaires were sent to the 31 schools of nursing to be completed with information as of March 8, 1937. Thirty of the schools cooperated. The information was sought as a basis for discussion at a joint meeting of the Iowa Hospital Association and the Iowa League of Nursing Education on the topic "What are the existing conditions for a well rounded education in nursing schools in Iowa?"

In part, the survey revealed the following information:

1. There were 3,340 patients hospitalized in the 30 hospitals on March 8, 1937.
2. There were 1,477 nurses working that day.
3. The ratio of nurses to patients was 1:2.62.
4. Special duty nurses were working an 8 hour day in four cities. Six hospitals still used a 12 hour day for special duty nurses, and some nurses were still working a 20 hour day.
5. There were 28 of the 30 hospitals employing general staff nurses. The other two hospitals were depending entirely upon student help.
6. The employed nurses were earning per month:
   50.83 with full maintenance.
   56.80 with partial maintenance.
   94.00 with no maintenance.

7. Length of student weeks ranged as follows:
   1st year students  48-66.6 hours per week.
   2nd year students  48-67 hours per week.
   3rd year students  46-65 hours per week.

8. Several schools still required a 12 hour night duty period for students.

9. First year students were placed on night duty before the end of the second semester. The first year students were placed on night duty in pediatric and obstetrical wards (Board of Nursing. Minutes. 1937).

A report on what one school of nursing was doing to improve the curriculum is published in the February, 1938, issue of Modern Hospital.

Raymond P. Sloan wrote of St. Luke's Hospital in Davenport:

Two full-time instructors . . . are now employed. Science is taught by one while the other does the follow-up work in the hospital. This personal direction at the bedside, in the service room and at the chart desk, has done much to impress upon the minds of the students the lessons learned in the classroom.

Another step forward has been the extension of the course of study to include eighteen hours of English and ten hours of culture. These two subjects have added poise and self-confidence to the students and have had a noticeable effect on the nurses' notes and their bedside manner. This year, too, the students are given three hours off duty in addition to their classwork, and there are no night classes except those devoted to English literature and culture, which are in reality extra-curricular activities.

The health of the students is carefully guarded. Regular physical examinations are given including chest x-rays wherever indicated and each new student receives a thorough check-up by the hospital doctor in addition to the examination by her home physician before entering the training school (Sloan, 1938, pp. 44-48).

Legislative Activity

During the Biennium (1935-1936) the Legislature amended four practice acts; Denistry, Optometry, Nursing and Embalming, and completely revised the Osteopathic Practice Act. The dental act was amended to
prohibit all forms of advertisement other than the use of the ordinary professional card. The Osteopathic Act was entirely repealed and a new law enacted in its stead. The new act broadened the authority and scope of practice for osteopaths. The Nurse Practice Act was so amended that for a while there was confusion in the Iowa State Department of Health as to where the nursing division belonged (Twenty-seventh Biennial Report, 1936, 1937, pp. 238-239).

The Nurse Practice Act, as amended, needed clarification from the Attorney General. The problem was whether this division would remain with the Iowa State Department of Health or be operated as a separate division. The Attorney General held, in a written opinion, that it was the intention of the Legislature that the amendments to the Nurse Practice Act separate the division of nursing entirely from the State Department of Health (Twenty-seventh Biennial Report, 1936, 1937, p. 240).

The 46th General Assembly had enacted a bill, effective April 21, 1935, which stated that the State Department of Health was no longer required to furnish to the nursing division personnel, supplies, or services necessary for the functioning of the nursing division. Under the bill it was contemplated that the Nurses' fund would be adequate to pay all of the expenses incurred by the division. Except for the duty of receiving and filing occasional reports from the secretary of the Board of Nurse Examiners, and certifying lists of applicants who passed the examination given by the board, the bill transferred to the Board of Nurse Examiners "the duties heretofore held and discharged by the State Department of Health" (Twenty-seventh Biennial Report, 1936, 1937, p. 240).
By 1935, the Iowa State Association of Registered Nurses had two nurses acting as lobbyists at the State House and was receiving information concerning nurse practice acts of other states from the American Nurses' Association Headquarters. The Iowa nurses were aware of the weakness of the bill which kept them tied to the State Department of Health and to the disadvantage of having all of the funds not needed to administer the department returned to the state treasury. According to a letter written by Helen Needles, Chairman, Legislative Committee of the I.S.A.R.N., to Ella Best, Acting Director, Headquarters American Nurses' Association, and dated February 11, 1935:

... We have known for the last fifteen years that some legislative action was necessary if we were ever going to be able to accomplish anything through our Board of Nurse Examiners.

To date, only about a third of the monies paid by the nurses of the state in examination, reciprocity, and renewal fees have been used for the administration of our Act. The rest of the money has gone in to the state treasury, and as administered, has amounted to a special tax on the nurses of the state. As you will note in our bills, we are asking that this money go into a special fund to be used to administer the Act and promote a nursing education program (Note 5, February 11, 1935).

**Iowa in World War II**

Just eight years after it seemed there were far too many nurses, the 1940 preparedness program disclosed the need for training many more nurses. For most Iowa Schools of Nursing, more classroom space and more nurses' residence were imperative. This was true especially if the nursing school planned on the implementation of the Nurses' Cadet Corps.

The Lanham Act, providing funds for the acquisition and equipment of public works and made necessary by the defense program, could be used to help
the hospitals. Means (1951) stated "Funds from the Lanham Act provided for enlargement of Westlawn [training school complex] including improved facilities for teaching purposes" (p. 6).

Bjornstad (1952) stated that Iowa Methodist Hospital, Des Moines utilized federal funds and a private financial campaign to enlarge and improve facilities for the training school (pp. 124-125). In addition, "in 1945 the hospital was awarded $67,000 to instruct nurses in the Nurse Cadet Corps. Under the Bolton Bill . . . students pledged themselves for essential service for the duration of the war and six months afterwards" (p. 125).

According to Bjornstad (1952), just prior to Pearl Harbor in November, 1941, "seventy graduate nurses were employed for general floor duty. A year later there were only forty-seven. By 1943, there were only twenty-seven graduate nurses, although there were 136 students, to care for 15 percent more patients than were cared for before World War II (p.126).

The shortage of nurses was especially felt in the hospitals for the insane. The 23rd Biennial Report to the Board of Control of State Institutions ending June 30, 1942, (1942), stated, "On account of ward relief we scarcely feel we can continue our nurses training course from which we had 10 graduates in 1942" (p. 90). By the end of the next biennial period the report stated "there are no registered nurses working at the hospital" (Twenty-fourth Biennial Report, 1944, 1944, p. 86).

The war years were difficult in Iowa hospitals because of the shortage of nurses, doctors, and nonprofessional help. The Bolton Act served as a boost in helping the schools of nursing improve quarters for
nurses. In addition, the monies provided improved teaching facilities and equipment. Probably most important, the war effort demonstrated that nurses could be prepared in less than three calendar years.

Implications of the Times on Nursing

The years of 1930-1945 were important years for nursing. During this period, nurses became aware that they were a potent social power. Nursing became recognized as something far more comprehensive than taking care of the sick. An equal emphasis was being placed on the prevention of illness.

While realizing their importance, nurses became critical of themselves. It was not enough to have established high aim and standards. The time to enforce them was overdue.

Surveys made during this period pointed to the fact that the nursing profession was aware it needed change. On one hand there was increased demand for quality nursing care and higher standards of education; on the other hand, the increased cost of hospitalization was criticized. One handicap in carrying out improvements in nursing education was the lack of trained personnel. Baccalaureate level programs were designed to increase teaching capabilities of graduates. Clinical expertise was not emphasized.

Even prior to the outbreak of World War II a militaristic image of the nurse was evolving within the hospitals. Military discipline pervaded the environment. Nurses were expected to obey immediately and without question.

The military influence extended even to the uniform worn by the
nurse. Stripes were added to the nurse's cap to reflect status. A probationer had no cap but was awarded a cap after successful completion of this period. The "capping" ceremony was a signal of achievement. After a successful first year, many students were allowed to wear a cap with one stripe, the third year students added a second stripe. In some hospitals, uniform inspection was a daily activity.

The military influence was also apparent in the terms used by the nurses. While other professionals had their services "requisitioned," student and graduate nurses "obeyed orders." The physician did not have "requests for care;" he delivered "doctor's orders." Student nurses were disciplined by losing "late leaves" and being curfewed.

The war effort showed the impact of organized recruitment on nursing schools, and the favorable effects of federal monies to improve nursing education. World War II stimulated the upward mobility of women. For the first time, top military ranks were achieved by at least a few women in the armed services.

From Depression to World War II: A Summary

How did economic factors influence the development of professional nursing education? The Great Depression had more than economic effects on nursing. The depression had long lasting effects on the image of nursing as well.

The Great Depression served to reinforce the poor self image of nurses. Graduate nurses were unable to secure employment in private homes. Graduate nurses were not employed in hospitals. The widely
held belief was that student nurses provided "better" care to the hospital patient. Therefore, hospitals continued to use student nurses to provide the majority of nursing care. Graduate nurses were forced to work for room and board, if they were lucky enough to find a hospital willing to allow such concessions.

The perspective of the hospital was task oriented. The task orientation reflected "things" to be accomplished to ensure the smooth functioning of the hospital. Task orientation also reflected the cost analysis of the tasks to be accomplished. Quantity of service, not quality, was rewarded.

Because most nurses can complete a given set of tasks more or less adequately regardless of educational preparation, there was little interest in exploring the potential role of the nurse. It did not matter to the employer whether the nurse was a student or a graduate.

The attitude of the patient was closely related to that of the hospital. The patient required that the necessary tasks be completed adequately at the minimum cost. In addition, the patient looked for comfort, compassion, and someone with whom he could communicate. While these activities reflect the nursing profession's emphasis on maintenance of homeostasis, nuturance, and comprehensive or holistic care, the patient and his family generally associate these activities with "mothering." These activities were and still are often considered to be instinctive traits of females. The activities are rarely recognized as being based on an in-depth scientific education. Many patients identify quality of care as a result of simple caring. They do not
identify quality of care as a process stemming from a sophisticated educational program. As long as the nurse filled the identified needs of the patient, the patient was not concerned about the nature of the nurses educational status. Nurses not giving quality care were simply identified as "not caring enough."

The lack of self-esteem of the graduate nurses has had some long lasting, self-defeating ramifications. Job insecurity caused anxieties that were reflected in a surge to maintain the status quo as far as new or different educational preparation was concerned. Security was found for the profession in the continuation of hospital schools of nursing. Nurses were content to accept any financial compensation offered. By functioning in this manner, the profession has perpetuated the concept of second-class citizenship and encouraged the continuance of the inequities in education, employment, and compensation. This professional disunity is reflected today in the profession's inability to help the patient and other health professionals better understand the educational framework and the potential role of the nurse in the health care delivery system.

During the depression the American Nurses' Association launched a campaign to promote the hiring of graduate nurses in hospitals. The campaign met with considerable resistance. The resistance came from hospital administrators and from the nurses themselves.

The economy of being able to hire graduate nurses at less cost than operating a school of nursing was the reason for the closing of many schools of nursing. There was no consideration of the dangers
inherent in forms of education that meet only the service needs of hospitals as defined by the management of the hospitals. This narrow focus does not meet the needs of the larger community or the nation as a whole.

What has been the influence of medical domination on the health care field? Nursing is health care. Nurses wanted to be instrumental in helping people care for themselves. The nurses wanted to place an emphasis on health care and prevention of disease. The hospital insurance plans initiated during this period of time did not provide rewards for health. The insurance plans paid only for illness. Clearly, the emphasis of the national policies were placed in favor the physician whose reward was in sickness, not in health.

The public health movement of 1935 provided an opportunity for nurses to teach people about caring for themselves. However, even today, the public funding is greater for caring for those who are ill rather than assisting those who are well to stay well.

Both religious and military forces have supported the image of the nurse as subordinate. The era now being considered emphasises the military influences. Even prior to the United States involvement in W.W. II, the military influence was predominant in the hospital. The subordinate-superordinate line organization prevents creative decision making. Within this framework there are no rewards for innovative approaches to nursing care. The bureaucratic hierarchy of the health care system has also served to deter colleague interactions between nurses practicing in different areas. There is little to no consultation
among nurses. The military influence serves the purpose of having raw recruits respond to orders immediately and without question. The military influence does nothing to improve the professionalism of nursing.

Has the Woman's Movement had an impact on the development of professional nursing education? While nurses brought honor to the profession during the war, the glory was short lived. Once the war was over, the nurses were expected to return to their former role. Nurses were women and, as good wives and mothers, were expected to be self-sacrificing for the dependent, weak, and ill. Nursing, as a profession, provided few career incentives. Many nurses left the profession for more stimulating careers.

Members of the National League of Nursing Education recognized that they were not going to secure support from medical or hospital groups to determine accrediting standards. Therefore, they established the League's own accrediting committee to evaluate and determine the standards that should be maintained in programs of recognized caliber. This event was significant in that it was the first time in the history of nursing that the nurses decided to make their own policies and control their own standards in schools of nursing. They decided they did not need the support of other groups to make this step.

The result was opposition from the members of the American Hospital Association. However, the League stood firm and refused to grant the Hospital Association official representation on their accrediting committee. A temporary accrediting program was begun by the League.
The result was improvement in hospital schools of nursing. It had taken nurses one half a century to take a positive step toward the control of their own profession.
Chapter Six: Postwar to a New Age, 1945–the Late 1960s

This chapter discusses the major conflicts in nursing and nursing education for the period between 1945 and the late 1960s. These conflicts are discussed in relation to the research questions.

The nursing shortage is discussed in light of the economic factors influencing nursing. Because nurses could earn no more than $.30 to $.75 an hour for an evenings work, were not allowed a rest period, or paid overtime, it should not be surprising that many nurses decided not to work.

The many needed changes in nursing education were highlighted by the Brown (1948) report. The changes especially challenged the medical domination of nursing education. The general thrust was for higher education for nurses, a thrust which was usually opposed by physicians.

Federal monies became available for nursing education. The effects of federal funding were usually far reaching and interrelated. The federal funding was especially significant for the collegiate education programs for nurses. Certainly not all of the activities and types of curricula initiated by schools of nursing receiving federal money were the school's top priority. In order to receive some of the monies it was necessary for the schools to comply with certain requirements. Increasing enrollment was one requirement for receiving federal money. Other requirements were special projects that often directed attention of the school toward activities that might not otherwise have received the attention of the faculty.

The health care crisis is discussed in relation to the medical
domination of the health care system. Most attempts to resolve the health care crisis have been aimed at extending the work of the physician. The nurse practitioner/physician extender movement has introduced considerable confusion into the efforts of nurses to evolve valid, substantive higher education for nurses. The thrust is toward having the nurse take over some assigned medical tasks. The nurse then frees the physician's time and facilitates the practice of medicine. There is no mention made of freeing nurse time and facilitating the practice of nursing. There should be serious concern over the national emphasis on medicine and physicians at the cost of the depletion of nurses and nursing.

Postwar Iowa and the Iowa survey are discussed to demonstrate the relationship of Iowa to the national scene. The diploma schools in Iowa were seeking National League of Nursing accreditation and the course of study was being revised to include psychiatric experiences.

A short history of the collegiate nursing programs in Iowa is reviewed to demonstrate the different stages of development of these programs. Iowa collegiate programs faced problems similar to those of colleges and universities throughout the nation. The programs existed as hospital schools of nursing and a program of liberal arts. There was no upper division nursing requirement until very late in the 1960s.

Students nurses, for the most part, were treated as if they existed a notch below women. Student nurses were subjected to an attitudinal structure that placed physicians first, head nurses or supervisors second. The results were nurses who understood the subordinate role.
The influence of the professional organization is reflected as a political force and should not be minimized. The continued efforts of the organization have been largely responsible for federal funding of nursing education.

This chapter reviewed the major trends affecting health care to demonstrate the progress in nursing education caused by the passage of time.

During this period of time, the Practical Nursing Programs and the Associate Degree Nursing Programs came into existence. The development of these programs is not discussed in full in this study. Additional information concerning the development of these programs in Iowa is contained in *A Study of the Development of Vocational and Associate Degree Nursing Programs in Iowa from 1920-1978* by Donna Story (Story, Note 5).

**Nursing Shortage**

The end of World War II did not bring an end to the demand for nurses. Military nurses were not returning to civilian hospitals. Marriage, the opportunity for advanced education under the GI Bill, better pay in non-hospital jobs, and greater autonomy in nursing practice kept nurses from returning to hospital nursing.

In 1946, a national salary survey found that the average starting salary for a staff nurse was $35.75 per week. The average work week was 48 hours, yielding an hourly pay rate of 74 cents per hour. In contrast, typists were averaging 97 cents per hour, bookkeepers $1.11, and seam-
stresses $1.33 (Whitman & Inglls, 1947). Each nurse had to bargain independently for her wages. The March, 1944a, issue of Modern Hospital states, "When the nurses come to the hospital organizations with a request to open joint negotiations for the adoption of a uniform salary schedule, it is easy for the hospital association or council to reply that it is not empowered by its member institutions to act as their bargaining agent" (p. 47). Further, when it came to overtime pay, care of the sick was not seen as a continuum but as a series of tasks.

The December, 1944b, issue of Modern Hospital discusses the role of the "professional" nurse in relation to overtime pay:

If . . . a situation arises in which a nurse cannot finish her regular assignment on time, as a professional woman she should be willing to give a little overtime service (p. 39).

The registered nurse had achieved a status of "professional" in the nomenclature but often was not treated accordingly by physicians, administrators, or the public. Few nurses thought of hospital nursing in terms of a professional career. A 1946 survey of nurses reported that one of five hospital nurses was critical of her job as a whole. Comments about the work were typical of those cited as follows:

You work like a demon, wondering why you couldn't be an octopus and a centipede at the same time. You stay on duty until everything is completed, and if you punch the clock an hour or more late, it apparently is your own fault for not being able to plan your work better. Our time clock seemed to be installed as a means of checking on the time we reported for duty, but the payroll department blindfolded their eyes and their conscience to any overtime. People expect nurses to be more or less like a high-class servant, instead of giving them the status of an actual professional (U.S. Department of Labor, Economic Status of RNs 1946-47, 1948, pp. 42-43).
The shortage of nurses persisted into the late 1940s. Students were not entering schools of nursing. Schools did not have the Cadet program to offer students, and the type of schooling offered nurses was once again held up for public criticism. An article in the June, 1949, Woman's Home Companion, titled "Student Nurse - Could You Take It?" was critical of nursing education practices (Woodbury, 1949, p. 36). The article caused a flurry of counter articles in Hospital Management denouncing the charges of poor food and harsh discipline. One administrator felt that "as far as the majority of schools go, I would believe a lack of discipline would be the more proper charge" ("What's All This," 1949, p. 31).

Coupled with defense of the nursing education programs as they were was the charge that nurses were legislating and educating themselves out of jobs. This charge by Dr. Frank Lahey, former president of the American Medical Association, was countered by nurses such as Eunice D. Johnson, Director of the Nursing School of Saint Luke's Hospital, New Bedford, Massachusetts, who maintained that "you can never over educate a nurse" (Brent, 1949, p. 68).

Edith W. Bailey, Administrator of Canonsburg General Hospital Canonsburg, Pennsylvania, demonstrated the gap between administrative expectations and nursing goals when she commented:

The nurses attending universities and colleges insist only on supervising - no physical work . . . Not everyone is fitted for supervising - and strangely enough, a sick person doesn't give a hang whether his nurse possesses a B.A. or B.S. The root of the question is "Can she make him comfortable?" (Brent, 1949, p. 69).
Another similar comment came from A. M. Frank, M.D., chairman of the staff at Lutheran Hospital, St. Louis, Missouri. He predicted that the practical nurses would be in greater demand than those with college educations and said,

one definitely does not need a Ph.D. degree to carry a bedpan. The patients are only interested in whether it is hot or cold. Student nurses are spending too much time in the lecture halls and too little time on the floor so that we are getting too many desk models and insufficient floor models (Brent, 1949, p. 70).

Thirty-three years later feminist Angela Barron McBride addressed the constant reference to bedpans in an article in the May, 1976, American Journal of Nursing. McBride said:

Characterizing nursing that way reduces all those in the profession to the lowest common denominator: bedpans . . . . The underlying message, of course, is that nursing must be shit work, and anyone in it must be a trifle tainted (p. 757).

One solution to the shortage of nurses was to train nurses' aides and practical or vocational nurses to work in the hospitals. There was a widespread introduction of this type of hospital worker.

The first school for practical nurses had been organized in 1897. By 1930 only 11 more schools had been established. Between 1930 and 1947, an additional 25 schools were opened. Between 1948 and 1954, an additional 260 more schools opened. Federal vocational education monies supported the training of practical nurses. Without any professional association to police the programs, some schools resembled exploitative trade schools (Kalisch & Kalisch, 1978, pp. 503-506).
Needed Changes in Nursing Education

World War II, as all wars before it, brought a focus on nursing practice and education. The focus resulted in a demand for innovation in both practice and education. The postwar era also encouraged the general education movement in all phases of higher education. Voices in reaction against over-specialization were getting louder. The plea for a more prominent role for general education in nursing came from outside the profession. Eldon L. Johnson (1947), Dean of the Liberal Arts College of the University of Oregon, stated:

> We have enough ways of seeing man as this, that or the other interest. We have precious few ways of seeing him as a composite that transcends all these specialties. We take elaborate pains to train him or her as a doctor, lawyer, nurse . . . but we give less attention to training him as a man and as a unit of society . . . .

> If I seem to burden you with emphasis on humanism, or the whole man . . . I do so because that is the core of general education (pp. 348-49).

Three years later, Earl S. Johnson (1950), a social scientist, addressing the nursing profession, stated:

> We have already too many uneducated specialists, however paradoxical that may sound . . . . I speak of the nurse's need for a truly liberal education which will liberate her from knowing only nursing . . . . I want the nurse to be the best kind of human and humane being the liberal arts can create. Each will, by that logic, be a better specialist because each will know better the relation of his specialty to the rest of life (p. 73).

The need of being liberated from knowing only nursing was experienced by a researcher who, after completing a three-year hospital diploma program, was afraid to greet people. The fear was based on the fact that for three years she had not greeted people without inquiring about their bowel function.
A thoughtful statement made by a nursing group about the aim of general education was contained in a report of the Committee on Educational Problems in War Time of the National League of Nursing Education. The committee recognized that the nurse must have "sufficient general education to understand the world in which she lives and practices" and that preparing for living as well as for earning a living must be a part of her education (National League of Nursing Education, Committee on Educational Problems in War Time, 1945, p. 21).

For the most part, nursing educators advocated general education—not for its non-specialized aspects but for its value as a base on which to build the professional curricula.

In 1948, Esther Lucille Brown published a report entitled "Nursing for the Future." Among other items, the report pointed to the education provided for nurses. Brown (1948) stated "by no stretch of the imagination can the education provided in the vast majority of some 1250 schools be conceived of as professional education" (p. 46). Brown (1948) recommended that nursing make its own examination of every school. She encouraged lists of accredited schools to be published and distributed, with an explanation that schools not listed had failed to meet minimum requirements for accreditation. Brown urged public support for accredited schools and public disapproval of schools not meeting minimum criteria (pp. 132-170).

The publication of this study for the National Nursing Council gave nursing education the first significant impetus to the strengthening of the general education components in the postwar period. The report, directed by Brown, emphasized the essentiality of collegiate preparation
for the professional nursing practice. Further, the Brown (1948) Report proposed that such preparation be offered in an interrelated unit of professional and academic work (pp. 138-142).

There was considerable opposition to the Brown report, much of it coming from physicians and hospital administrators. Graham Davis, then president of the American Hospital Association, told the 1948 convention of the American Medical Association that Dr. Esther Lucille Brown's report ignored the facts of life. Davis (1948) was especially critical of Brown's characterization of many small hospital schools of nursing as "socially undesirable." He defended these small schools and pointed to the manner in which they had made hospitals able to deliver nursing service throughout the war and postwar shortages (p. 138).

In spite of the opposition, the nursing organizations began to establish their goal of accreditation. West and Hawkins (1950) state that although school participation was voluntary, 96 percent of the schools participated in the survey conducted by the National Committee for the Improvement of Nursing Services.

The results of the study were published in 1950 in a report called "Nursing Schools at the Mid-century." Statistical procedures were utilized to analyze information submitted on the questionnaires. Each school was evaluated in terms of a 100 point scale. The weight given to each criteria was as follows:
Administrative policies 3
Financial organization 3
Faculty 22
Curriculum 16
Clinical field 22
Library 6
Student selection and provisions for student welfare 13
Student performance on state board examination 15
(West & Hawkins, 1950, p. 56).

Not all nursing educators were pleased with the classification project or the general thrust toward nursing in higher education. The National Organization of Hospital Schools of Nursing was formed for the purpose of assisting hospital schools of nursing maintain their status ("New Group," 1950, p. 128).

The State Board Test Pool had been initiated in 1944. At first only six states had agreed to use the examination; however, the advantage of a national test soon became apparent to the licensing authorities in other states. The test pool broadened each school's concept of its goals and pointed toward a standard minimum level of performance acceptable for licensure ("State Board Test," 1952, pp. 613-615).

In the early 1950s, many nurses did not receive psychiatric training in their course of study. Mental health hospitals were generally large custodial care centers; there was little psychiatric treatment. The emergence of psychiatry was one of the major scientific developments of the twentieth century. Karl Menninger (1945) defined mental health at mid-century as "the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness" (pp. 43-45). The emergence of psychiatry required curriculum changes in schools of nursing.
Olga Weiss (1947) described the psychiatric nurse's role:

She must learn to respect her patients as fellow human beings. The person who develops a wholesome respect for other persons as individuals with the same rights and privileges as himself has taken great strides toward reaching understanding.

This is perhaps the most difficult lesson for the nurse to learn, as it means giving up some of the "privileges" of being a nurse, an authoritative creature in a white uniform whose word is law. Because nurses are trained so rigidly, they tend to become rigid, and it is not easy for them to give up some of the percepts learned so painfully. It is difficult to substitute skillful conversation for manual dexterity; the former actually demands more of the nurse. The psychiatric nurse must learn to give much of herself to the patient: her time, patience, and understanding. By understanding we do not mean the useless, sweet, blanket understanding of the willing, but untrained volunteer who pats the head of the schizophrenic and speaks condescendingly to him. The nurse working with such patients must have a true scientific knowledge of the illness and its symptoms and must recognize that these people, no matter how withdrawn they seem, are acutely aware of what goes on around them and that condescension is as infuriating to them as to any well person (pp. 174-176).

Progressive educators of the era pointed to the fact that a psychiatric nurse should have all the education and ability of a general hospital nurse plus additional experience in the psychological aspects of mental illness. The applicability of psychiatric nursing content to all aspects of nursing practice was not yet generally accepted.

Until the outbreak of the Korean War on June 25, 1950, married women generally were not accepted as students by most schools of nursing due to the conflict between living in the nursing home and maintaining an outside home. The Korean war caused many hospital administrators to rethink the problem of married nursing students. Some schools wisely asked that permission be obtained by the student to stay in the school of nursing after marriage, rather than permission to marry.
Another significant cause for change in the nursing education practices of the nation was the National League for Nursing's accreditation program. The program was improving nursing education standards.

The temporary accreditation program, in effect from 1952 to 1957, was provided in an effort to help the less than adequate schools find ways of improving themselves. The improvements in the schools were evidenced by increased numbers of full-time faculty members per school who were also better qualified for their positions than were the faculty of 1949.

Under the temporary accreditation program, many special meetings were held. The purpose of these meetings were:

To learn more about the needs and problems of nursing schools throughout the country so that the professional nursing organizations could take steps to provide assistance in improving education programs.

To assist nursing schools in interpreting information presented on the school profiles as well as other information sent to them following the meetings of the board of review.

To discuss the criteria which were used by boards of review in evaluating programs for temporary accreditation.

To discuss other criteria which probably should be used in evaluating nursing school programs.

To discuss steps which individual schools could take to improve their own programs.

To discuss measures which could be taken to help schools offering programs not approved for temporary accreditation.

To discuss whether a consultant service should be set up by the National League for Nursing through which schools of nursing could obtain individual assistance (N.L.N. Report on Program, Part I, 1952, p. 3).

When the temporary accreditation program ended in 1957, there was an increase by 72.4 percent of the number of fully accredited schools of nursing. (N.L.N. Report on Hospital Schools, 1959, p. 5).
Some problems remained unsolved. The National League for Nursing report noted that there was a need for the redefinition of clinical learning experiences. This was the area least influenced by school improvement. Further, the area of financing education was without progress. The report stated "in most schools of nursing . . . the curriculum is developed as an income producing as well as a 'learning producing' operation" (N.L.N., 1959, p. 30).

Bridgman (1953) explained the confusion concerning the financing of nursing education in the fact that the costs have been concealed in the mixed purposes of hospital schools. Bridgman stated:

The relative proportion of education and of mere expenditure of time and labor has been obscured for the student because her service, no matter how extended beyond the learning stage, is considered practice. The ironical fact is that, since the length of the program is three years, regardless of the amount of teaching and content, the less a student's time is used for her education, the more she pays in service (p. 90).

Federal Monies for Nursing Education

The first federal aid to nurses was effected with the Health Amendments Act of 1956. Title II of the Act authorized funds for financial aid to registered nurses for full time study to prepare for administration, supervision, and teaching in all fields of nursing. The funds were limited to expenditures for tuition, fees, stipends, and some allowances. The funds were given to the institutions for distribution to students. In 1960, part-time students were included for short term programs. From 1957 to 1964, the appropriations grew from $2 million to $7.3 million (Progress Report on Nurse Training, 1970).
The Nurse Training Act of 1964 was a much larger program of federal aid for professional nursing education. The bill provided for nursing school construction grants as well as for student loans and scholarships. Special assistant to the HEW Secretary, Boisfeuillent Jones, called the bill "the logical next step in strengthening and coordinating existing programs aiding nurse education with a major new nationwide effort to alleviate critical shortages of nurses required for health care of all citizens" (U.S. Congress, 1964, p. 27).

The American Nurses' Association gave supportive testimony at the House hearings for the bill. The nurses organization emphasized aid for collegiate schools of nursing. During the floor debate over the bill, Kenneth A. Roberts of Alabama, a sponsor of the bill and its floor manager in the House, reported on the proposed $41 million formula grants to diploma schools of nursing to help meet educational costs. He explained the provision by stating there had been concern over "the trend that has been developing in recent years, under which the number of diploma schools of nursing has declined from 1,134 in 1949 to 875". Roberts stated that "a number of these 875 schools face the very real possibility of having to close their doors because they are unable to meet the additional costs to them for training nurses [and] these schools run a continuing deficit, which of course, is borne by increased costs to patients in hospitals" (U.S. Congress, 1964, p. 3).

The Nurse Training Act of 1964 was approved by the Senate with a few technical changes and an amendment that incorporated recommendations made by the American Hospital Association. The latter amendment added
diploma schools of nursing to the five-year, $17 million program for special project grants to aid schools in meeting the cost of improved or expanded nursing education. The House-passed version of the bill had limited the special project grants to public and nonprofit private collegiate and associate degree nursing schools.

When signed by the President, the five-year legislation authorized $283 million for five programs and an additional $4.6 million for administration of the programs. Building of nursing education facilities, including new, renovated, or replacement buildings, was limited to $90 million. Of this amount, $55 million was for the diploma and junior college programs and $35 million was for collegiate programs. Another $17 million was provided for "teaching improvement grants" or special projects, available for use by all programs (U.S. Congress, 1964 , pp. 1-24).

On August 1, 1968, the Nurse Training Act of 1964 was extended through fiscal years 1970 and 1971 with authorized appropriations totaling $250 million. The Act extended the program of federal aid for schools of nursing construction grants, and special project grants, as well as the student assistant programs of loans, scholarships, and traineeships (U.S. Congress, 1968, pp. 41-43).

**Collegiate Education Needed**

According to 1954 estimates reported in Kalisch and Kalisch (1978), "about 20 percent of the positions held by registered nurses entailed responsibilities that could be best fulfilled by persons who were prepared in master's degree programs; for another 30 percent of these
positions preparation at the baccalaureate level would be adequate" (pp. 590-591). However, at the time the number of nurses holding master's degrees was estimated to be only one percent. Only 7.2 percent of all nurses held baccalaureate degrees - not all of which had been conferred in the field of nursing (p. 591).

The year 1952 marks the birth of Associate Degree Nursing Programs in the United States. Ninety percent of the nation's nursing schools were owned and operated by hospitals, therefore were outside the general system of education. The Associate Degree Nursing Education Programs were to be two years in length and terminal. Located in Vocational-Technical schools and junior colleges, the students represented state and federal reimbursement numbers for the schools. "Open door" admission policies were encouraged and the vocational education philosophy of "no one fails; given enough time all can be successful" prevailed.

According to Bridgman (1953), one obstacle to the growth of baccalaureate nursing education programs could be the character of many of the programs. In many instances the program was nothing more than a standard diploma program that was offered in a collegiate setting with a few science and general education courses added to the curriculum. Many programs were affiliation type. The student completed two years of general studies, then enrolled in a regular diploma program. The difference between baccalaureate preparation and diploma preparation was not recognized by the employer or the graduates. The main difference noted by prospective students in such programs was probably financial.

In 1957 the National League for Nursing published *Nurses for a Growing Nation*, which projected nursing personnel and education needs to
1970. The publication pointed to the need for increasing the number of baccalaureate degree graduates. The report estimated that one-third of all nursing graduates should be from baccalaureate programs to meet the need for teachers of nursing, administrators, supervisors, and clinical specialists (Nursing for a Growing Nation, 1957).

In 1962 the number of nursing students graduating from baccalaureate programs in nursing accounted for 14 percent of nursing's basic students (American Nurses' Association: Some Facts about Nursing, 1962-63, 1964). During the six-year period from 1956-62, the number of baccalaureate nursing programs increased from 161 to 178. The average enrollment in these programs increased from 116 to 132 (ANA, Some Facts about Nursing, 1956-62, 1963).

Margaret Bridgman (1953) outlined some of the responsibilities to be undertaken by any college or university that would offer a program in nursing education:

Recognition of nursing as a subject comparable to others that are established as college majors and realization that it must be developed in the same way to justify a degree and give students the benefits they have a right to expect from college education for their chosen profession.

Recognition of the need to produce graduates really competent for the functions for which college-educated nurses are so urgently needed.

Establishment of an educational unit in nursing in the institution on a completely equal basis with other units of the institution, with a faculty adequate in number and well qualified in the various special types of nursing to teach all the courses in nursing, including faculty-guided clinical practice. A minimum number of faculty members is six, with specialists, respectively, in medical, surgical, obstetric, pediatric, psychiatric, and public health nursing. Provision for the necessary facilities for education: classrooms, faculty offices, and library.
Provision of housing and all other student personnel services required for college students.
Provision of available and accessible hospital and other agency facilities for the practice of nursing, since it is here that faculty help students to develop professional skills and to use pertinent knowledge from all preceding academic and professional sources (pp. 185-197).

The Bridgman (1953) study revealed that following the Brown Report there was a decided trend toward integrated and shortened programs. Even though collegiate programs of diverse length, organization, and credit requirements still characterized nursing education, the trend was in the direction of a four academic year integrated program. The conversions were made in many colleges by gradual reductions in length of the program over an extended period of time.

Bridgman (1953) discusses the curriculum revision as follows:

Since, in most curricula, the general education portion was already two academic years in length, to achieve balance it would seem that the professional portions were most in need of reorganization. An examination of the changes that were actually made reveals quite a different picture.

To be sure, shortening and reorganization of the professional portion of programs did occur. Unfortunately the shortening process also infiltrated the general education portion of the programs in insidious ways. First electives . . . began to disappear . . . Second, general courses in sciences were replaced by specialized science courses, that is, sciences courses taught by and/or for nurses, either in separate groups or with other allied professional groups. The five year programs traditionally required general science courses as prerequisites to admission to the professional phase . . .

Third, courses which were formerly part of the professional curriculum, such as nutrition and diet therapy, became classified as general education,

Fourth, newly organized courses with quasi-professional purposes, such as courses in child growth and development and social case work, were increasingly classified as general education courses.
Fifth, the range or courses offered in the liberal arts narrowed, frequently being limited to those courses which provided the scientific background upon which to build the professional curricula . . . (pp. 205-206).

Democrat John Fitzgerald Kennedy was elected President of the United States in 1960. He brought to the presidency the vigor of youth, and to the country a hope for equality among people and an inspiration to work for the good of the country. Hofstader, Miller, and Aaron (1964) described Kennedy's election as a victory for Northern cities, big government, religious and racial minorities, and the spirit of internationalism (p. 380).

Kennedy's brief administration did not meet all of its expectations; however, steps were taken to seek solutions for the health care delivery problems facing the nation. Kennedy acknowledged the acute shortage of nurses in his message to Congress on February 27, 1962:

. . . Modern health care is extremely complex. It demands the services of a skilled and diversified team of specialists and technical personnel. But there are shortages in almost every category—and the shortages are particularly severe in nursing. Last year [1961] I authorized the Surgeon General of the Public Health Service to set up a consultative group on nursing, and a comprehensive study of this field is well underway. I expect to receive their report in the near future (ANA, Legislation News, 1962, p. 1).

In 1961, the Surgeon General of the United States Public Health Service appointed a special Consultative Group on Nursing to advise him on nursing needs and to identify the appropriate role of the federal government in assuring adequate nursing services for the country. The report of this group, Toward Quality in Nursing (1963) stated the crux of the nursing problem:
Today nursing education is at a crossroad. We need a careful examination of the existing types of nursing education programs, to determine how they can be merged into a pattern that will adequately prepare the nurse to render better patient care and allow her to advance professionally in an orderly manner... pending the outcomes of such an orderly study, we need immediate action to expand and improve nursing service within the evolving framework of education and patient care (U.S. Public Health, 1963, pp. xiii-xiv).

The first Position Paper on Education for Nursing, prepared by the American Nurses' Association Committee on Education and adopted by the ANA Board of Directors in September, 1965, marked the beginning of what would become a long and sometimes bitter controversy among nurses. The statement pointed to the need for improved nursing practice and stated:

The education for all of those who are licensed to practice nursing should take place in institutions of higher education; minimum preparation for beginning professional nursing practice should be a baccalaureate degree; minimum preparation for beginning technical nursing practice should be an associate degree in nursing; education for assistance in the health service occupations should be short, intensive preservice programs in vocational education rather than on-the-job training ("ANAs First Position," 1966, pp. 515-516).

The implications of the ANA position were discussed in the March, 1966, issue of the American Journal of Nursing. Among other points, the article pointed out that:

responsibility for the education of nurses historically has been carried out by hospitals, and the graduates of hospital-based diploma programs comprise approximately 78 percent of nurses now in practice. However, economic pressures on the hospital, and other developments in society, are increasing the movement of nursing education programs into the colleges and universities... ("ANAs First Position," 1966, p. 516).

The trend in nursing education away from diploma schools and toward colleges or universities is marked when traced over the 10 year period beginning in 1956. In 1956, 82.8 percent of all nursing students received
their education in hospital schools. This represented an enrollment of 94,920 diploma students out of a total of 114,570 students. By 1966 the number of students enrolled in diploma programs had decreased to 90,651. The number of hospital diploma schools decreased from 956 in 1956 to 797 in 1966 and 390 in 1977 (Grippando, 1977, pp. 147-169). Baccalaureate programs for nursing increased from 161 in 1956 to 210 in 1966. Ten years later, in 1976, there were 341 baccalaureate programs for nursing education.

The rising expense of education placed an increasing burden on the students and their families. Unlike that of other health professions, the cost of nursing education was not offset by one's eventual earning capacity. Since federal traineeships were awarded only for full-time academic study, nurses generally had to drop out of the work force to seek a master's degree. Few if any hospitals hired nurses on other than beginning pay scale, regardless of the number of years of experience. Therefore, unlike teachers, each nurse who gave up her job to return to school was rewarded by starting over again on the bottom of the pay scale when she returned to work. Many nurses had financial obligations and the responsibility for support of dependents.

Health Care Delivery Crisis

Overbuilding of small community hospitals, unnecessary duplication of hospital and medical facilities, and growing technology marked the beginning of the crisis in health care (U.S. Congress, Senate, National Health, 1974, pp. 19-25). The evolution of the nurse's role strained her traditional relationship with the physician.
According to Kalisch and Kalisch (1978), the physician wanted an "assistant who would do what he told her to do. The physician wanted to make use of an extra pair of eyes and ears and hands, but he was not concerned with developing a pattern of work which would allow the maximum combined output of a nurse and himself to achieve better health care for patients" (p. 642). During the 1960s and early 1970s there was a national proliferation of more than five hundred programs preparing nurses for an "expanded" role in primary care. These programs may be categorized in three ways: (1) physician's assistant or associate; (2) nurse clinician; and (3) nurse practitioner.

Marchione and Garland (1980) differentiate the three roles as follows:

The physician's assistant has been distinguished from the other two categories as follows: a person trained by a physician to be a subordinate and to carry out those technical skills which require fewer judgments and which could then free the physician for more complex functions. The title physician's associate was to have identified a person requiring more specialized training as an extensor of the physician's role. Both the assistant and the associate are regarded as apprentices to the physician. The term "associate" generated two problems: (1) many physicians regarded the use of the term "associate" to be the exclusive domain of the physician-physician collegial relationship; and (2) many nurses regarded the term as a facade to make the physician's assistant role attractive to uninformed nurses (p. 38).

The years from the mid 1960s to the early 1970s, dominated by the domestic and foreign conflicts brought about by the Vietnam War, were years of controversy for the nursing profession as well. Nursing educators were caught between tradition and progress. The ANA position paper on nursing education brought to a crisis the deep-seated emotional issue over the role of the traditional hospital diploma program. The
shortages of nurses continued as the health care arena continued to enlarge creating thousands of new nursing jobs.

Postwar Iowa

According to the Board of Nursing minutes of 1944, admissions to Iowa Schools of Nursing for 1943-1944 totalled approximately 1,372. The quota for the fiscal year set by the Department of Studies, National League of Nursing Education, was 1,683. Iowa was about 311 under goal, or within 18-19 percent of the total (Board of Nursing, p. 266).

Number of students in Iowa Schools of Nursing as of June 30th were:

<table>
<thead>
<tr>
<th>Year</th>
<th>1940</th>
<th>1941</th>
<th>1942</th>
<th>1943</th>
<th>1944</th>
<th>1945</th>
<th>1946</th>
<th>1947</th>
<th>1948</th>
<th>1950</th>
<th>1951</th>
<th>1952</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1694</td>
<td>1793</td>
<td>2234</td>
<td>2488</td>
<td>2947</td>
<td>3020</td>
<td>2412</td>
<td>1878</td>
<td>1589</td>
<td>1901</td>
<td>2265</td>
<td>3082</td>
</tr>
</tbody>
</table>

During the 1940s, the Board of Nursing recognized a very evident need for a "rotation plan." With some schools admitting three classes a year, careful planning was required in order that all students would have the experience necessary to be competent beginning practitioners.

Faculty problems plagued the schools during the war. The shortage of teachers, directors of schools, and supervisors was evident. To assist some members of the Iowa Schools of nursing faculty prepare for their teaching positions, Loras College, Dubuque, offered a summer course. The course covered ward management, teaching and administrative problems. Sister M. Bernice Beck of Catholic University, Washington, D.C. was the instructor (Board of Nursing. Minutes, 1944, p. 273).
Iowa nursing programs having affiliations with colleges in 1944 were listed in the Board of Nursing minutes as follows:

<table>
<thead>
<tr>
<th>City</th>
<th>Hospital</th>
<th>College/University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burlington</td>
<td>Protestant</td>
<td>Iowa Wesleyan (B.S.)</td>
</tr>
<tr>
<td>Cedar Rapids</td>
<td>Mercy</td>
<td>Loras (B.S.)</td>
</tr>
<tr>
<td>Cedar Rapids</td>
<td>St. Luke's</td>
<td>Coe (A.B.) Upper Iowa (B.S.)</td>
</tr>
<tr>
<td>Des Moines</td>
<td>Iowa Methodist</td>
<td>Drake (B.S.)</td>
</tr>
<tr>
<td>Dubuque</td>
<td>St. Joseph's Mercy</td>
<td>Loras (B.S.)</td>
</tr>
<tr>
<td>Dubuque</td>
<td>Finley</td>
<td>U. of Dubuque (B.S.)</td>
</tr>
<tr>
<td>Sioux City</td>
<td>St. Vincent's</td>
<td>Briar Cliff (B.S.)</td>
</tr>
<tr>
<td>Fort Dodge</td>
<td>St. Joseph's</td>
<td>Trinity College (B.S.)</td>
</tr>
<tr>
<td>Sioux City</td>
<td>St. Joseph's</td>
<td>Trinity College (B.S.)</td>
</tr>
<tr>
<td>Sioux City</td>
<td>Methodist</td>
<td>Morningside (B.S.)</td>
</tr>
<tr>
<td>Iowa City</td>
<td>SUI</td>
<td>SUI (B.S.)</td>
</tr>
</tbody>
</table>

All 11 programs were the five year program leading to a degree (Board of Nursing. Minutes, 1944, pp. 270-311).

**Iowa Survey**

Recognizing the fact that the demand for nurses in Iowa far exceeded the available supply, the State Nurses' Association invited representatives of allied health groups to meet with them to discuss the situation and to make recommendations. The meeting was held in the fall of 1949. It was agreed that a shortage existed, but definite numbers were not available. Reasons for the shortage were named as: the rapid expansion of pre-payment hospital plans; increased emphasis on early diagnosis; greater awareness of the preventative aspects of diseases; acceptance of the relationship between physical and mental states; and recent discoveries in drug and medical therapies.

It was agreed to determine the exact deficits by a state survey to be made under the auspices of the Iowa State Nurses' Association, the Iowa League of Nursing Education, the State Organization for Public Health Nurses, the Iowa Hospital Association and the Iowa Medical Association.
The report of this committee, *Iowa Survey, Nursing Needs Resources* (1952), indicated that the average work week for nursing personnel in all classifications of hospitals was 44 hours, although the range was from 40 to 60. Administrators put in an average work week of about 48 hours in general hospitals (p. 7).

At the time of the study there were twenty-seven schools which prepared nurses for professional nursing and one which prepared practical nurses. Of the twenty-seven schools, two were controlled by colleges, and one by the state university. The college-controlled schools were Mount Mercy College in Cedar Rapids, and St. Ambrose College in Davenport. The remaining twenty-four schools were controlled by hospitals. However, sixteen of the hospital-controlled schools included in their program some college or university courses (*Iowa Survey*, 1952, pp. 21-23). Students enrolled in schools of nursing which included some college or university courses did not usually receive college credit for such work. Generally there was an agreement whereby the hospital paid the college for a certain number of students, but all records were kept by the school of nursing. The college would have no record of who attended classes.

Many of the sciences taught the nurses were not the usual college level courses. The course might be "Chemistry for Nurses", a title which could imply that the chemistry not needed for nursing practice was not taught, but in fact, more often than not, the course was a watered down version of chemistry. As recently as July 29, 1980, a new graduate of one of the diploma programs in Iowa stated to the researcher that the chemistry professor "greeted us by saying he knew that if we failed
chemistry we were out of the school and he did not want to be responsible for that, therefore the lowest grade he gave was a C." Simonds (1975) states his belief that education is in a key position to effect change in the knowledge, attitudes, and practices which are intimately involved with quality assurance and accountability (p. 5). This thought places heavy responsibility on those who would call themselves educators.

In 1952, three Iowa schools of nursing were approved by the National League for Nursing accrediting service. The schools were: Mt. Mercy College Department of Nursing, Cedar Rapids, Mercy Hospital School of Nursing, Iowa City, and St. Ambrose College, Davenport.

At the same time all other nursing schools except six were given temporary accreditation. The six schools not given temporary accreditation were:

- Burlington Protestant
- Mercy
- Jane Lamb
- Evangelical Deaconess
- St. Joseph
- Lutheran

(Burlington

Jane Lamb Clinton
Evangelical Deaconess Marshalltown
St. Joseph Ottumwa
Lutheran Sioux City

(Board of Nursing, 1945, p. 638).

Cost of the various diploma programs ranged from $200 to $800 with a mean cost of $455. These costs were borne by the students. The wide range of estimates was caused partially by the fact that some of the estimates included the cost of transportation from the nursing school to the college (Iowa Survey, 1952, p. 24). On June 17 and 18, 1953, the subject of teaching nutrition without laboratory hours was discussed by the board. Permission was granted for St. Ambrose College Department of Nursing, Davenport, and Burlington Hospital School of Nursing, Burlington to try an experimental program of teaching the nutrition course without a
cooking laboratory (Board of Nursing, July 1953, p. 678). Nutrition classes were taught by dieticians. Clinical experience for the students in nutrition was in the special diet kitchen. Generally there was a minimum of cooking in the clinical experience. Mostly, the students prepared trays from foods already cooked. Diabetic foods were weighed by the students. In the formula room the student nurse assisted the individual hired to make formula. For most students the formula room experienced was two weeks long. In the first week the student learned the procedures; in the second week she was able to be a valued helper. This researcher's experience was extended an additional two weeks in order that the individual employed to make formula might take her vacation.

The nursing education committee questioned whether "we should still insist upon the emphasis on communicable disease nursing which was appropriate a decade ago when the morbidity and mortality rates for many of the acute communicable diseases were higher" (Iowa Survey, 1952, p. 24). There was no question about the appropriateness of a cooking laboratory which required this researcher to memorize twelve recipes for cakes. The Iowa Survey reported, "by far the greatest portion of nursing services rendered in Iowa are performed in our general, psychiatric, and tuberculosis hospitals" (p.2), not in private homes, where cooking by the nurse was a slight possibility.

The minimum age requirement for students entering schools of nursing in 1951 was lowered to 17. This had an effect upon the educational
preparation of students admitted to schools of nursing. When the admission age was 18 years, or 17 years and 8 months as it was in 1940-1949, the number of students entering nursing with one year of college ranged from 10 to 21 percent of the total entering; in 1950, when the age requirement was lowered the percentage dropped to 1.3 percent (p. 34).

Marriage was the major reason given for withdrawal of students from Iowa schools of nursing from January 1947 to June 1951. There were 30.7 percent of the students giving marriage as the reason for withdrawing; 26.4 percent were failing the classwork (p. 34).

**Psychiatric Nursing**

By 1950 the majority of schools of nursing in Iowa provided psychiatric nursing experiences for their students through affiliation with larger mental health facilities either in Iowa or out of state. The usual pattern was for staff and faculty of the mental health facilities to act as instructors. The majority of the affiliations lasted for three months (Iowa Survey, p. 25). The change in psychiatric nursing during the postwar period to the late 1960s was very marked. Prior to the use of medication, students were taught wet sheet packs, hydrotherapy, insulin therapy, and electroconvulsive therapy, and in some hospitals brain surgery was used to modify behavior. After medication became established as a modality of treatment, nursing care focused on group work, reality orientation, and other methods of therapy.
Collegiate Nursing Education in Iowa

On May 8, 1952, the Board of Nursing approved of a new four-year college program between Jennie Edmundson hospital School of Nursing in Council Bluffs and Omaha University. The plan called for the three-year program to be dropped, allowing only juniors to continue for a three-year diploma. The graduates of Jennie Edmundson completing the program were eligible to receive a Bachelor of Science degree in addition to their nursing diploma (Board of Nursing, Minutes, 1952, p. 636).

The Board of Nursing noted that Mercy Hospital in Council Bluffs had signed a contract for a four-year college course with Duchesne College. The contract was signed without the Board's approval. The Educational Director of the Board of Nursing discussed approved patterns of Basic Collegiate programs with both the Educational Director of Mercy Hospital and the Nurse Administrator of Duchesne College (Board of Nursing, Minutes, 1953, p. 638). In 1954 the Board of Nursing was told that the Mercy Hospital School of Nursing, Council Bluffs, had discontinued the four-year program instituted in 1952 with Duchesne College in Ohaha, Nebraska. The program had proven unsuccessful. The four students remaining in the program were allowed to complete the four-year program as originally planned. Effective in September, 1954, the freshman students were enrolled at Creighton University for course affiliation in the basic sciences, Anatomy, Physiology, Chemistry, and Microbiology (Board of Nursing, Minutes, 1954, p. 721).
Mousel (1954) states that St. Vincent's Hospital in Sioux City established affiliation with Briar Cliff College in the 1930s, "This meant that Briar Cliff faculty members taught courses for the benefit of the nurses at St. Vincent's, through which they earned college credit (p. 346). In 1951 Briar Cliff college established a Department of Nursing in association with St. Vincent's Hospital and St. Joseph Mercy Hospital of Sioux City, which made it possible to offer a four-year integrated academic-professional curriculum in nursing leading to the degree of Bachelor of Science in Nursing granted by the College (pp. 345-346). This association had the approval of the Iowa Board of Nurse Examiners. This association lasted three years; in 1953 it was terminated. In September, 1953, St. Joseph Mercy Hospital was granted the status of associate in the Briar Cliff Department of Nursing, with the approval of the Iowa Board of Nurse Examiners (Mousel, 1954, p. 346). With the establishment of this association between Briar Cliff College Department of Nursing and St. Joseph Mercy Hospital, Sioux City, St. Joseph Mercy Hospital became an integral part of the Department of Nursing of Briar Cliff College and the clinical facilities of the hospitals were available to students in the Degree Program (Board of Nursing, 1954, p. 683).

The granting of degrees in nursing by colleges and universities which did not have departments of nursing was discussed at the July 20, 1956, meeting of the Board of Nursing. Of concern was:

The implications in the practice of granting a degree of this kind of educational programs, namely the confusion of the public and the student about collegiate education in nursing, the fact that individuals with such degrees do not have the increased skills necessary, they may not be qualified for graduate study and the poor use of resources (Board of Nursing, 1956, p. 802).
The Board of Nursing reviewed the degree programs for general information. The discussion included the type of affiliation between the college and the school of nursing, and the granting of the degree by the College for nursing credit, especially when the degree was granted in Nursing by the college. Colleges discussed were:

St. Luke's in Cedar Rapids affiliation with Coe College for a five-year combined program granting the A.B. Degree. In Davenport, St. Luke's Hospital had a five year combined course with Augustana College of Rock Island, Illinois. A B.S. Degree was granted. In Des Moines, Iowa Methodist Hospital had the same type of arrangement with Drake University. Dubuque's St. Joseph Mercy Hospital had a five-year combined course with Loras College. In Sioux City, Lutheran Hospital had a five calendar year combined course with Morningside College, and Finley Hospital School of Nursing of Dubuque had an arrangement with the University of Dubuque that allowed the students to take two years at the college either before entering nursing, or after the completion of the nursing program to earn a B.S. Degree in Nursing (Board of Nursing, 1956, p. 779).

According to Roth (1979), Mercy Hospital School of Nursing, Cedar Rapids, established an affiliation with Mount Mercy Junior College in 1933. Through this arrangement, the teachers from the college conducted the courses in biology, chemistry, and sociology. Ten years later, in September, 1943, the hospital school began an affiliation with Loras College in Dubuque as the Loras College Division of Nursing Education. With this arrangement Mercy students were granted college credit for their basic professional courses and, by taking an additional two years
of college work at Mount Mercy, were awarded a Bachelor of Science in Nursing Education. Eight years later, in 1951, a lack of student interest in the five-year nursing plan moved the school of nursing to discontinue the affiliation with Loras, effective with the freshman entering in 1951, and to reorganize as a department of Mount Mercy Junior College and became known as the Mount Mercy School of Nursing (p. 75).

Roth (1979) recorded the affiliation with the college lasted until 1957. With the beginning of Mount Mercy as a four-year institution in 1957, the nursing program "became known as the Mercy Hospital School of Nursing and operated on a traditional three-calendar-year schedule until 1966, college teachers still conducting some courses at the school"(p. 75).

Mercy Hospital School of Nursing was unique in that, beginning with the incoming freshmen of 1964, the school went on an academic calendar of nine months. The school had not been providing nursing service to the hospital since 1959; therefore, it was easier for them to achieve their educational goals in a nine-month setting.

Plans for a baccalaureate program leading to a Bachelor of Science in Nursing degree were approved by the Iowa Board of Nursing in 1968, and the program began in the fall of 1969. The Mercy Hospital School of Nursing was phased out, with a closing date of 1971. Roth (1979) states "when the hospital school of nursing closed in 1971, it had been in existence for sixty-seven years and had graduated 1,188 nurses"(p. 77).

In 1962, the Board of Nursing approved a request from Marycrest College, Davenport, for the establishment of a Department of Nursing within the Division of Community Service (Board of Nursing, 1962, pp. 1016-2).
According to Means (1951), the University of Iowa School of Nursing abandoned the five-year program in favor of a six-year program in June 1945. Three years were to be spent in the College of Liberal Arts and "36 months in the school of nursing" (p. 7). This course of study led to the Bachelor of Arts Degree and Certificate of Graduate Nurse.

The University of Iowa School of Nursing celebrated its fifteenth anniversary December 6, 1948. Twenty-one days later academic rank was granted for the first time to a member of the faculty of the School of Nursing. Amy Francis Brown was appointed Assistant Professor. One year later, December 3, 1949, the University celebrated the inauguration of the college of nursing and Myrtle Kitchell became the first Dean (Means, 1951, p. 8).

In her statement on assuming the leadership of the College of Nursing, Kitchell stated, "Two very specific basic goals are the immediate objectives of this new organization; first, the development of a three-year graduate nurse program in which individuals will have been trained primarily as capable bedside nurses . . . . Second, the development of a four-year graduate program leading through the College of Nursing to the degree of Bachelor of Science in Nursing" (State University of Iowa Publication, February, 1950, p. 17).

It is ironic that it was December 27, 1948, that academic rank was granted to a member of the faculty of the school of nursing. Twenty-seven years earlier, December 27, 1921, Effie J. Taylor, a nursing leader who would become Dean of the Yale School of Nursing, wrote to Dr. Lomas at Iowa City concerning an offer of the position of
Superintendent of Nurses for the Iowa City Hospital. Her letter concerned the status of nurse educators and the salary of nurse educators of the day. She wrote:

You state that the School of Nursing is a recognized department of the University, but you do not say whether or not the Director of the department represents the School on the University Faculty. I inferred from your letter something to the contrary, and if this is true, it would constitute a barrier to my considering the position. I speak thus because I know there are some affiliations with universities in which the director of the department is represented indirectly but not directly, but in all universities where there is a satisfactory affiliation, the director of the department is a member of the faculty.

The salary, I feel, is inadequate (Taylor to Lomas, 1921).

Taylor did not accept the position of Superintendent of Nurses at the University of Iowa Hospital. In a note to Mary Adelaide Nutting, Taylor wrote:

I have just heard from the University of Iowa and they are not quite ready to reorganize their School of Nursing. They are running along now with a substitute Supt. of Nurses as a part of the hospital under Dr. Lomas and they are not ready yet to take any decided step in the reorganization (Taylor to Nutting, 1922).

Taylor, on invitation, visited the Iowa University Hospital to discuss the appointment to the office of Director of the School of Nursing of the University Hospital. At Dr. L. W. Dean's suggestion, she carefully considered the appointment and then wrote on January 21, 1922:

As I understand the situation, at present the Training School for Nurses is a department in the University Hospital under the administration of the Superintendent of the Hospital, is maintained by the hospital, is under the direction of a Superintendent of Nurses "closely
affiliated with the College of Medicine and under the general
direction of that College." I have tried very hard to see
clearly through this organization . . . I well see the
difficulty with which it is functioning. I infer from con­
ferences with members of the Faculty of Medicine, the
Superintendent of the Hospital and the School of Nursing
that the present organization does not bring satisfaction
. . . . An organization which is so flexible and so causal
that as the result of a faculty meeting the whole policy can
be changed and the responsibility and authority transferred
is to say the least unstable and unsound and would offer no
incentive to me to consider the appointment . . . "A
student of the school is a student in the University and
profits by all its advantages." This sounds extremely well,
but when student nurses are on duty daily doing nine, ten
and twelve hours hard physical labor under frequently
distressing circumstances, it makes little difference how
many advantages are placed, by courtesy, in their way, for
they have little time and less energy to avail themselves
of them . . . while no one refuses to give lectures and
classes and apparently all are desirous of HELPING THE
NURSES, it is with difficulty that a satisfactory schedule
is planned and the all too meager theoretical instruction
given. This condition exists in the Iowa University
Hospital School of Nursing, but it is not alone there I am
sorry to say. Few, if any, hospital training schools for
nurses in even a small way approach the ideal in education
. . . I have a very definite conviction that the
possibilities for the development of a School of Nursing
within the Iowa University associated with the Iowa
University Hospital are as great or greater than those
already or to be developed in any university of which I
know . . . Iowa University appears at the present time
to be in a position to lead the way, and it would seem a
desirable and enviable position in which to place itself
if feasible to develop an independent college of nursing
with a dean and nursing faculty organized under an
administrative board functioning as a university department
with the same opportunities and facilities to develop the
department that are afforded to other departments of the
University . . . I have consulted with Miss Nutting and
Miss Goodrich, and I know either or both of them would be
glad to discuss any points or points you may wish to take
up with them. They both feel that it is a great
opportunity (Taylor to Dean, 1922).

In 1961 students entering pre-nursing courses at the State Univer-
sity of Iowa were on the regular University schedule throughout their
college years. They were permitted to live in regular university housing. Clinical assignments followed schedules similar to those of laboratory hours for other "fields, fixed for a semester at a time and with no weekend working hours" (Bulletin of Iowa Nurses' Association, 1961b, p. 10).

The Bulletin of the Iowa Nurses' Association (1961) reports on the new conditions for the S.U.I. students:

Under the present program, student nurses have spent summers following their sophomore, junior and senior years in class and in clinical practice in University Hospitals. They have lived in Westlawn, nurses' dormitory, during the junior and senior years. Holidays during the year have been limited to one day except at Christmas, when they received a seven-day vacation, about half that of other University Students.

The new program will give student nurses a chance to hold part time jobs during the school year, to vacation or work during the summers and to spend time at home during vacations of the academic year . . . they will have the same opportunities as students in other fields to participate in University cultural and recreational activities . . . Student nurses . . . will pay their own tuition, board and room during the four academic years. Present students are earning these fees during their junior and senior years by working in University Hospitals . . . . Supervised laboratory practice will replace time-consuming apprenticeship methods . . . . In a recent survey of 46 nursing colleges, only three besides Iowa still had programs comparable to the one currently in operation at S.U.I. (Bulletin, 1961b, pp. 10-11).

A detailed history of the University of Iowa School of Nursing is now in preparation by Etta Rasmussen, Faculty member of that College.

Students

Psathas (1968) states that small institutions, colleges as well as nursing schools, often pose unnecessary difficulties for their students. They create rules for reasons that are not always clear to the students
or to the administrator. Some rules are championed by administrators because they are "part of our tradition. Other rules appear to have emerged with the laying of the cornerstone of the students' dormitory" (p. 153).

On March 31, 1952, the Director of Nursing Education of the Board of Nursing was asked to go to a hospital school of nursing in Iowa because the students were causing some trouble. The students were nearing a strike and had refused to report for duty or attend classes when the Director arrived on March 29, 1952. The reason given was that a junior student had been "campused" (privilege of leaving the premises denied) due to poor grades in nursing theory and practice. The demands of the students were for: a set of rules, student government that would give them some power, information about the grading system, a work schedule, their vacations scheduled a few weeks in advance, and their parents notified when they were ill (Board of Nursing. Minutes, 1952, p. 634).

The situation was settled within a month. The students were granted their requests. Glaser (1966) pointed out that probably these students had been pressed into a setting which severely limits the degree of autonomy and control they can exercise (pp. 1-59). The troublesome students were being socialized for their future roles by administrators who did not realize that it is difficult for those who are in power to extend power to those whom they govern with benevolent intentions, but it is much harder for those who are benevolently governed to demand that rights be extended to them (Becker, 1961).
As late as February 6, 1968, the Board of Nursing was called to a hospital school of nursing in the interest of three junior students who were dismissed from the school. Among other justifications for dismissal was the reason of "unprofessional attitudes." The girls had dated individuals deemed inappropriate by the faculty of the school of nursing. Fox (1964) stated that the student nurse in the hospital diploma school often found that her every activity was subject to scrutiny, and her outside social activities were often reported to her instructors and counselors. As a nurse in training, her attitudes, morals, manners, mode of dress, speech, grooming and habits were all subject to inspection sanction. This setting is more restrictive than that of college, particularly the co-educational college where dating is a major activity.

One of three students had failed a test. The nurse educator, apparently having no background in tests and measurements, felt that the lowest score on any test, no matter how high, was a failure. From a total of 120 test questions, the highest score received was 112, the lowest 97. The student with the 97 failed (Board of Nursing, 1968, p. 637).

During the late 1960s, progress was evident in the area of students' rights. The Board required a statement concerning the rights of students, and student government was encouraged.

As the climate of inquiry and discovery of the sixties affected nursing, patterns of learning were examined by faculty. The trust in rote memorization in curriculum was seen as casting a concrete prison on the minds of the practitioner. Nursing faculty sought ways to measure
educational outcomes through the use of objectives stated in behavioral terms. The focus had shifted from vaguely stated and broad objectives and content rote memorized to specific theoretical concepts and performance that utilizes discovery methods (Gendrop, 1976, pp. 169-192). The shift from conformance to performance had a positive effect in the way in which students were viewed by faculty.

Major Trends Affecting Health Care

Wars seem to produce major changes in various aspects of people's lives, interests, and priorities. Health care needs especially seemed to capture the interest of Americans once the acute war needs were past.

Since World War II, the areas of public health and psychiatric-mental health expanded in many directions. Many communities increased the scope and size of existing health facilities or built additional ones, aided by both voluntary and federal funds.

Major factors influencing health care have been: the expansion of knowledge, a change in attitude toward health, an increase in health care personnel, decreased hospitalization, a change of population trends, growth in junior and community colleges, and the continued emancipation of women. In general diagnosis and treatment of disease has undergone revolutionary changes because of the development of drugs and equipment.

Health is considered a right, not a privilege to which all individuals are entitled. This change in attitude has been the result of mass public awareness of various diseases and their cure. The informed public demanded excellence in health care.
There has been increased specialization in medicine and other health care areas. There has been an expansion of preventive and rehabilitative services. Nurses have specialized in acute care areas. At the same time the emphasis has shifted away from hospital and toward increased home care. Follow-up care is provided in clinics or by community health nurses. The population age, and therefore health needs, shifted away from youth orientation. Increased longevity has changed the health care delivery system. With longevity came chronic health problems associated with the increased incidence of degenerative diseases.

The tremendous growth of junior and community colleges followed the population explosion after World War II. Nursing and many allied health careers have been established under the aegis of the junior/community colleges.

More women entered the labor force and opportunities for employment in service occupations increased. The predominantly female occupation of nursing no longer had the first claim on young women. The number of women electing nursing as a career declined.

The old methods of treatment of a disease were no longer adequate, nor were the old methods of educating nurses satisfactory to meet the demands placed on nurses by society.

Postwar to a New Age: A summary

The questions, how did economic factors influence the development of professional nursing education, and what has been the effect of medical domination on the development of professional nursing education are closely related during this period of time. The answers, therefore,
are interwoven in this discussion.

Wars always produce major changes in various aspects of people's lives. World War II was not an exception. Since World War II most Americans have experienced an increase in new knowledge concerning health and an attitude change toward health.

Health education has been supported by federal monies. Technological developments have made health care more complex. Society has viewed health as a right rather than a privilege, and has assumed an obligation to provide health services to its members.

The Brown report caused a great deal of criticism from physicians, hospital administrators and some nurses. Among other suggestions, Brown recommended that schools of nursing should have affiliation with universities and should have separate school budgets. Brown pointed out that the inadequacy of nursing service in most hospitals existed because nurses were poorly trained and inadequate to meet the demands placed on them.

Many registered nurses feared the recommendation that nurses be college trained. The nurses insecurity, in the face of new or different educational requirements, caused anxieties. The result of their anxiety included professional disunity. The lack of unity was reflected in verbal degradation of the developing educational frameworks in nursing and unresponsiveness to innovative ideas. Additionally, there was resistance to hiring or working with nurses graduating from new and different nursing education programs. These actions discouraged purposeful goal orientation for the profession.

One major stumbling block in the development of collegiate pro-
grams in nursing has been the cost of collegiate education. As nursing education moved from the hospital-controlled schools into colleges or universities, students assumed more financial responsibility for their education. Unfortunately, unlike other health professions, namely medicine, nurses may not depend upon increasing wages to offset the cost of their education. Many scholarships, loan funds, and other forms of monies are available for students of nursing. Most of the money is reserved for the full time student.

The American Nurses' Association position paper on education, announced in 1965, caused deep resentment among most diploma prepared nurses. The position simply stated that the education for all those who are licensed to practice nursing should take place in institutions of higher education. The bickering and debate over educational programs intensified among nurses. The profession experienced difficulty in defining projected roles and responsibilities.

The physician's assistant movement emerged at this time, when nursing was involved in a major internal struggle about its future direction. The 1965 position paper of the American Nurses' Association had suggested that nurses with advanced preparation at the baccalaureate and graduate levels should have a social-psychological, rather than a technical base. The physician's assistant appeared as a new occupation ready to move in between nursing and medicine. The physician's assistant was claiming a greater amount of power, status, and income than nursing because this new occupation was ready and willing to take over technical medical tasks. Such a situation was irksome and threatening to the profession of nursing.
Nurses were further irritated when in 1970, the American Medical Association announced its plan to make 100,000 office nurses into physician's assistants. The American Medical Association made its announcement without consultation of the American Nurses' Association. The nurses deplored the announcement and stated that nursing practice was much more than the performance of delegated medical tasks. The discussion tended to unite nurses in the goal of determining the future of nursing.

Economic security has been a major problem for nurses. As late as 1952, nurses were still working at least a 48 hour week while the rest of the other workers in the United States had succeeded in significantly reducing their work week. Shirley Titus, spoke at the 1952 American Nurses' Association Convention about the economic security program of the organization. One immediate result of her talk was that nurses walked out while she was speaking. Nurses, as well as other women, have usually complied with systems that have kept them oppressed. This compliance has hampered their efforts to develop their own professional organization and improve the status of nurses. Male-dominated professions have made considerably more rapid progress.

Nurses have not looked at their long history. Repeatedly, nurses have worked with physicians and hospital administrators on joint committees, expecting that they would be helped to solve nursing problems. However, physicians and administrators were sought out for approval and have remained in a position of dominance. Nurses have failed to be liberated because they have failed to act in an assertive fashion. As is common in other women's occupations, nursing has been associated
more with labor than with professional activity.

During the decade of the 1960s, hospital schools decreased in numbers. Associate degree programs demonstrated rapid expansion. Baccalaureate degree education programs increased and career mobility became a reality.

Despite these positive sounding changes, all is not well within the profession of nursing. There is a movement to resurrect hospital schools of nursing. Employment practices deny the dimension of the knowledge base of different levels of nursing practitioners. There is not yet respect for the diversity of educational programs preparing the nurse practitioners.

Alongside the traditional patterns of nursing education are a range of experimental programs. The experimental programs have been introduced purporting to provide more flexible learning opportunities that are better suited to an increasingly diverse population of nurses seeking a college education. The shortage of students has been responsible for the universities and colleges looking to nursing as a potential pool of students. New York State is currently offering an external baccalaureate degree in nursing. One could wonder when they will plan to offer external M.D. degrees for physician's assistants? Will there be an external dental degree for dental hygienists? It would seem the nurses are acting without validating the educational programs offered at any level. Until the baccalaureate and higher degree programs in nursing which are offered in colleges and universities are validated the noncollege-based programs seem dubious to say the least.
Chapter Seven: The New Profession, Late 1960s-1978

Today is probably the most crucial period in nursing and nursing education. It is a time of unrest in the profession and a time of crisis for health care delivery systems. The actions taken today, and the decisions made, with all of the ramifications, will help to decide the role of nursing in the health care delivery systems of tomorrow.

It is critical for nurses to examine the past in relation to the questions of this research. Such an examination could direct the action of the future away from the mistakes of the past.

The political issues of the era are discussed in light of the economic ramifications of federal monies spent on health care. Nursing education programs receiving federal money have lived from one year to the next not knowing whether or not there would be funds available. Economic conditions of the country are presented to illustrate the effect of the economy on health care.

The question of the impact of the Woman's Movement on the development of professional nursing education is discussed as a social force. Nurses have been identified as the most subservient of all women. This identification has been made by ardent feminists who advise women not to enter nursing as they will perpetuate their inferior status as women.

The domination of the medical profession over nursing is examined in a discussion of the American Medical Association's stand on both nursing education and the practice of nursing. The Lysaught report illustrates the confusion in the profession of nursing. The report stresses placing nursing education within institutions of higher
education at the same time it encourages hospital based schools of
nursing.

Expanded practice and the necessary changes in nursing licensure
is presented to illustrate the medical domination of the practice of
any health care profession, especially nursing. The past gullibility of
nurses must be avoided. Nurses have not increased their own theoretical
base by taking over delegated physicians functions.

The Iowa political and social influences on health needs are
presented to demonstrate that Iowa, as other states, has attempted to
solve health care problems. The major problems in health care were
identified and announced at a state wide conference. In part, the
problems in Iowa were created by the inadequate attention given to
long-range planning after World War II. Health care has been placed
second to the medical model of diagnosis and treatment.

Iowa schools of nursing responded to the new profession era.
The number of baccalaureate programs increased, the course of study in
these programs began to resemble baccalaureate study, not that of a
hospital school located in the university. The economic ramifications
of a decrease in the number of high school graduates entering college has
been felt in Iowa schools of nursing. The nurse, as a student, is now
actively recruited by many types of college programs. A baccalaureate
degree is offered in any one of a number of "majors." Diploma schools
of nursing are decreasing in number; however, the enrollment has been
constant due to the number of students enrolling in the remaining
programs.
Contemporary nursing practice in Iowa is presented as an example of Iowa's progress. Iowa has not been identified as a bellwether state, nor have Iowans been last in moving toward innovative ideas. Some Iowa nurses caught the attention of the nation with a demonstration of accountable and autonomous nursing practice. The project was conducted at the Iowa Veterans' Home in Marshalltown. The innovative nursing education programs in Iowa are also discussed in this chapter. Donna Story, nurse educator at Northeast Iowa Technical Institute, Calmar, Iowa, gained national recognition with an open curriculum project.

Political Issues

If nurses are to make any impact on health care, it would seem that political activity is necessary. Politics is the art of influence, and therefore, it is a part of our everyday life. Nurses, as women, have appeared to be resistant to developing political awareness. The problem might be that women and nurses have been taught to feel that the visibility of political life is unfeminine or in bad taste. An examination of the past political issues should shed light on the political action of nurses.

Health legislation seemed to decline in importance as the Nixon years in the White House progressed. The Nurse Training Act of 1964 was revised in 1971 when, for the first time, there was authorization for basic support grants (ANA Capital Commentary, 1968, p. 5).

The American Nurses Association alerted its membership that some of the major health programs would expire in 1974 and would need reconsideration and support. These programs were Regional Medical Programs, Community Mental Health Center, Comprehensive Health Manpower Training Act and the Nurse Training Act. Health Legislation had a high priority on the 1974 Congressional agenda. The major issue was National Health Insurance (American Nurse, 1974, p. 3).

The president of the American Nurses' Association, Rosamond Gabrielson, expressed nurses' support of the National Health Insurance concept at a subcommittee hearing early in the 1974 Congressional session. She urged that "recognition be given to the nurses' role in delivery of primary care" (American Nurse, 1974, p. 1).

President Nixon apparently did not heed her words, for at the same time he was proclaiming National Nurses' Week in 1974 he was drastically cutting monies that would support nursing. While proclaiming "... more nurses are assuming primary care roles," his budget contained no funds to train nurses for the skills needed (American Nurse, 1974, p. 1).

Following the resignation of Nixon, Gerald Ford became President of the United States. He received the thoughts of the nation's nurses expressed by Gabrielson as she stated: "Nursing is a healing profession and it is in this spirit that I express the well wishes of ANA's 200,000 members" (American Nurse, 1974, p.2).

Although the National Health Planning and Resources Development Act of 1974 established a method of health planning for the use of federal
funds and for the development of goals for more satisfactory health care delivery, the Ford Administration apparently did not see nursing's role as part of the health care delivery system. However, Ford's veto of the Nurse Training Act of 1975 was overridden by Congress.

Ford was permitted by the people of the United States to complete Nixon's term of office. James (Jimmy) Carter, calling for tax reforms, a return to simple government, and the reorganization of federal bureaucracy, defeated Ford in the 1976 election (Carroll & Nobel, 1977, p. 410).

The Carter Administration during 1977 was characterized by identification and analysis of the problems facing the nation. The State of the Union Address in January, 1978, reflected on the year 1977 and spoke to priorities for the coming year that were of prime concern to the President. Health legislation and funding were not mentioned (From the Washington Office, 1978).

**Economic Conditions**

In 1971 President Nixon established a ninety-day wage-price freeze. This was followed by an increase in the cost of living and a decrease in the purchasing power of the American public. The American Nurses Association opposed the extension of wage-price controls on the basis of the negative impact it was having on health care, especially hospital care.

By 1973-1974 the downward trend of the economy had degenerated into a major recession (Carroll & Nobel, 1977, p. 388). Toward the end of 1975 the United States had begun to recover from the widespread economic slump. The Gross National Product began to rise and the production of
factories, mines, and utilities began once again to climb. The stock market indicated an increase in the economy's growth.

The nation's nurses' salaries continued to be very low. Between 1960 and 1975 the American Nurses' Association expanded its economic and general welfare program "to (1) achieve an employment status for nurses commensurate with their preparation and qualifications and with the intellectual and technical nature of their services and (2) to involve nurses actively in determining the conditions of employment under which they practice, through collective action" (Flanagan, 1976, p. 261).

Social Forces

The 1970s were characterized by a concern for ecology, consumerism, and the purpose of democracy. Two important movements that came of age were the Civil Rights movement, which had its roots in the early 1960s, and the Woman's Movement. The Woman's Movement has had two different origins representing two different strata of society with two different styles, orientations, and forms or organizations (Walum, 1977, p. 201).

According to Walum (1977) the older branch of the movement, which includes the National Organization for Women (NOW), was formed after Kennedy's establishment of the first Commission on the Status of Women in 1961. The second branch of the Women's Movement includes women who had worked in other movements concerned with civil rights, peace, and other human concerns.

Women in Western society have historically held a subordinate status. They have been encultured to avoid competition with men and to
seek satisfaction as wives and mothers (Kessler, 1976, p. 2). It is an accepted sociological concept that the dominant group usually defines one or more acceptable roles for those in the subordinate groups and the acceptable roles typically involve providing services that no dominant group wants to provide for itself (Miller, 1976, p. 6). The new feminism has challenged the traditional institutions of family, marriage, and the roles of men (Filene, 1975, p. 184). The Woman's Movement has had an impact on nursing and nursing education.

Cleland (1971) expressed concern that nursing would not be able to attract the young equality-minded woman because the nursing profession and nursing leaders were settled into a pattern of control by the male systems in medicine, hospital administration, and higher education. Cleland stated the majority of directors of nursing did not control their departmental budgets, and nurse faculty members were not involved in formulating educational policy (pp. 1542-1547).

The most helpful trend for nurses in overcoming some of the psychological barriers in their profession has been the Women's Movement. At first this movement had difficulty gaining a foothold in nursing. Ardent feminists have been advising women not to become nurses because by doing so they will perpetuate their inferior status as women (Edelstein, 1971, p. 298). Now, however, nurses have joined the movement. Assertiveness training has been incorporated into nursing curricula or offered in continuing education programs throughout the country. As nurses have become more assertive they have recognized that there is a need to open and free communication systems between all branches of the
helping professions and that sex roles at work are obsolete. This point is assisted by the increased numbers of men entering nursing.

The American Medical Association's Stand

The American Medical Association Committee on Nursing, in a statement of concern over the nursing shortage, committed itself to increasing the significance of nursing as a primary component in the delivery of medical services. The statement consisted of six objectives, including the intention to support efforts to increase the number of nurses, facilitate expanding the role of the nurse in providing patient care and support all levels of nursing education. In regard to the latter point, they reaffirmed support of diploma programs as a resource to be supported and expanded. They noted that as the role of the registered nurse expands in medical care, the potential for expansion of the practical nurse's role will also be increased. A further objective recognized the need to promote, and influence the development of a hospital nursing service aimed at increasing involvement in direct medical care to the patient. To this end they favored a professional nursing service, separate and distinct from hospital administration and accountable to the chief of the professional staff, a physician. The fifth objective stated that the delivery of medical care is, by its nature, a team operation and, as such, requires the constructive collaboration of medicine with the various elements of the nursing profession (American Medical Association, 1970, pp. 1881-1883).

Cathcart (1968) expressed the view that preferential attention should be given to hospital schools of nursing because the baccalaureate,
associate degree, and master's degree programs have been "firmly launched" with the aid of federal funds. He further stated there is a great need for regional planning to "help forestall some of the ill-advised hospital [school] closings just because they are costly ... at the expense of a valued educational resource" and also to "bring order to the present chaos in nursing education" (pp. 108-16).

Thomas Hale (1968) defended diploma schools of nursing as the only solution to the nursing shortage. He suggested an internship for graduates of baccalaureate and associate degree programs to provide them with the necessary hours of clinical experience which he believed they did not receive in their curriculums. He further protested the requirement of college educated nurses as nursing school faculty as he believed the continuing shortage of faculty members with such qualifications played a significant role in the closing of hospital schools of nursing (pp. 879-86).

The Lysaught Report

The National Commission for the Study of Nursing Education in the United States, supported by $500,000 in foundation funds, issued its final report in 1970. The report, An Abstract for Action, was called the "Lysaught Report on Nursing" because the director of the Commission was Dr. Jerome P. Lysaught of the University of Rochester. The major recommendations of this Commission, were:

- Reestablish practice as the first and proper end of nursing as a profession.
- Increase research efforts and funds for investigating the impact of clinical nursing practice on the quality, effectiveness, and economy of health care.
Encourage preparation of more nurses for expanded practice roles in the future by organizing state member planning committees to facilitate nursing education. Establish a national Joint Practice Commission, with state counterpart committees to promote dialogue between medicine and nursing concerning congruent health care (pp. 86, 89, 92 and 107).

The Lysaught (1970) study reported, "However, many nurses, and even more physicians and [hospital] administrators feel that there is much to commend the hospital school approach" to education of nurses (p. 6). In noting the reduction of hospital-based schools of nursing, the Lysaught report explained that societal trends, lack of qualified faculty, lack of qualified student applicants and the fact that students preferred programs that included general education all were instrumental in the decline of hospital based schools of nursing (p. 107).

The Lysaught (1970) report stressed placing nursing education within institutions of higher education and at the same time it encouraged hospital based schools of nursing. Lysaught made the unusual recommendation that:

Those hospital schools that are strong and vital, endowed with a qualified faculty, suitable educational facilities, and motivated for excellence be encouraged to seek and obtain regional accreditation and degree granting power (p. 109).

The recommendation seems unusual in that it has not been the custom for service agencies that maintain educational programs to seek or receive regional accreditation from general educational bodies. In addition, service agencies have not been empowered to award educational degrees.

Lysaught (1970) encouraged innovative techniques to enhance learning effectiveness and efficiency by calling for federal, state and
private funds for these activities. Additionally, it was recognized that a true profession enlarges the body of knowledge it uses and improves its own education and service through research. Therefore, Lysaught (1970) recommended that:

Federal, state, and private funds be extended to support a limited number of institutions to establish or expand doctoral programs in nursing science. These programs should focus on developing research capabilities for the study of nursing practice and nursing education, and should undertake the specification and development of nursing theory and knowledge.

The Federal Division of Nursing, the National Center for Health Services Research and Development, other governmental agencies, and private foundations provide research funds and contracts for basic and applied research into the nursing curriculum, articulation of educational systems, instructional practices, facilities design, etc., so that the most functional, effective, and economic approaches are taken in the education and development of future nurses (p. 120).

Although there has been some change noted after each study in nursing, the changes are never proportional to the apparent input of significant data. Some recommendations are carried out following major studies, but it seems that soon lethargy conquers. Many nurses have been aware of the persistence of problems within the nursing profession as well as those problems faced by the nursing profession. In nursing especially, the problems seem to reappear while the solutions are lost through time.

Nursing has undergone a variety of studies. In examining what effect certain of these studies have had on nurses and nursing, the following list reveals the trend in numbers of programs.

Year        Number of schools
1873        4
1888        22
1900        400
1910        1100
1920        3000
1923 Goldmark Report- "Nursing and Nursing Education in the United States"
1930        1900
1940        1300
1948 Brown Report - "Nursing for the Future"
1950        1190
1960        1137
1973        1373


Typical of most reports of commissions studying nursing, the Lysaught report met with opposition. Christy, Poulin and Hover (1971) took issue with the Abstract For Action, and pointed out that in their opinion the observational data were obtained only in atypical settings. According to Christy et al., the two controversial recommendations -- one concerning episodic and distributive care and the other encouraging strong and vital hospital schools to obtain degree-granting powers -- were neither "derivable from the findings nor strongly supported by nurses" (pp. 1574-1581).

Expanded Practice and Licensure

In isolated sections of the country it has not been too unusual to find a nurse practicing alone. With no health care agencies readily available, the nurse has taken on the responsibility of providing nursing care for the people in the community. Often the nurse has not even considered that she was practicing independently. In 1971, M. Lucille Kinlein hung out her shingle in an area where there were many physicians
and health care agencies (Kinlein, 1977). That was the first recorded instance of a nurse in an urban area who practiced nursing on a fee for service basis. This practice was the first on record where the nurse was responsible only to herself and her clients, not to a physician or an organization, for the care she gave.

Kinlein stated, "When my nursing colleagues asked if I could legally open an independent nursing practice, I was surprised . . . I was already licensed to practice nursing . . . and I knew that I would operate my independent practice within the boundaries" (p. 40).

As nurses have moved to extend or expand the practice of nursing, the profession and the state legislatures have turned their attention to the need for revision of nurse practice acts. Most of the changes in the practice acts are in the direction of lessening restrictions on nurses, including the most notable prohibitions against diagnosis and treatment which were added to nurse practice acts after the publication of the Model Practice Act by the American Nurses Association (ANA) in 1955 ("ANA Board Approves", 1955, p. 1474).

The new nurse practice acts are indicative of the changing self-image of the professional nurse. A model definition, provided by the American Nurses' Association, reads as follows:

Practice of Nursing by a Registered Nurse
The practice of nursing as performed by a registered nurse is a process in which substantial specialized knowledge derived from the biological, physical, and behavioral sciences is applied to the care, treatment, counsel, and health teaching of persons who are experiencing changes in the normal health processes; or who require assistance in the maintenance of health or the management of illness, injury, or infirmity or in the achievement of a dignified
death; and such additional acts as are required by the nursing profession as proper to be performed by a registered nurse (Model Practice Act, 1976).

The current movement to expand the scope of function of nurses is probably related to other trends in the laws regulating nursing. These trends include less domination of nursing boards by medicine and a beginning trend toward more consumer power in regulation. A major trend is the current movement to certify nurses as advanced specialists, including nurse midwives, nurse anesthetists, and nurse practitioners. This trend, if it gains momentum, will have far-reaching implications for health care delivery systems, because it means that the states are giving sanction to an advanced level of nursing practice.

Iowa Political and Social Influence on Health Needs

The Iowa Legislature passed the Equal Rights Amendment in 1975. Women played active political roles in the 1970s and seemed to be making some progress in securing rights. The Iowa Women's Political Caucus was one of the first in the nation.

The Midwest Continuing Professional Education for Nurses (MCPEN) Survey of 1971 states:

Life in Iowa is a smooth blend of the environmental factors which are necessary in the balance of all societies... family, community, education, farming, business and industry. Truly a place to grow, Iowa is a wholesome environment boasting steady, unrushed growth (Midwest Continuing Professional, 1971, p. 5).

The Forty-seventh Biennial Report of the Iowa State Department of Health, (1976) pointed to three achievements in health promotion for Iowans. Public health nursing service had been made available to an
additional 96,000 Iowans with the initiation of Public Health Nursing Service to seven counties which did not previously have programs, the Deaf Services Section was started, and more than 2,500 ambulance attendants successfully completed the EMT-Ambulance Training Course, with an additional 250 persons successfully completing the newly developed Emergency Rescue Technician training (Forty-seventh Biennial, 1976, p. 21).

Iowa's health care delivery status was the focus of discussion at the eight regional conferences held prior to the Iowa 2000 Commonwealth Conference of 1977. Those meetings resulted in the following proposals:

1. We should discard the idea of mandatory retirement and permit more flexibility based on an individual's needs and abilities.
2. Health professionals should take responsibility for teaching people how to make decisions about the use of leisure time that will improve their health and longevity.
3. Educational institutions and recreational/athletic programs should place more emphasis on developing the athletic talent of the average person and on preparing people for lifelong physical activity than on competitive sports.
4. Health institutions should use volunteers extensively. They should actively recruit the young and the old. There should be a "Good Samaritan" law to limit the liability of the hospital or clinic for the acts of volunteers.
5. Health care professionals should oppose junk food, alcohol abuse, sedentary living, poor diet, malnutrition and environmental poisons as actively as they have against smoking and drug abuse. This should be done through media campaigns as well as person-to-person contact.
6. Health institutions and professionals should address problems of job motivation, appreciation for work, and stress in order to develop healthy attitudes toward work and leisure.
7. There should be increased support for health services in rural areas, especially if the trend away from
declining rural populations is reversed.

8. Health institutions should develop plans for reducing health care costs and charges rather than have controls imposed by the state and federal government ("The Times," 1977).

The major problems in health care in Iowa were identified, and circulated at a conference on "Strengthening the Iowa Health Care System" held at the University of Iowa in 1973. These problems were as follows:

1. There are problems in the provision of primary care.
   A. Insufficient number of primary care physicians.
      (Family Practitioners, Internists, Pediatricians, Obstetricians).
   B. Insufficient number of primary care dentists.
   C. Maldistribution of physicians and dentists in rural areas.

2. There are problems in the provision of home health services for the elderly, the poor, the physically handicapped, children, and the homebound.
   A. Limited home service programs.
   B. Limited number of personnel to provide services.

3. There are problems in the recruitment of physicians and dentists to practice in the State.
   A. Lack of graduate education programs in community hospitals.
   B. Slow development of small group practice.
   C. The isolation of the provider in most rural practice arrangements.

4. There are problems in obtaining financial support for educational programs that train health providers.
   A. The demand for more professionals (dentists, nurses, pharmacists, physicians) increases costs.
   B. The demand for new types of health providers creates new costs.

5. There are problems in the rising costs of health services.
   A. Inefficient arrangements for providing health services.
   B. Increasing hospital and provider charges.
   C. Cost of the improved technology required to provide modern health care.

6. There are problems in the support of the tertiary care center.
   A. Tertiary care is so expensive that public tax dollars are required.
   B. Lack of recognition that the tertiary care center is the site of medical education, especially the education of specialists.
7. There are problems in developing areawide health planning.  
   A. Lack of participation in health planning the part of health professionals.  
   B. Lack of funds for the employment of technical staff for areawide planning agencies.  

8. There are problems in the provision of emergency services for catastrophic medical-surgical problems.  
   A. The required statewide organization of facilities, personnel, and equipment does not exist.  
   B. There is a shortage of all types of personnel needed to staff an emergency care system (Major Problems, 1973).  

In part, the problems were created by the inadequate attention given to long-range planning after World War II. The quantitative aspects of problem solving were stressed -- the production of more health care providers and more nurses of varying educational backgrounds to end the shortages of nurses after World War II -- occupied the nurse educators (Montag, 1977, p. 15).  

Instead of considering the preventive aspects of health and health care delivery as a goal, those involved in health care became preoccupied with developing new manpower roles to determine which task could best be performed by whom (Ford, 1974, p. 1). The lack of change in the health care system stems from the commitment to the old medical model of treatment and the exaggerated concern on how to support and extend the physician.  

The creating of the nurse practitioner role and the nurse clinician at the Master's level was to improve the accessibility of primary care (Extending the Boundaries, 1969). The nurse practitioners and clinicians were not intended to be physician extenders; rather, they were viewed as independent health professionals providing health maintenance nursing care while collaborating interdependently with other health professionals (DeTornyay, 1971, pp. 974-976).
Difficulties in achieving the role of health care provider was not due to difficulty in learning new skills but in the re-socialization of the female nurse, who had previously internalized the concept of the superior status of the medical profession as being the profession responsible for the care of the patient. In part, the re-socialization process is the acknowledgement of the history of nursing as a female dominated profession unable to achieve professional status because of the role of women in the health care setting. The great majority of nurse work in bureaucratically organized medical settings emphasizes hierarchy and conformity and discourages individuality and autonomy (Wood, 1976, p. 9).

Nurse practitioners have faced difficulty in gaining acceptance both with physicians and with other nurses. The difficulties have been the result of the traditions due to the sex segregation of medicine and nursing and the subordinate role of women (Bullough, 1975, p. 232).

Martha Rogers (1972) offered encouragement to nurses when she stated:

Nursing's boundaries have advanced through an earlier, prescientific era into an emerging, scientifically based, humanitarianism that promises new and expanded benefits to people and society (Rogers, 1972, p. 43).

Iowa Schools of Nursing

In 1975, there were 27,956 registered nurses with Iowa licenses and Iowa addresses, 5,300 more than had been registered seven years earlier (Report of the Governor's Commission to Study Nursing, 1975). Nursing education in Iowa followed the national trend of a marked
increase in associate degree nursing programs and a decrease in the number of diploma programs. In 1968 there were two associate degree nursing programs in Iowa; by 1972 there were 12 such programs; by 1976 the number had increased to 14; and by 1978 there were 16 associate degree programs in Iowa.

Hospital diploma programs decreased from 22 in 1963 to 10 in 1974. In 1977 there were nine diploma nursing programs remaining in Iowa. However, the number of graduates from the diploma programs remained steady because of the larger enrollments in the existing programs (Report of the Governor's Commission to Study Nursing, 1975, p. 27).

Baccalaureate programs, on the other hand, have increased. In 1963 there were two programs in Iowa; by 1977 there were 11.

Baccalaureate Programs

Careful examination of the early collegiate programs for nurses reveals that they resembled hospital school of nursing programs more than liberal arts or sciences schools. The resemblance between nursing and other professional schools is also lacking.

Although students who elect nursing as a major must demonstrate above-average criteria for admission into the school of nursing, the myth of the strong-backed, kind-hearted, not too bright candidate persists. Diluted science courses "for nurses" and academic advising into less than rigorous courses reinforce the poor self image of the nurse and her profession.

Today registered nurses are sought as students. The University of Northern Iowa is actively encouraging students into a baccalaureate
program for registered nurses leading to a Bachelor of Science Degree in any one of a number of fields loosely related to health. In addition, Norris G. Hart, Director of the University of Northern Iowa Center for Urban Education, and Dr. Sharon Hoffman of the University of Minnesota have an ill-defined agreement whereby registered nurses can take courses at the University of Northern Iowa and the Center for Urban Education for credit toward the B.S. Degree in Nursing at the University of Minnesota (Hart, Note 7). To add to the confusion, Dr. Howard Lyon of the University of Northern Iowa apparently is actively engaged in seeking a liaison with the University of Iowa College of Nursing. A letter to registered nurses, dated July 21, 1980, states, "If we have the interested students, it is possible that another extension course could be offered as early as the 1981 Spring Semester by the College of Nursing of the University of Iowa. The courses being considered are 'Pathophysiology' and 'Historical, Philosophical and Social Foundations of Nursing.' These courses would be taught on the campus of the University of Northern Iowa by faculty members of the College of Nursing of the University of Iowa" (Meyseburg, Note 8).

It is obvious these efforts have as a focus the recruiting of students, not providing educational opportunities for nurses. No overall curriculum plan is presented. There are no prerequisites. The questionnaire accompanying the Meyseburg and Lyon letter addresses the interest of registered nurses in courses and degree programs. There is no evidence of state-wide planning for allocation of resources. It would seem some Iowa nurses, together with the support of University officials, are ready to build where there is no foundation.
Of no greater comfort to some nurse educators is the recent trend in small liberal arts colleges. In less than one decade six small liberal arts colleges in Iowa have opened schools or departments of nursing. It would appear that the thrust is more toward increasing their total enrollment and thus saving the college than a realization of a community obligation. This phenomenon is reminiscent of the past when the opening of schools of nursing enabled early twentieth-century hospitals to function. It seems that nursing students and schools of nursing are now involved in saving small colleges. This constitutes a unique type of service relationship between nursing and the academic community.

In 1977 a study of the impact of types of basic nursing education on the practice of registered nurses in the State of Iowa, a research commissioned by the Iowa Board of Nursing, the researcher, Arthur Brief, suggests:

. . . the Board should encourage specific alternations in curricula such that the program of education provide the nursing student with a realistic preview of the type of nursing practice he or she is most likely to engage in. To accomplish this end, the Board should require the heads of the nursing programs to include in their annual reports to the Board a listing of where their most recent graduates have been placed. This listing should specify the employment status of each recent graduate, name and address of employer, and title of position occupied. Furthermore, the annual report should include a brief statement specifying the relationship between curricula content and the duties performed by the majority of the most recent graduates on their jobs. Such a statement should place strong emphasis on the relationship between structured clinical experiences in the program and the clinical demands placed on the new graduates . . . (p. 31).
Brief further states that "the Board should seriously explore what administrative and/or legislative steps would be required to insure that employers differentially utilize nurses with varying levels of preparation" (p. 32).

Brief's suggestion that "the Board should encourage specific alterations in curricula such that the program of education provide the nursing student with a realistic preview of the type of nursing practice she or he is most likely to engage in" would mean that the nurse educator would prepare nurses only for the "here and now" role. No doubt concentrating educational efforts toward preparing well-qualified nurses to function in our present day health care system would please many. Such nurses would be highly employable and would serve to maintain the status quo.

An alternate plan would be to prepare nurses to function in the here and now, but at the same time lay a base for the expanded nurse role. The accusation that "they just don't train nurses the way they once did" stems from the description of nurses by physicians, patients, and hospital administrators primarily in terms of manual activities. While there can be no argument that all nurses should enter their first jobs armed with a basic repertoire of interpersonal relationship skills, the basic list of manual skills required needs to be clarified. In addition, the professional nurse should be prepared for skillful coping with the bureaucratic organization. The base for the expanded nurse role would include theoretical knowledge and skills in areas of communication, teaching, systems analysis, conflict resolution, and first level clinical assessment and diagnosis.
Diploma Schools

A typical story is reflected in the Broadlawns School of Nursing. Broadlawns Polk County Hospital School of Nursing closed the school in 1974. The events surrounding the closing are summarized in the "Report of Plans to Close the School of Nursing" (1972):

The Hospital Administrator met with the Faculty on December 30, 1971 to inform them the Board of Trustees of Broadlawns Polk County Hospital was going to recommend the School of Nursing be phased-out and discontinue admitting new classes beginning in the fall of 1972. This decision was made only after much study, evaluation and budget projections for the fiscal year 1975. This still was a difficult decision to make in view of the commitment of the Administration to Diploma Education.

The necessity for this recommendation was a financial one in that by the school year 1974-75 there would be insufficient funds in the Hospital budget to continue the operation of a school. This was compounded by the facts that, being a County institution, the law does not allow us to operate at a deficit spending level and we are currently spending our entire tax millage allotment, the emergency one mill levy, and have asked for and received an additional one-half mill tax levy from the 1971 Iowa Legislature.

At the Annual Meeting of the Board of Trustees on January 4, 1972. the Chairman of the Finance Committee recommended the phasing out of the School with the plan to include allowing all current classes to graduate but not accepting any new classes beginning in the fall of 1972. Action upon this recommendation was postponed until the regular Board Meeting on January 11, 1972.

During that week, the students began organizing a campaign to "Save the School!" They appeared on local radio and television stations and received coverage in the newspapers. They wrote to physicians and nurses in Polk County, soliciting their support for their cause. Their efforts produced a fairly large response from persons both sympathetic to their cause and those sympathetic to the recommendation of the Board of Trustees.

At the Board of Trustees meeting on January 11, 1972, supporters and nonsupporters including students, prospective students, parents of prospective students, alumni, nurses working in the community, physicians and members of the community expressed their opinions on the proposal to the Board. The students asked for a one month delay in the
final decision so they could investigate ways to obtain sufficient funds to keep the School open. The Board granted this request and postponed the final decision until February 15, 1972.

The students proceeded in a mature and orderly fashion. They held public meetings, continued their contacts with the news media, talked with State and National legislatures, attended meetings of neighborhood groups, and met with the Governor of the State of Iowa and worked with members of the Governor's staff on possibilities of obtaining Federal grants. They were, however, unable to obtain tangible forms of support.

On February 15, 1972, after hearing from students and other representatives, the Board of Trustees made the final decision and approved the plan to phase out and close Broadlawns Polk County Hospital School of Nursing after the present freshman class has been graduated and to not admit any more freshman classes beginning the fall of 1972. The Board of Trustees, at the same meeting, also adopted the following: "RESOLVED: The Board of Trustees, to the best of their ability, will furnish the nursing students now enrolled; (1) adequate faculty; (2) clinical experience; (3) dormitory use, until graduation." With this tangible support from the Board of Trustees, the Faculty could proceed with the business of continuing to provide a quality education to the students currently enrolled and plan for the orderly phasing-out of the School. The parents of all students currently in the school were informed of this decision and assured the School would continue to remain open until the Class of 1974 graduates (Report of Plans, Note 9, pp. 1-2)

The 54th and final graduation exercise for Broadlawns Polk County Hospital School of Nursing was held June 5, 1974, at the First Church of the Open Bible in Des Moines. According to the Broadcaster, a publication of the hospital, upon graduation of the final class a total of 1062 nurses graduated from Broadlawns School of Nursing "since the first class of 3 was graduated in 1921" (Broadcaster, Note 10 p.2).

Across the nation and in Iowa diploma schools of nursing are decreasing in numbers, but they have not disappeared. They still seem firmly established and continue to function as major socializing agents for nurses.
One major reason hospital diploma schools for nursing have persisted so successfully is that hospital administrators like to hire diploma school graduates. Hooker (1977) defended diploma schools with the major argument that "hospitals are still the largest employers of nurses, and hospital administrators continue to support the diploma school graduate" (p. 37). Diploma school graduates are trained within the confines of the bureaucratic organizational structure of the hospital. Since their training is geared to suit that structure, it is little wonder that diploma graduates are seen by hospital administrators as knowing what they are doing and as requiring less orientation than graduates of non-hospital programs (Estok, 1977).

Graduates of diploma schools of nursing are seen by hospital administrators as having characteristics that enhance the smooth and efficient functioning of the hospital. For example, habits of obedience to rules and regulations and a tendency not to engage too often in critical questioning of ongoing procedures contributes to smooth functioning of the hospital. In addition, the technical skills of diploma graduates are perfected at graduation time.

Diploma school students experience the rotation system which prepares them for pressure and change. Students moved regularly from a situation in which they were beginning to feel comfortable to a new situation meant constant change. Therefore, the student accepts flux and change without alarm.

Diploma school students and graduates tend to play the "doctor-nurse" game better than college graduates (Stein, 1967). Among other
things, this game involves the nurses as helpers in the socialization of physicians. The nurse orients the physician to the hospital environment while making the physician believe, or at least look as though, he were really in charge.

Tradition plays an important part in maintaining the status quo. Diploma schools were the first nurses' training schools to develop. They did so at a time when the social roles for women rarely extended beyond the home. The shaping of the role of nurse was strongly influenced by the traditional roles of women. Social views have liberalized the possibilities for women, but traditional views remain in force and diploma schools continue as proud bearers of that tradition.

Another source of support for hospital diploma school education comes from those socio-economic and socio-cultural groups for whom diploma school education provides a safe vehicle for social and occupational security and upward mobility, separated from the confusion of new ideas and choices found in university settings. For families desiring strict regulation and control of their children, the diploma school offers a degree of reassuring protection and control. Financially, hospital based education appears a more economic form of education. It is goal directed and practical. Most graduates are assured a job in the hospital in which they trained.

It would seem logical that it is time to define the differences in the values and training offered by both diploma and baccalaureate degree nursing programs. The differences in values between the various programs must be addressed without the effort to define a homogenized goal.
A variety of skills in the field of nursing are required for today's practitioner. These skills should be delineated and if one system is most likely to train more effectively in one area, it should be used for that training. Certainly all types of practitioners cannot be educated by each system. The bizarre educational process in nursing which has hospital diploma graduates seeking employment in public health, associate degree nurses indicating position title as clinical nursing specialists, and both diploma and associate degree prepared nurses stating their position as nurse practitioner or nurse midwife (Moses & Roth, 1979) must be resolved.

**Contemporary Nursing in Iowa**

Although the majority of nurses in Iowa have been practicing nursing in the confines of the bureaucratically organized setting, some have demonstrated the courage and ability to control their own practice. The nurses at the Iowa Veterans' Home in Marshalltown demonstrated accountability to the resident and autonomy in nursing practice. Begun as a project to develop a professional model of practice within a bureaucratic organization, the project has demonstrated the growth of accountable, autonomous practice since 1967. Using the peer review process, every nurse including the director of nursing has been accountable for her own maintenance of standards of care ("How Nurses in Iowa", 1975, pp. 2201-2207).

Another example of contemporary nursing practice in Iowa is the establishment of nurse practitioner programs. A Pediatric Nurse Practitioner Program was begun in September of 1972. The program,
sponsored under the joint auspices of the University of Iowa, College of Nursing and the Department of Pediatrics, College of Medicine, prepared registered nurses to assume an expanded role in the primary care of children. The program was designed for the registered nurses employed in child care settings. Focus of the program was child health maintenance. This collaborative effort of the College of Nursing and the College of Medicine had the potential of increasing colleagueship between Iowa physicians and nurses.

In 1974 the Iowa Hospital Association, Division of Nurses, inaugurated a program to teach registered nurses to function as family nurse practitioners. This program was a demonstration effort and feasibility study of the utilization of nurse practitioners who had received special didactic and clinical training to prepare them for extended responsibilities. Six registered nurses completed the program.

The Iowa nurses were in the forefront of nursing with their successful lobbying efforts for the passage of a revised Nurse Practice Act in 1975. The Iowa Nurses' Association (former I.S.A.R.N.) once again took the initiative in the rewriting of the act under which nursing had practiced in Iowa since 1907. The revised act was written in cooperation with the Iowa Board of Nursing, the Iowa Medical Society, the Iowa Hospital Association, and other organizations. The revised act was established for the purpose of enabling Iowa nurses to practice their profession in a manner consistent with current trends in health care delivery systems.
The Iowa Board of Nursing has been supportive of experimentation in education programs for nurses. The wording of the law has not always been clear in granting authority to the Iowa Board of Nursing for approving nursing education programs other than the traditional hospital based programs. In December, 1972, the Iowa Board of Nursing asked for an Attorney General's opinion concerning the Board's authority.

In a letter dated December 15, 1972, to the Attorney General of the State of Iowa, The Honorable Richard C. Turner, the members of the Iowa Board of Nursing posed the following questions:

1. Does the Iowa Board of Nursing have legal jurisdiction over colleges and/or universities in the State of Iowa offering a Baccalaureate Degree in Nursing and/or a Master Degree in Nursing to individuals who are Registered Nurses?

2. If the response to number one is negative, which state agency would have the legal authority to set the minimum standards for regulation of these programs to ensure that nursing educational criteria are being met? The Iowa Board of Nursing is presently approving fifty-two nursing education programs in the State of Iowa based on the following section of the Code:

   152.4 Approval of training schools. No school of nursing for registered nurses shall be approved by the board of nursing as a school of recognized standing unless said school is affiliated with a hospital and requires for graduation or any degree the completion of at least two years course of study in subject described by the board.

Of the fifty-two nursing education programs, the programs which offer a Baccalaureate Degree in Nursing are recognized and approved by the Board for meeting minimum educational requirements as defined by the Iowa Board of Nursing Rules and Regulations:

- Mount Mercy College
  Department of Nursing
  Cedar Rapids, Iowa

- Marycrest College
  Department of Nursing
  Davenport, Iowa
These programs are recognized and approved by the Board of Nursing because following completion of the program all graduates are eligible to write the State Board Test Pool Examination for Registered Nurse licensure. If a passing score is achieved on this examination, these individuals become licensed in the State of Iowa as Registered Nurses.

In the past it has been assumed by the Board that their legal authority for approval of nursing education programs extended only to those programs preparing the generic nursing students.

An unforeseen situation is arising within the State of Iowa that has precipitated this request for an Attorney General's opinion. Certain colleges and/or universities have either started or are considering offering a Baccalaureate degree in Nursing to Registered Nurses who have graduated from accredited nursing programs not leading to a degree. Students, parents, nursing educators, etc., are voicing concern as to why these programs are not listed as approved programs by the Iowa Board of Nursing.

On August 30, 1971, notice was received from the Department of Health, Education and Welfare that the Iowa Board of Nursing had been granted full recognition for a four-year period as the state agency for approval of nurse education under the authority of the Nurse Training Act, (42 U.S.C. 298 (b)), as amended.

The Department of Health, Education and Welfare, for the purpose of determining eligibility for federal funding, requires this Department to keep them informed of nursing programs approved by our Board and to have available on each program specific criteria which Health, Education and Welfare has defined.

Because of this past assumption by the Board, these colleges and universities who have elected or are considering the offering of a Baccalaureate Degree in Nursing to Registered Nurses are:

1. Not being listed as programs approved by the Iowa Board of Nursing for dissemination to Health, Education and Welfare, other state boards of nursing, professional
organizations, potential applicants and/or other individuals.
2. Not being required to meet minimum standards for
baccalaureate nurse education as outlined by the Iowa Board
of Nursing Rules and Regulations (Board of Nursing. Minutes,
1972).

The January 15, 1973, Attorney General's opinion reads as follows:

. . . Code of Iowa, Section 152.4 provides in part:
"No school of nursing for registered nurses shall be
approved by the board of nursing as a school of recognized
standing unless said school is affiliated with a hospital
and requires for graduation or any degree the completion of
at least a two year course of study in subjects described
by the board." The same is provided for licensed practical
nurses. There is nothing in this section which distinguishes
between initial training programs and programs offering a
Baccalaureate or Masters Degree. It appears from the
language of the section that all schools of nursing with
programs for registered or licensed practical nursing come
under the jurisdiction of the Board of Nursing for the
purpose of approval of programs. Accordingly, we are of
the opinion that the Board of Nursing has the authority to
approve and accredit all schools of nursing and programs
. . . (Board of Nursing. Minutes, 1973).

Innovative Nursing Education Programs

The National Commission for the Study of Nursing and Nursing Educa-
tion placed major emphasis on educational articulation in the repat-
terning of career perspectives for the profession. Lysaught (1974)
stated:

We ought to be able to have the various levels of preparatory
institutions so designed and articulated that a student
leaving one level could, immediately or at a later point,
transfer easily and with full credit for work completed,
to an upper level program . . . . Such a career ladder
in education must have a recognized beginning, a definite
set of "rungs," and a total length that reaches the desired
ends (Lysaught, 1974, p. 253).

Many nurse educators realized that if nurse practitioners were to
be retained as active professionals, if turnover and withdrawal were to
be reduced, a rational educational system must be provided which promotes progress and long-term commitment. The system would be characterized by multiple points of entry, access to higher levels of challenge and accomplishment, and a recognition of the need for lifelong learning.

In early 1970 the Board of Directors of the National League for Nursing issued a statement supporting the concept of open curriculum in nursing education. The National League for Nursing then involved itself in a program of study and action directed toward: (1) identifying schools and consortia engaged in implementing the open curriculum concept through the mechanism of an annual survey, and (2) the study of a selected small group of these schools. A sample of 51 schools were involved in a total of 32 open curriculum programs. Six of the programs were consortia (Open Curriculum Conference IV, 1976).

Area One Vocational-Technical School now called Northeast Iowa Technical Institute at Calmar was identified and selected by the National League for Nursing to participate as one of the project schools. Area One at Calmar initiated its open curriculum in 1970.

The action phase of the study called for four national conferences. The conferences, held in New York, were made possible through funds provided by Exxon Education Foundation and the Educational Foundation of America.

Open curriculum concepts were encouraged by the Iowa Board of Nursing. According to the Iowa Board of Nursing Communication of October 15, 1978, the Iowa Schools of Nursing are:
26 practical nursing programs, 8 of these are generic and 18 have the ladder concept. 
16 associate degree nursing programs, 3 of these are generic, 11 are ladder concept, and 2 admit only practical nurses. 
11 baccalaureate degree programs, of these 8 are generic and 3 are upper division. 
9 hospital diploma programs (Board of Nursing, Note 11).

The Iowa schools participation in innovative programs has promoted accountability in education of Iowa nurses. McMullan (1975) stated that "... nursing education must see itself as not only accountable for providing students with the quality of education to which they are entitled, but also with the kind of education that will prepare them to meet the people's health and nursing needs" (p. 502).

According to Lenburg (1976), society requires more flexible opportunities for education while obtaining an even higher standard of excellence in performance. While recent major strides have been made in making technical level nursing education more accessible, flexible and individualized, progress has also been made in higher education.

The use of educational technology, challenge examinations, modules, and competency-based approaches have made learning more reality-oriented and beneficial, especially to experienced adult learners . . . . Many of the most important points emphasized by these alternate patterns [of education] is that the responsibility for learning belongs to the student and that the teachers are education planners, facilitators, and evaluators. Florence Nightingale must have perceived this when she wrote in the preface to Notes on Nursing: "I do not pretend to teach her, I ask her to teach herself, and for this purpose I venture to give her some hints" (p. 172).
The New Profession: A Summary

This is an important time for nursing to change its image. It is important for nurses to be seen not only in a caring role but in an assertive and authoritative role as well.

The question concerning the Woman's Movement and its impact on the development of nursing education is of prime importance. Many nurses now realize that colleagueship within nursing can occur through a change in attitude in relation to subordination. The forces which have supported the nurse's subordinate role include religious and military influences, and the servile status of women. In addition, the bureaucratic hierarchy of the health care system has also served to prevent nurses from giving direction in health care delivery. Finally, nurses are socialized not to take risks. Rather, they are socialized to perpetuate things as they are.

There are many changes occurring in the conflict between the historical orientation to nursing and the new scientific era. The historical orientation of service and obedience is giving way to the activities of nurse scholars.

Nurses cannot be successful in the future if they are not willing to look at their position in the past. The nurses can only break away from the oppressive past by understanding their history. One lesson of history is how not to repeat past errors.

The question of economic factors in relation to the development of professional nursing education cannot be ignored. Economic factors have caused a change in the role of the nurse. Schools of nursing have been created or expanded to meet the needs of local institutions, not of a
larger community or the nation.

The role of the nurse will continue to change. New practitioners will function more independently and will probably tend to be more specialized. The great danger is that nurses will move away from the practice of nursing in an effort to "extend" the physician. There is a body of knowledge unique to nursing. Nurses must learn the pitfalls of expanding practice into the functions performed by physicians. The nurse practice acts of each state must be carefully written to avoid legal subordination of nurses.

How nurses should be educated has been a highly contested issue in nursing's long history. Iowa nurse educators have responded to changes in nurse education practices. In Iowa, hospital school graduates seeking further education are not penalized for their hospital school preparation. But there could be cause for concern over whether or not the profession of nursing itself was being penalized by a patchwork system of remedial education programs. There is no evidence of planning for total nurse education. Each program appears to be meeting its own needs. Additionally, there appears to be a great rush to lure nurses into any type of an educational program. There seems to be worry about the consequences of selecting one fully professional modality of preparation for nursing. A baccalaureate in anything is considered adequate for professional practice, including teaching nursing. While Iowans can be pleased with the innovations in nursing education that have taken place in Iowa, there is a need for concern about the lack of state wide planning for nursing education.
Chapter Eight: Summary and Conclusions

The study of the evolution, emergence, and expansion of nursing practice evokes both a fascinating and a frustrating response. The nurse has moved from a knowledgeable, respected, skilled, independent practitioner to the subservient status of an assistant to another member of the health care team. The present struggle to regain the former independent status has been faced with severe opposition from the same groups throughout time, including some nurses who find being assistants to physicians a prestige symbol and personally rewarding.

Educational programs that prepare nurses to enter practice have been changing since just prior to the turn of the century. Over the past 40 years, many studies have been conducted but none yet has listened, heard or heeded their recommendations. The concept of collegiate education for all registered nurses has been supported by many studies, but the movement of nursing into college programs has been slow and difficult. Resistance to collegiate education for nurses has developed from physicians, hospital administrators, and nurses themselves. The resistance has its base in economy, social status of women, and tradition, to name just a few of the major forces.

The original model of nursing education, as described by Florence Nightingale, was adopted in the United States about 1873 and stressed self-discipline, devotion to duty, and morality rather than intellectual learning. Nightingale insisted that nursing instruction be given in an educational setting which was independent of the service agency. However, in the United States, nursing schools soon became part of the
hospital. As a result the nursing school was controlled by hospital boards and administrators. The nursing schools were founded to provide nursing service for the hospital. The students were used to solve the desperate staffing problems of the hospitals. The students labor was inexpensive, available, and caused no major administrative problems. The thought of hospitals functioning without a three-year apprenticeship program for nurses simply did not exist.

Through the efforts of a few leaders, nursing organized in an effort to improve training programs and gain licensure. By 1900, there was some improvement in the educational system that stressed education along with service. However, students still worked long hours with only a minimal amount of formal classroom instruction.

Nightingale had been recognized as an expert statistician. She was elected to fellowship in the Royal Statistical Society in 1858, and to honorary membership in the American Statistical Association in 1874. Regretfully, a research approach to solving nursing problems was not transmitted as a part of the Nightingale tradition. The development of inquiring minds was not a part of the American training schools system for nurses. The apprenticeship system effectively checked the spirit of inquiry.

The first major college-affiliated nursing program was established at the University of Minnesota in 1909. However, upon graduation nurses were awarded a diploma rather than a degree. In 1916, a five-year degree program was established at the University of Cincinnati, and in the next seven years, 22 other colleges had developed such programs.
In 1923, the Report of the Committee for the Study of Nursing Education emphasized the need to strengthen educational studies for nurses. This was not an original idea. Nurse educators had been struggling with the problem for over a quarter of a century. The 1923 report criticized the continued use of student nurses for hospital services. Following this report the exploitation of students for hospital service began to draw to a close. But, it was difficult for many nurses to differentiate between exploitation and learning, since they had been taught under the old apprenticeship program.

The National Nursing Council sponsored the first major report stressing the importance of collegiate education for all registered nurses. The report was written by Esther Lucille Brown and published in 1948. The report supported a change in the educational philosophy of nurse preparation, stating that a college education should be provided for all nurses entering practice on the professional level. The same year the Committee on the Function of Nursing issued its report calling for two levels of nursing personnel: the practical and the professional. The professional was described as someone with a basic collegiate educational background.

In 1952 the two-year degree program began. Although this program was counter to the recommendations of both the Brown and Ginsberg reports, the idea of associate-degree education for nurses quickly spread. Prospective nursing students were then able to choose a two-year associate degree program, a three-year hospital diploma program, or a four-year baccalaureate degree program. Each program prepared the
student to write the same licensure examination. The levels of job stratification were unclear without definitions of the responsibilities. Any nurse could do any job. With any nurse doing any job, additional pay for additional education was not a reality.

The American Nurses' Association, in 1965, presented a position paper which suggested a two-level division of nursing practice: technical and professional. The technical nurse was to be educated in the associate degree programs while the professional nurse would have a baccalaureate degree. This simple solution, however, has been difficult for the profession to implement ("ANA's First," 1966, pp. 515-517).

In 1970, the Report of the National Commission for the Study of Nursing and Nursing Education, directed by Jerome Lvsaught, was presented to the profession. It expanded the position paper of the American Nurses' Association and called for articulation between the levels of nursing preparation. Articulation has been difficult to implement. Without a clarification of the nursing roles, nursing educators are caught between the ending of one role and the beginning of another.

In 1978, the American Nurses' Association House of Delegates voted to support the baccalaureate degree as the minimal educational requirement for the professional nurse to enter practice. The action was long overdue. However, in this final hour, many nurses are reluctant to support this change.

Iowa nurses met in 1904 to formulate the Iowa State Association of Graduate Nurses. It was this organization that struggled to gain registration for nurses. This organization also pushed for improvement
in nursing education and practice. Apprenticeship type nursing education programs were located almost everywhere there were hospitals. Hospitals with schools varied in size from four to over one hundred beds. Even with the law requiring registration of nurses, there was an acknowledgment of the need for standards and uniformity in nursing education. The employment of a state educational director was a long awaited goal of the I.S.A.C.R.N.

Iowa Schools of nursing showed the same improvements noted on the national level. During the 1920s, many schools discussed the possibility of affiliating with high schools for chemistry, dietetics, psychology, bacteriology and physiology. During the 1930s, the emphasis on the development of a curriculum, the use of the graduate nurse in hospital work, and the shorter work week for students concerned nurse educators in Iowa.

World War II found Iowa schools of nursing involved in recruitment of students, building of better nurses' homes and teaching laboratories, and participating in the U.S. Cadet Program. Postwar years were filled with the shortage of nurses and the development of a system of accreditation for the nursing schools. The University of Iowa College of Nursing began to function as a truly collegiate nursing program.

The Iowa Board of Nursing has a history of facilitating education for nurses. Since late 1970 there has been a growth in the number of nursing programs that encourage articulation between levels of education.

The Iowa Nurses' Association endorsed the 1978 American Nurses' Association House of Delegates support of the baccalaureate degree as
the minimal educational requirement for the entry level of professional practice. With the Iowa Board of Nursing encouraging nursing programs to promote articulation between levels of education, and the Iowa Nurses' Association endorsing the baccalaureate level as entry level for professional practice, it would appear Iowa is ready for the future.

Major Findings of the Study

Has the Woman's Movement had an impact on the development of nursing education? Have nurses been supportive of the Woman's Movement? The answer to these questions is evident. To the detriment of their own growth as professional persons, nurses were among the most conservative of all women. They were, with rare exception, nonfeminists. Instead, the early leaders in nursing identified with limited social movements. These social movements were in the direction of the development of hospitals. Apparently, the early nursing leaders were unable to see their status as second-class professionals.

This failure of nurses to identify with the larger social movement of Women's Rights led to the failure of the nursing profession to liberate either education or nursing practice. Nurse education was a part of hospital management. The women were exploited in the hospital system. Other than providing efficient care for the sick, nurses have had little influence on health care development in this country. Hospitals grew to major businesses because of the nursing care. The reward for nurses was further oppression of women in the health field.

Historically nurses were among the conservatives. The nurses assumed very narrow political and social positions, devoting attention
not to major issues to change the social order itself, but to limited problems related to their own professional and educational development. Thus, nurses have made little progress in the professional world which is still dominated by men. Women have remained an oppressed class, with nurses the most oppressed of women.

What role did religious factors play in the development of professional nursing education? Are religious factors significant today? It would be difficult to separate nursing from its religious heritage. The great element of altruism contained in the Jewish religion later became further emphasized by Jesus Christ in His teachings of love. The care of the sick, the poor, the orphans, and the travelers were the practical expression of this altruism.

Nursing became one of the few acceptable means for women to express self-actualization, or to support themselves. The nurse was to nurture her patients as a mother nurtures her children, and to show deference to the physician as a wife to a husband. The nurse-mother role is with us today. While resented by physicians as a colleague, the nurse was nonetheless valued as an aide. The strict discipline of religion served to control the behavior of nurses, to keep them in their "place."

In Iowa, many of the early hospitals were established by Catholic sisters. The goal was to care for the sick and homeless. The establishment of schools of nursing as a part of the hospital resulted in a large number of Catholic schools of nursing in Iowa. In addition, other religions, such as the Lutherans and Methodist, were responsible for establishing hospitals, and consequently schools of nursing, in Iowa.
How did economic factors influence the development of professional nursing education? Was the establishment of nursing education programs reactive or proactive? The evidence indicates that the economic influence on the development of professional nursing education has been profound. Additionally, nursing programs in Iowa have been initiated as a reaction to local needs. This study revealed that the problem of shortages of nurses was basically an economic problem. Lack of pay, poor working conditions, and poor hours, all are indicators of poor economic conditions. This study revealed that the usual method or procedure for solving the problem of a shortage of health care workers was to initiate a new classification of worker and call her "nurse." The heterogeneity of persons labeled "nurse" commonly prevents communication between nurses. This lack of communication deters the growth of nursing as a profession. In addition, there is no recognition of career differences in nursing. Because recognition of the need for career differences in nursing is absent, the public is left at the mercy of a largely undifferentiated group of personnel all called "nurse." Economic influences have been primary in nursing's educational system. Nurses have attempted to respond to every need. Therefore, nursing's educational system prepares persons for three different entry levels to practice but licenses for only two of these levels: (1) registered nurse practice, prepared in associate degree programs and hospital programs, and (2) practical nurse practice. Baccalaureate prepared nurses are not licensed separately. At the same time, the baccalaureate degree, with a substantive upper division major in nursing, is considered the cornerstone
of the nursing education system.

In relation to the question of whether nursing education programs were established reactively or proactively, the evidence indicates a lack of statewide planning for nursing education. It appears that nursing education programs in Iowa have opened and closed in response to short term local needs.

Statewide planning for nursing education must be responsive to the state plans for higher education. In many states, nurse educators can benefit from the greater interest in higher education being expressed by the youth of today. Leon (1967) states:

. . . the youth with intelligence who go to college will not study nursing if no nursing programs are available. In one five-year period recently ended, for example, the number of women entering college increased by 50%, while the number entering all the schools of nursing which prepare registered nurses increased by only 6%. An even higher percentage of college graduates are entering graduate school, but again this does not mean they will enter graduate nursing programs unless planners can take advantage of this development in higher education (p. 14).

Leon (1967) states that comprehensive statewide planning must be geared to prompt action. Each type of nursing education must be in balance. For example, if too many aides and practical nurses are produced, the quality of care is diluted and supervision skimpy. When too many baccalaureate level programs are established too rapidly there is an acute lack of qualified faculty, resources, and students (p. 16).

According to Leon (1967) the planning must be continuous. The spot check type of study is costly and not always effective. Both short-term and long-term goals should be developed and priorities established. Planners must be able to study the nursing situations in their state and,
be able to pinpoint the most strategic problems immediately and go to work on these at once. The best plans are unfinished. Flexibility in planning within a stable framework should permit experimentation without capricious action to meet very temporary local needs (pp. 17-18).

Public support through well planned use of mass media is necessary to a successful planning program. This type of publicity also provides information helpful in recruiting students by informing them of the variety of education and careers available.

Planners must cope with the pressures of politics, traditions, and vested interests. According to Leon (1967) the planners must assess and, if necessary, change public attitudes toward health and nursing. "When ideal planners present the ideal plan to the real world, they will encounter less than ideal circumstances" (p. 19). Stereotyped antagonisms and prejudices persist and are identified as follows:

- nursing leaders who are possessive about decisions affecting their fields
- hospital administrators - harried daily by rising costs, shortages of nurses, and increasing number of patients - who may not favor the changes in nursing practice and education
- physicians who adhere to sweeping generalizations regarding the solution of the nursing shortage
- educators who have little regard for nursing education
- legislators committed to special interest groups
- and a large assortment of other people who have pat, contradictory, sweeping or bizarre solutions to all nursing problems (pp. 19-20).

The planners must have a sound planning organization, be knowledgeable about nursing and related fields, develop a well thought out plan and gain strong support.
The cost of nursing education cannot be overlooked in the planning. The per capita costs are higher when enrollments are small. Yett (1975) alludes to some of the difficulty with the Nurse Training Act monies when he states:

Finally, for schools which meet the eligibility re-requirements, each increase in enrollment brings a $100 bonus, over and above their annual $250 per student operating subsidy, and another bonus of $250 when the student graduates. Predictably, attrition rates – already low in comparison with other forms of higher education – will fall.

If this is brought about via better applicant screening, student counseling, tutorial programs, etc., no adverse "quality" effects are likely. However, if standards are lowered in order to graduate a higher portion of entrants, this aspect of the legislation could have serious negative "quality" implications (p. 267).

Implications not mentioned by Yett (1975) are of the opposite effect. The number of clinical opportunities does not increase merely because there are increased numbers of students. Therefore, competition to maintain a place in the nursing program becomes fierce and students with grade point averages of 3.6+ are forced to make alternate plans for their education.

Also not mentioned by Yett (1975) is the fact that the funds are available only for full time students, a deterrent to encouraging part time programs or part time students.

Planners should try to keep the cost of education to students as low as possible. A large number of students in all types of nursing education programs requires partial or total scholarships, fellowships, or loans. Planners must estimate the funds needed for this purpose and identify potential sources of such funds. A large number of programs, each with a small number of students, is financially unsound.
The job market must be considered in the planning. Yett (1975) states in part:

there must be "explicit recognition of the fact that oligopsonistic [hospitals] employers will almost certainly report "vacancies" even though they are unwilling to attempt to fill them by raising wages. Moreover, they will report such "vacancies" whether or not a "shortage" exists . . . he will not be willing to pay higher salaries, but he would be willing to hire more labor at the going salary. Under these circumstances, vacancies . . . will not exercise any upward pressure on wages (p. 76).

Although the American Nurses' Association has had an Economic Security Program in effect for over twenty-five years, and virtually every state nurses' association has developed some type of economic security program, results in securing satisfactory wages have been slow. Probably less than 10 percent of all active professional nurses are covered by collective bargaining contracts (U.S. Bureau of Labor Statistics. Industry Wage Survey, 1971, pp. 219-221).

It is not difficult to list reasons why collective bargaining has spread so slowly among nurses (Miller, 1971, pp. 218-225). Many nurses do not expect to be permanently employed. Their responsibility for the patients' welfare makes a strike more of a moral issue than in most other occupations. Some nurses feel that collective bargaining would deprive them of their status as professionals (Kleingartner, 1967, pp. 236-245).

Low paying jobs, frustration in practice because of a chronic condition of understaffing, and high cost of education will not attract clear thinking individuals into nursing.
The planning success must be evaluated. Leon (1967) names the
criteria for evaluating success in planning:

Three main criteria may be used to gauge success:
. Are the right kinds of programs in the right places?
. Are they high quality programs?
. Are these programs attracting students of the quantity
  and quality desired?

More specifically, a planning body may ask itself some
subsidiary questions in order to evaluate more precisely
the results of its planning efforts:
. Are enough well-qualified teachers being prepared
  for the programs in which they are needed?
. Are enough top-flight leaders, administrators and
  specialists being prepared?
. Is the supply of nurses achieving better balance
  among the professional, technical, and vocational
  categories?
. Is the capacity of all institutions offering nursing
  education expanding sufficiently to accommodate the
  present and projected supply of students?
. Are students enrolling in the right kinds of programs?
. Are nursing services and nursing education opportunities
  well distributed throughout the state?
. Are large medical centers finding the kinds and numbers
  of nurses they need for all their programs (many of
  which are highly specialized)?
. Is there a faculty development program or an in-service
  education program in every educational and service
  agency in the state?
. Is there an up-to-date continuing education program? Is
  its remedial function (short-term education for
  unqualified personnel) still needed?
. Is research paying off? (pp. 37-38).

The planners should also evaluate their own planning methods in
light of their ability to modify their goals and plans. The quality of
their studies should be evaluated in light of realistic action suggested.
It does not seem reasonable to suggest, as did the Brief study, that job
dissatisfaction is corrected by preparing fewer practitioners to become
dissatisfied. Leon (1967) concludes:
For many public and private institutions, the statewide plan will provide a sense of direction and assurance to institutional planning for nursing which may not previously have existed (p.38).

What has been the effect of medical domination on the development of professional nursing education? Male dominance is a problem for women in the whole of society, but nurses have special problems in this respect. The sources of the conflict are deep rooted. Through the years the predominant behavior pattern between physician and nurse has been dominance by the former and deference by the latter. The explanation for this problem does not stem from tradition alone; the reasons are manifold. The lack of knowledge of the other's profession, psychosocial emphasis in education, the wide range of education existing among nursing personnel, the two systems of authority in the hospital, and nursing's lack of control over nursing all have been implicated in the physician-nurse conflict.

There is power in knowledge. It might be worthwhile to question the physician's objection to higher education for nurses. This study has indicated that physicians, as a group, have not favored higher education for nurses. Indeed, they have openly objected to the concept of higher education, and have supported the diploma programs. Given society's need for well-educated professionals, it seems reasonable that a broad-based education, as found in a collegiate program, is desirable for the professional nurse.

The rapid growth and complexity of the health-care delivery system, the increasing technology, and the vast new information available in the
social and physical sciences give impetus to a broad based college program for nurses. The wide variety of courses afforded the college or university student provides a background of current information that is relevant for today's practice. The background of information is essential as an integral part of the strong base upon which tomorrow's practice must grow. Collegiate nursing courses are not centered on hospital practice. The collegiate nursing courses provide a wide variety of clinical experience in recognition of the changing and expanding roles of the nurse. These experiences move the student through the hospital, the community, and the multiplicity of areas open to nurses outside the hospital setting. Future nursing roles will continue to be too numerous for nursing education to focus on any one aspect. It would be shortsighted to expose students to only one type of practice.

Perhaps, by supporting the baccalaureate degree as the minimum requirement for professional nursing practice, society will recognize that nursing has a knowledge base that can only be acquired through an extended period of time in an educational setting. The college classroom has traditionally been used for the transmission of knowledge in other professions. The hospital diploma programs have modified their own programs to offer general college courses. Some have even altered schedules to simulate changes initially found in college settings. It seems incongruous to continue producing professional nurses through methods other than traditional college education, when for more than one
hundred years American colleges and universities have provided society with a highly successful mode of professional education.

The nurse's status among other health professionals is also relevant to this issue. To be recognized as an equal member of the health team, the nurse must be as well educated as the other members, who, from social worker to nutritionist, and from pharmacist to doctor, all have, at minimum a college degree. Nursing must continue to exert its influence in patient-care situations with as much educational know-how as other health care professionals. Nurses educated in the academic atmosphere of the university are exposed to a socialization process that influences their own and other professionals' concept of the nurse. From interaction with other professionals, the nurse gains a similar background to that enjoyed by other professionals.

The present health care system is not satisfactory. Consumers' health-care expectations have, in many instances, surpassed the services presently available. Consumers have become increasingly educated and their demand for responsible care has increased accordingly. Nursing, as a part of the health care system, must continually reevaluate its role. Many college programs have acknowledged this responsibility and have directed themselves to the examination and modification of the nurse's role. Collegiate nursing is attuned to society's perception of health as a personal asset. Curricula in the collegiate programs have been altered to reflect society's perception of health. These programs have expanded to include many and varied health promotion aspects, such as physical assessment skills. In addition, college nursing programs
have recognized the need for outpatient and ambulatory health care and have pursued new directions in an attempt to keep pace with society's needs and expectations of health-care delivery.

Nurses are faced with a choice of continuing to permit medical domination of the health care field, including nursing education, or of taking control of their own practice and education. Control of nursing practice belongs in the hands of the nurses. From all educational and experiential backgrounds, and from all levels in a bureaucratic hierarchy, nurses must act as colleagues to share problems in nursing practice and education.

Conclusions

The purpose of this study was to provide contemporary nursing educators in Iowa a written account of the development of early schools of nursing in Iowa. Additionally, the study traced and recorded the growth and development of those schools that today provide diploma or baccalaureate level nursing education. This purpose has been accomplished.

Specific questions addressed were: Has the Woman's Movement had an impact on the development of nursing education? Have nurses been supportive of the Woman's Movement? What role did religious factors play in the development of professional nursing education? Are religious factors significant today? How did economic factors influence the development of professional nursing education? Was the establishment of nursing education programs reactive or proactive? What has been the effect of medical domination on the development of professional nursing education?
There are no easy answers to the research questions. For the most part, the Woman's Movement is beginning to have an impact on nursing education. Assertiveness, autonomy, identity, and politics are being stressed by some nurse educators. However, the impact will probably not be remarkable. Presently, there are more "diploma" graduates serving as nurse educators in Iowa than baccalaureate graduates. Therefore, the values of the diploma system are being perpetuated. Many nursing students are being socialized not to take risks, not to question, but to maintain the status quo.

The religious factors played an important role in the development of nursing education in Iowa. The factors are more covert today, but they are still present. Nurses are still expected to possess "good moral character." Self-sacrifice, devotion to duty, and value of human life are still evident in nursing practice and nursing education.

Economic factors influenced the development of professional nursing education in Iowa in many ways. The first schools of nursing were begun as an economic undertaking. Schools of nursing have moved into vocational schools, in part, because of the increased economic value to the vocational school. Additionally, nurses as students, are being courted by universities and colleges. Nursing schools have opened and closed in response to short term local needs. When more nurses were needed, the school was expanded. When less nurses were needed, the schools were closed. All of the openings and closings appear to have been in response to the hospital needs, not the needs of the graduate nurses, or society as a whole.
The effect of medical domination on the development of professional nursing education in Iowa has been addressed throughout the study. Briefly, medical domination of nursing has prevented the growth of nursing as a profession. The wave of new practitioner programs should signal danger to nurses. The danger is that nurses will move away from the practice of nursing in an effort to "extend" the physician. The nurses must learn the pitfalls of expanding practice into the functions formerly performed by physicians. Physician dominance, combined with licensure laws and training programs which have been defined by the physicians, will ensure that nurses will not practice any more independently that formerly.

Recommendations:

As a result of this study, the following recommendations are made:

1. That each school of nursing develop within its own library its own archival materials.

2. That currently functioning schools record, in a scholarly fashion, their own history.

3. That the records of closed schools, other than those records required by the Board of Nursing, be collected in a central location. The University of Iowa Library Nursing Archive Section is suggested as the collection point.

4. That further studies be completed in the area of:
   a. methods to promote intraprofessional colleagueship among nurses.
b. the impact of legislating the baccalaureate degree in nursing as the minimal educational requirement for the practice of professional nursing in Iowa.

c. the feasibility of an ongoing statewide planning committee for nursing education in Iowa.

d. methods to promote positive nurse-physician relationship. Some approaches suggested are to foster open communications between nurses and physicians. Shared educational opportunities offers a potential method of developing team relationships.

e. nursing history for nursing students. Nursing educators must look at the type of education they are providing for their students. Do Iowa nursing students recognize the names of nursing leaders in Iowa? Are students taught subordinate roles? Does the reward system respond to intra-professional colleagueship? Do hospital administrators value diversity in nursing's educational preparation? Is creative decision making rewarded? Do Iowa nurses know and understand their history?
This research has demonstrated the impact of the historical role of women on the development of nursing education in Iowa. Additionally, the economic pressures of health care delivery, the relationship of traditional medicine to nursing education, and political activities have been examined. The research has documented the development of a profession from its earliest prescience role to its current emphasis on preparatory education in science, psychology, and education. The need to understand the history of nursing, in order to better plan future educational programs, has been presented. Understanding of the history of nursing will provide a basis for the establishment of minimum educational requirements. Professional practice can be improved through a better understanding of the past. The future of nursing rests now on efforts to articulate the desired roles of nurses, development of theories, procedures and knowledge which facilitate those roles, and the implementation of those educational programs and standards which insure quality of health care delivery services.
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