

EVOLUTION OF THE PROFESSIONAL NURSING ORGANIZATION:
DEVELOPMENT OF POWER

by

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DISSERTATION

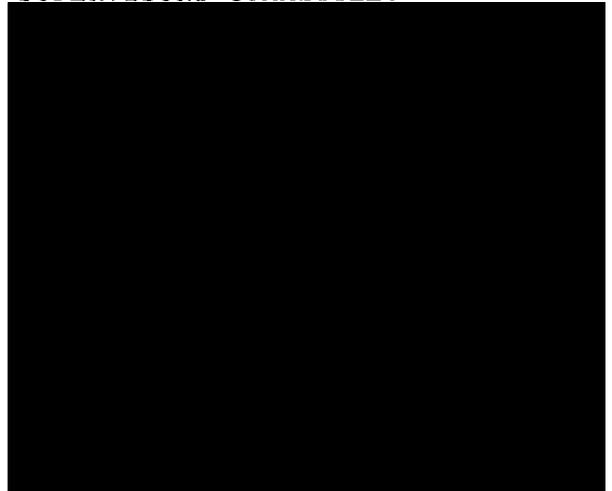
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An historical analysis of the evolution of the American Nurses' Association relative to its development was done. Concomitant to that historical evolution, Peter Blau's conceptual framework of power as a social relationship was analyzed.

The issue of power of the nursing profession has been an ongoing concern to nurses. Early nursing leaders believed that the most effective way to obtain power was through the formation of organizations for nurses. They also believed that collectively nurses could address such issues as self-regulation of nursing education and nursing practice. The attainment of this regulation would give to both the profession and the association power. Thus in 1896, the American Nurses' Association (ANA) was organized as the association to

represent professional nursing in the United States. Today, it represents the largest group of registered nurses. Therefore, for purposes of this study, ANA was referred to as the professional nursing organization.

The purposes of conducting this study of the American Nurses' Association were to:

1. Trace the evolution of the professional nursing organization (ANA) relative to the development of power
2. Illustrate structural changes and their effect upon the organization's development of power
3. Demonstrate the use of power to influence acceptance of controversial issues
4. Identify changes that have occurred within the organization to promote its power

An analysis of ANA historical material from its inception in 1896 until 1980 was performed. The years 1896-1980 were divided into five time periods considered by the author to be critical. Data were analyzed within these time periods in light of socio-economic and political factors impinging upon the profession.

The historical data led to the conclusion that nursing leaders, working through ANA, were able to unite groups of nurses to work toward common goals despite

controversial issues. Through structural changes, ANA was able to build upon its developing power base, thus strengthening the association. The data also showed that ANA was a multi-faceted organization which was impacted from internal as well as external concerns. Even so, ANA was not only able to build a strong national association but contributed to the strengthening of the state associations.

Additionally, there was evidence that despite ANA's position on controversial issues such as the entry level for professional nursing and its economic and general welfare programs, ANA was able to gain support and implement those programs. Even when nurses had left the organization to join other nursing groups, ANA was able to work collaboratively with those groups toward mutual goals.

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CHAPTER I

INTRODUCTION

The issue of power of the nursing profession is one of concern to nurses. This concern has been present from the formation of the first two formal national organizations for nurses, the American Society for Superintendents of Training Schools for Nurses in 1893 and the Nurses Associated Alumnae of the United States and Canada in 1896.¹ The need for affiliation of nurses and the need for control of educational preparation was recognized by early leaders of the nursing profession (Dock, 1900, p. 9; Palmer, 1900, pp. 59-60). They also identified obstacles that hindered the profession's attainment of this control and power. The nursing leaders believed that the most effective way to deal with those obstacles was through the formation of associations or

¹The American Society for Superintendents of Training Schools for Nurses changed its name to the National League for Nursing Education in 1912, and in 1952 it combined with other national nursing organizations to become the National League for Nursing (NLN). The Nurses Associated Alumnae of the United States and Canada changed its name to the American Nurses' Association (ANA) in 1911. For the remainder of the paper these two organizations will be referred to as the NLN and the ANA.

organizations of nurses. Those leaders also noted that organizations were necessary for nurses to work toward obtaining characteristics they believed necessary for nursing to become a profession. The characteristics were: a scientific body of knowledge, self-regulation of nursing's educational programs and practices, and an official journal (Palmer, 1900, p. 59). There was a belief that the attainment of those characteristics would bring power to an organization or profession.

The American Nurses' Association assisted nursing in its evolution as a profession and in its development of power. The establishment of the American Nurses' Association "brought nurses to where they were ready to work for the good of not the individual nurse or individual school of nursing, but the whole profession" (Damer, quoted in Flanagan, 1976, p. 4). The American Nurses' Association (ANA) has from its beginning in 1896 spoken for nurses and for nursing. Today it represents the largest group of registered nurses. Therefore, for purposes of this study, ANA will be referred to as the professional nursing organization.

Statement of the Problem

Nursing has, since its inception, had difficulties establishing itself as a profession. Those difficulties emphasized the importance for nurses to

organize. The needs of a changing profession and a changing society have underscored this importance. The first attempt to organize nurses was the formation of the American Society for Superintendents of Training Schools for Nurses. At the International Congress of Charities, Corrections and Philanthropy in 1893, superintendents of training schools were invited to a planning meeting at the World's Fair in Chicago (First Annual Report of the American Society of Superintendents of Training Schools for Nurses, 1894, p. 19). Those nurses organized in an attempt to standardize curricula and instructional programs for nurses. To obtain membership in the society, the nurse(s) had to ". . . be graduated in good and regular standing from training schools connected with incorporated and well-organized hospitals" (First Annual Report of the American Society of Superintendents of Training Schools for Nurses, 1894, p. 19). A primary goal of the NLN was the improvement and standardization of nurse education in the United States.

The second national nursing organization to be formed was the American Nurses' Association. This organization was for nurses who did not qualify for membership in the NLN but who also felt the need to be organized. This group represented the grass roots

effort of the profession. The focus of this organization was nursing practice and the welfare of nurses (First Annual Report of the American Society of Superintendents of Training Schools for Nurses, 1894, p. 19). This organization has and continues to represent American nurses by representing registered nurses in the United States and its territories.

In the attainment of its goals, nursing has been confronted with problems, both intrinsic and extrinsic to the profession. Three major concerns that have persisted throughout the evolution of modern nursing are:

1. The need to develop criteria based on educational preparation and practical experience by which to judge a nurse's competency
2. The need to establish laws which set forth certain standards deemed essential for nurses wishing to function in a professional capacity, and
3. The need to create descriptive terminology which reflects not only specific functions, but also levels of competency. (Flanagan, 1976, p. ix).

From the beginning of the professional organization, the profession and its leaders were attempting to address these concerns. Those early leaders believed that organized nurses could elevate the standards of nursing education, establish a code of ethics, and promote the interests of nurses (Flanagan, 1976, p. vii). Thus, the profession was attempting to establish its power through self-regulation.

Today, as in the past, most nurses agree upon the need for the profession to regulate the practice of nurses. However, within the profession there is disagreement regarding the solutions to issues and problems. The tolerance of lack of agreement and slow movement toward resolution has been viewed by some as a lack of power within the organization. Two controversial issues that have heightened these views are economic security through collective bargaining and the baccalaureate degree as the entry level into professional nursing practice. The organization's response to these issues has affected nurses' view of its power base. The ability of the leaders of the professional organization to get nurses to support positions can be viewed as an indicator of their power. ANA, therefore, needs to develop strategies to establish and maintain power bases that are visible to nurses, other professionals and society.

Purpose of the Study

This study is being conducted as an historical analysis of events that have occurred with the evolution of the American Nurses' Association. These events will be analyzed to determine their relationship to the establishment of the organization's power. The purpose of conducting the study is to:

1. Trace the evolution of the professional nursing organization relative to power
2. Illustrate structural changes and their effect upon the organization's power
3. Demonstrate the use of power to influence acceptance of controversial issues
4. Identify exchanges that occurred within the organization to promote its power

Significance of the Problem to Nursing

There is a "social contract" between society and the professions. Under its terms, society grants the professions authority over functions vital to itself and permits them considerable autonomy in the conduct of their own affairs. In return, the professions are expected to act responsibly, always mindful of the public trust. Self-regulation to assure quality in performance is at the heart of this relationship. It is the authentic hallmark of a mature profession. (Donabedian, 1972, p. xi)

As part of this contract, the profession needs to respond to a changing society and reflect these changes within nursing and within health care delivery in order to prepare for the future.

Historically, the changing roles in nursing practice as well as the educational preparation for professions in general, have necessitated a need for change in the educational preparation of nurses. From the inception of the first schools of nursing, there has been controversy over the education of nurses. There

was variation from school to school regarding length of the educational program, hours of practice, curriculum of the program, preparation of teachers and funding of the programs. Attempts were made to standardize these programs from one to two years and finally to three years with eight hours a day of practice (Flanagan, 1976, p. 28). The concern for standardization of programs led to a recognition of the need for legislation to establish and maintain a universal standard for nurse training. Early nurse practice acts were enacted to accomplish this goal. Despite these efforts by nursing, there were no mandatory nurse practice acts until 1950 (Ashley, 1976, p. 65).

Standardization of educational programs was the major concern of the early leaders of nursing. There was a gradual shift in the focus over the years. Today, changes in health care delivery, resulting from advances in technology, emphasis on health and prevention rather than illness, and a tremendous increase of aged population, have also necessitated changes in the roles and practice of nurses. These changes once more have implications for the educational preparation of nurses. There is an increased demand for the educational preparation of nurses to occur in institutions of higher education away from hospital control. Nursing needs to continue

in its attempt to gain and to maintain self-regulation of its educational preparation and nursing practice.

Additionally, nurses are assuming more leadership positions and are becoming more involved in setting health care policies. If nurses are to maintain and further develop these roles, then, they must be able to control both their educational preparation and standards for their practice.

The need to control both educational preparation and practice standards requires organization of nurses. The importance of organizing nurses and educating the public was recognized by an early nursing leader. "The power of the nursing profession was dependent on its ability to maintain the cooperation of individual nurses who had the ability to influence public opinion" (Palmer, quoted in Flanagan, 1976, p. 30). Today, as in the past, nurses have daily contact with the public and can use this contact to educate the public as to the roles of nurses and to the needs of the profession. ANA, as it speaks for nurses, must reinforce its power by getting nurses to articulate positions that are in the best interest of the profession. ANA's ability to communicate effectively with nurses and to gain support of nurses is an important indicator of its power.

The power of ANA is diminished by divisiveness among nurses. This lack of unity has centered on issues such as the baccalaureate degree as the entry level into professional nursing. Once again there is controversy over the educational preparation for nurses. Other issues such as the need to obtain economic security for all nurses have detracted from the entry level issue. Nurses also disagree as to the solutions for and priorities of issues. These disagreements should be discussed among nurses; however, once a goal has been determined, nurses should present a united front. When nurses display disunity rather than unity, they are in fact showing that they are "their own worse enemies." As Lysaught (1981, p. 29) states, "nursing must resolve its own ambiguities before it can assert its right to self-determination."

If nurses do not show that they are capable of controlling their own practice, then others are willing and wanting to control this practice. From the early formation of schools, physicians and hospital administrators have attempted to dictate how nurses were to be educated and where nurses were to practice. This early control by physicians and hospital administrators had the support of some nurses.

Nursing, in its attempts to move forward toward self-regulation and to meet its challenges, must be ready to act on its own behalf. ANA has in the past and continues to work for the advancement of the profession of nursing. ANA speaks for the interests of nurses as well as for the good of the profession. As ANA evolves in its attempts to meet the needs of nurses and the profession, it must also develop its power to fulfill its responsibility to society.

Definitions of Terms

For the purposes of this study, the following terms are defined in the way stated below:

Leadership. Nurses elected or appointed to official positions or structural units within the organization.

Structure. Units within the organization used to facilitate the organization's goals and mission.

Membership. Nurses who belong to the organization.

Nursing educational program. A formal course of study to prepare nurses. It is of such a nature that its graduates are permitted by the Board of Nurse

Examiners of the state to take the examinations necessary to become registered nurses.

Hospital diploma program. A hospital-based nurses' training program generally requiring three years to complete. Upon successful completion the graduate receives a diploma but not an academic degree and is allowed to take the state licensing examination to become a registered nurse.

Baccalaureate program. A college-based educational program for nurses generally requiring four to five years to complete. Upon successful completion the graduate receives a baccalaureate degree in addition to being allowed to take the state licensing examination to become a registered nurse.

Associated degree program. A junior college-based educational program for nurses lasting two years. Upon successful completion the graduate receives an associate degree and is permitted to take the state licensing examination to become a registered nurse.

Registered nurse. A graduate of a formal educational program who has passed the licensing examination given by the State Board of Nurse Examiners and has earned the right to use the title R.N.

Trained nurse. A nurse who had the benefit of having received a formal educational program prior to the advent of state licensing laws. The length of time in the educational program varied from hospital to hospital and from year to year.

Power bases. The sources of origins of power are obtained through the use of rewards, coercion, legitimation, reference and expertise. These are called power bases as formulated by French and Raven (1959).

Power. A relationship between two individuals where "B," the power subject, is willing to defer his wants to do what "A," the power holder, wants. It involves compliance of the power subject (Blau, 1964).

Self-regulation. Ability of the profession to control its educational programs and practice.

Methodology

Focus of study

The focus of this study will be an historical analysis of the evolution of the American Nurses' Association (ANA) to determine its relationship to the development of power. The ANA was chosen since it is the professional organization in the United States that is recognized as the collective voice for nurses in that

country. Currently, it is the organization that has the largest membership of registered nurses.

Nursing's professional society performs an essential function in articulating and strengthening, as well as maintaining, the social contract that exists between nursing and society, upon which authority to practice nursing is based. (ANA, Congress for Nursing Practice, 1980, p. 8)

ANA speaks to issues that affect all nurses, the nursing profession, and the profession's relationship to society. The Association has in the past and continues in the present to articulate the concern of nurses on nursing issues. Examples of these issues are economic security of nurses, educational preparation of nurses and standards of practice. The roles that the structure, leadership, and membership play in the development of power need to be analyzed. How these three roles interact also needs to be examined.

A second analysis, to determine how these three roles have been used to contribute to the establishment and maintenance of power in ANA, will be conducted using Blau's theory of exchange and power in social life. Blau's theory will be used as the theoretical framework for this study. His theory describes and explains the exchange or brokerage, that is, the "trade-offs" that occur between individuals and between individuals and groups or organizations in any social context. Blau's theory will be discussed in more detail in Chapter II.

Sources of data

Sources of data directly related to the early formation of the American Nurses' Association will be examined. These include: (1) minutes of early meetings; (2) proceedings of the conventions; (3) special reports; (4) staff documents; and (5) written histories of the organization.

Other sources to be examined are related to ANA's evolution in its articulation of issues and positions. These include: (1) position papers; (2) ANA publications, (3) reports of studies of nursing and nursing education; (4) reports regarding structural changes in the organization; and (5) professional periodical literature.

Analysis of data

An analysis of the materials related to the American Nurses' Association from its inception in 1896 until the 1980s will be done. This overall period of time will be divided into smaller segments of time to reflect suggested evolutionary phases of the Association. The identified periods will be:

1. Laying the Foundation--1893 to 1912
2. Structuring Organizations--1913-1946
3. Maturing: Further Evolution of the Organization--1947-1960

4. Controlling: Direction of Practice--1961-1979

5. Forecasting: Power Bases for Nursing--1980s
Data gathered will be arranged chronologically in these time periods. Major influences and their relation to the development of power in the organization will be discussed within each of these time periods.

External criticism of data will be done to establish the validity or authenticity of the documents. In order to determine reliability or the accuracy of statements within the documents, internal criticism of the data will be done. Any data for which doubts exist will not be used.

Data will also be examined using Blau's exchange and power theory to determine what power is, where power exists and where it does not, and how power is used by the Association.

Assumptions

The writer makes the following assumptions:

1. That the ANA needs to speak for all registered nurses
2. That the organization that speaks for all nurses be viewed as powerful

3. That Blau's exchange and power theory can be used to analyze the development of power within the organization

4. That the nursing profession through its Association has a responsibility to meet changing societal needs

Limitations

Limitations of the study include the scope and complexity of material to be analyzed. The evolution of an organization over such a long period of time involves many conflicting and overlapping issues and their various interpretations. This complexity presents a problem to the researcher.

This study is limited, also, in its focus on the examination of the standardization of education of nurses. Primary issues within designated time periods will also be discussed as they relate to the evolution of ANA.

Additionally, since the writer has been and is an active member of ANA, there is the possibility of personal bias. However, the researcher's awareness of this bias will be used to avoid prejudicial statements. This study was further limited by the amount of ANA historical material, the accessibility and availability of this material.

CHAPTER II

REVIEW OF LITERATURE

There is disagreement within nursing as to whether the nursing profession, in fact, has power. Kalisch and Kalisch (1982, p. 12) distinguish between actual and potential power. These authors state that the profession has potential power. The Kalisches state that nurses collectively have more potential power than actual power because they either choose not to or are unable to use their power. However, in their discussion of power, the concept is not clearly defined. As Beck (1982, p. 2) states, "total agreement among definers of power is non-existent." This lack of clarity and lack of a precisely stated, agreed upon definition necessitates going beyond nursing literature for a more in-depth look at the concept of power.

The literature on power has been reviewed in regard to two specific areas: (1) the concept of power, its description, various definitions, and typologies; and (2) tools that have been utilized to measure power or powerlessness, related concepts, and an individual's perception of his/her own power.

Concept of Power

Cartwright (1965) in his chapter "Influence, Leadership and Control" extensively reviewed various authors and their conceptualization of power. He discussed power in the context of organizations. The authors' definitions are derived from how they view power; for example, influence exerted by "actors," these actors being individuals, groups, roles, offices, governments, nations, states or other human aggregates (Dahl, 1957). Bass (1960) discusses power as "personal power" and "power of position." Other authors in their examples explicitly mention intention. Tawney (1931, p. 230) refers to the capacity of an individual to modify conduct in the manner which he desires. Russell (1938, p. 35) states that power is "the production of intended effects." Laswell and Kaplan (1950, p. 76) define power as the process of affecting policies of others with the help of severe deprivations for "nonconformity with the policies intended." Cartwright (1959, pp. 193-195) employs the concept of intention in defining "control" but not "power."

Cartwright, in his discussion of these authors' views, cites the differences and the similarities between their conceptualization of influence and control and their relations to leadership. Cartwright discusses

the concept of influence by (1) describing agent "O" as he exerts influence, (2) the method he uses to exert influence, and (3) agent "P" as he subjects himself to the influence. Thus, through this description we see how influence can be viewed as a dimension of power (1965, pp. 1-40).

Tedeschi (1974) in his book, Perspectives on Social Power, discussed how each definition of power is really a nominalistic device either for identifying a set of phenomena or for making a distinction between the types of phenomena that the theoretician considers to be important. Additionally, he believes that the papers contained in his book reveal that little consensus exists about the referent phenomena identified in the concept of power. Schopler and Layton believe that the attributions of power depend on the context of interactions, the outcomes for the parties involved, and the perspective of the observer (source, target, neutral third party) (Tedeschi, 1974, p. 5).

Sunar (1978) identifies two fundamental characteristics that theorists of power almost unanimously agree upon. First, power exists only in a social relationship between social actors. Second, power is a matter of ability or potential.

Clegg (1979) suggests that only with the emergence of task-discontinuous organization does the type of problem which has typically been characterized as "power in organizations" become apparent. This is the existence of unauthorized and informal sources of control over methods of production as a special skill uncontrollable at other levels of the organization.

Zander and Curtis (1962) assume that the private cognitions of "P" (the person whose behavior they are predicting) are determined by social pressures originating in "O" (other person) more effectively when these pressures are based on referent power than when they are based on coercive power. Zander and Curtis also assume that social pressures based on referent and coercive power are approximately equal in strength.

French and Raven (1959, p. 260), in their classic work "The Bases of Social Power," postulate a theory of social influence and power which is limited to influence on the person, P, produced by a social agent, O, where O can be another person, a role, a norm, a group or a part of a group. The authors go on to explicate that in cases where O intended to influence P in a given direction, a resultant force in the same direction may be termed a positive influence, whereas a resultant force in the opposite direction may be termed negative

influence. So that if O produces the intended change, he has exerted positive control, or if he produces change in the opposite direction, he has exerted negative control. French and Raven identify the relationship between O and P as the source of power.

French and Raven delineate five bases of O's power: (1) reward, (2) coercive, (3) legitimate, (4) referent, and (5) expert. Reward power is simply the ability to reward. Coercive power of O stems from the expectation on the part of P that he will be punished by O if he, P, fails to conform to the influence attempt. Legitimate power is based on the perception by P that O has a legitimate right to prescribe the behavior for him. Referent power is based on P's identification with O. Expert power is based on the perception that O has some special knowledge or expertness. The authors hypothesized that the stronger the base of power, the greater the power.

Most people have an intuitive sense of power. But scientists have not as yet formulated a statement of the concept of power that is rigorous enough to be of use in the systematic study of this important social phenomenon (Dahl, 1957). Dahl defined power in terms of a relation between people. He examined it in reference to the relative degree of power held by two or more

persons. Dahl specified that the means of exploitation of power is a "mediating activity by A between A's base and B's response."

Kalisch (1982, p. 2) stated that:

Power makes people do things that they might not otherwise do, or stops them from doing things that they might do. It can be thought of as potency or mastery, and the hallmark of power is effectiveness. The essential attribute of power is the capacity to determine or influence some aspect of the behavior of others, either individually or collectively.

A review of the literature on power is not complete without examining its opposite, impotence or powerlessness.

Studies that measure powerlessness

Several major studies have also tested the concept of powerlessness and related concepts. Neal and Seeman (1964, p. 216) developed a seven-item forced choice questionnaire that measured the perception of powerlessness. They identified the importance of organizational ties between the isolated individual and the massive state. The authors stated that the isolation produces a sense of powerlessness. This perception by the individual is a critical form of alienation. Neal and Seeman concluded that membership in a work-based organization is associated with a relatively strong sense of control over events, and the higher perception

of powerlessness of the unorganized worker is not simply a function of his socioeconomic status. The measure used in their study defined powerlessness as "low expectancies for control of events." The events are those which are most directly relevant to the idea of the mass society, e.g., control over the political system, the industrial economy, and international affairs.

The measurement scale used in Neal and Seeman's study was previously used by Seeman and Evans (1962) in their study of "alienation and learning in a hospital study." They confirmed their prediction that high alienation and poor learning are associated. From the patient's viewpoint, the situation is one that cannot be controlled by his/her own action, including the action of becoming knowledgeable about his/her situation.

Modifications of the Neal and Seeman measurement tool have been used to study perception of powerlessness in patients (Bullough, 1972; Guilbert, 1972; Roy, 1976; Farmer, 1981).

Another major study was Rotter's (1966) which summarized several experiments on internal versus external control of reinforcement. These experiments defined group differences in behavior when subjects perceived reinforcement as contingent on their behavior versus chance or experimental control. Rotter used a

forced-choice twenty-nine item scale including six filler items. By a series of studies Rotter (1966, p. 25) strongly supported the hypothesis that the individual who believes he can control his own destiny is likely to: (1) be more alert to those aspects of the environment which provide useful information for his future behavior; (2) take steps to improve his environmental condition; (3) place greater value on skill or achievement reinforcements and be generally more concerned with his ability, particularly his failures; and (4) be resistive to subtle attempts to influence him.

Srole (1956) conducted his research using an attitude-type scale which operationalized the concept of anomie (self-to-others alienation). A five-item forced choice--agree, disagree--measurement tool was administered. Srole's studies support the general hypothesis of an interactive process linking the individual's state of anomie with his/her level of interpersonal dysfunction.

Powerlessness was examined by Langford (1979) in a doctoral dissertation. The author proposed an inverse relationship between students' sense of academic powerlessness and their commitment to nursing. The hypothesis was supported in her findings. A Likert scale was used to measure students' perception of powerlessness.

All scales were examined for reliability and validity using factor analysis, Cronbach's alpha, and Guttman's scalogram procedure.

Studies that measure power

Tannenbaum and Kahn (1957) investigated power in the organizational structure of four local unions. For their study, they used a general schema which they called a "control graph." This graph is a descriptive technique for the study of organizational control structures. The horizontal axis represents a scale of hierarchical levels in an organization. The vertical axis represents the amount of control instituted by these various hierarchical levels. A curve may then be plotted by connecting the points that show the amounts of control or power characteristic of each hierarchical level.

Tannenbaum used the control curves to obtain information about the organizational structure of these unions. The curves showed how the control/power was distributed in the unions and how the total amount of control was instituted in each union.

The investigators asked union members to complete questionnaires used to assess their perception of control/power within the organization. These perceptions were checked by the investigators' observations

and judgements of international officers. The authors equate active control with power and passive control with constraints.

Dieterly and Schneider (1974) studied the concept of power using French and Raven's five bases of power. The subjects' perception of their own power (five dimensions) and their perceptions of the four aspects of organizational climate were investigated as a function of three characteristics of the work environment (level of participation, stockholder or customer orientation, and position level).

Subjects were 120 male and female undergraduate students taking the introductory psychology course at the University of Maryland, College Park. They had to report to a "personnel office," complete a set of materials and be available for one other session. If they agreed, they selected another day to work at the simulated job and then completed a job application, the Wonderlic Personnel Test, and the Allport-Vernon-Lindzey Study of Values.

On a later date, subjects appeared at a classroom. Upon entering the room, they each received a packet of materials with their name on it. The materials contained in the packet were a letter from the company president, a letter from the Chief of the Credit

Approval Department, the simulated work task with rules for completion of the task, and an organizational chart showing their formal position in the company. The session lasted ninety minutes, in which each subject reviewed a series of thirty credit applications.

The packet of materials was given to each subject randomly assigned to one of twelve experimental groups. Subjects all worked independently and were tested in groups of twenty to thirty at a time. The three independent variables were position level, degree of participation in decision making, and orientation toward customer.

At the end of the ninety minutes, the materials were collected and the subjects were requested to complete a job survey which contained statements relevant to the five power dimensions (reward, coercive, legitimate, referent, and expert) and the four climate dimensions (individual autonomy, position structure, consideration, and reward orientation). There were seven questions for each dimension. Respondents were asked to indicate their agreement (1 = strongly disagree, 5 = strongly agree) with the statement as a perception of themselves in their job (power) and their perceptions of their job and company climate. The

subjects were each given two credits for participating in the study.

As a result of this study, Dieterly and Schneider conceptualized the behavior of individuals in organizations to be a function of two perceptions: the individual's perception of the climate existing in an organization and the individual's perception of his/her power. Levels of participation appeared to be the main contributor to self-perceived power. Data were subjected to a series of analysis of variance (ANOVA) tests on each dimension of power and climate. There was no mention of reliability or validity of the tool used.

Another study was conducted by Raven and French (1958) using female undergraduate students. They were divided into two groups and given a task to complete. The students were to "elect" a supervisor for each group. They completed a questionnaire related to the task. In only one of the groups was the supervisor actually elected. Raven and French hypothesized that in an interdependent situation an election process would serve to grant to an individual a legitimate right to a supervisory position. Thus, the supervisor would have greater power to influence his/her fellow workers, and would be accepted personally. Both of these hypotheses were supported.

In yet another study to test power, Stolte (1978) hypothesized that persons located in central exchange networks will, through the bargaining process, come to perceive themselves to be (1) more powerful, and (2) more competent (capable) than will persons located in peripheral exchange network systems. He used two semantic differential measures: (a) self-perceptions of power, and (b) self-perceptions of competence (capability). The results of Stolte's study are consistent with his theory that asserts that the structurally based power a person enjoys will be an important determinant of either situationally specific or generalized self-efficacy (personal competency).

Cavanaugh (1979) developed a 74-item preliminary power orientation tool, conceptualized along the dimensions of power. The tool was administered to four samples: (1) management level personnel in private corporations; (2) management level personnel in government; (3) sales representatives; and (4) law enforcement officers. She obtained six factor clusters which achieved significant correlation across the four samples. The power orientation factor clusters were: (1) power as good, (2) power as a resource dependency, (3) power as instinctive drive, (4) power as political, (5) power as charisma, and (6) power as control and autonomy. Test

and retest reliability on clusters 1 and 2 were substantial at .83 and .77, and the others were moderately reliable. Validation measures needed to be further explored.

Conceptual Framework

The preceding review provides the background for a more definitive discussion of one theorist's conceptualization of power. Blau's description of his exchange theory traces the development of power within social life. His theory will be used for the theoretical framework for this study. The professional nursing association (ANA) will be discussed using Blau's theory.

Blau, in his book, Exchange and Power in Social Life, presents a lucid framework within which to examine the concept of power. He analyzes the processes that govern social associations and offers these processes as a preliminary theory of social structure. Blau repeatedly emphasizes the need to proceed from simple to complex structures. He sees the social exchange between two individuals as a central principle of social life (Blau, 1964, p. xi).

Blau builds upon and attempts to present a linkage between his work and the works of George Simmel, Erving Goffman, Max Weber, and Talcott Parsons (Blau, 1964, p. 2). Blau states that "the core of a theory of

society has to explain the complex interdependence between substructures of numerous kinds, often intersecting and on different levels." Blau analyzes the processes of social interaction from simple interpersonal relations between individuals to the most complex relations in and between large collectivities. His focus upon social associations rather than social action distinguishes his work from that of Simmel, Homans, Goffman, Parsons, and Weber.

Three major concepts in Blau's theory are:

(1) Reciprocity which he defines as the resulting mutual exchange of services which creates a social bond between two individuals. This social relation is a joint product of the actions of both individuals, i.e., the actions of one are dependent on the other. (2) Exchange which Blau conceives of as a social process of central significance in social life and which is derived from simpler processes and from which more complex processes are in turn derived. And (3) Social exchange, broadly defined, can be considered to underlie relations between groups as well as those between individuals; both differentiation of power and peer group ties; conflicts between opposing forces as well as cooperation; both intimate attachments and connections between distant members of a community without direct social contacts.

Blau also defines social exchange more narrowly as the reciprocal exchange of extrinsic benefit as distinguished from other social processes, for example, those in associations that have intrinsic significance, or the unilateral transactions in which power becomes differentiated (Blau, 1964, p. 4).

Blau identifies two conditions which must be met for behavior to lead to social exchange. First, behavior must be oriented toward ends that can only be achieved through interaction with other persons. Second, behavior must seek to adapt means to further achievement of these ends (Blau, 1964, p. 5).

Blau has divided his discussion of his theory into three sections. In the first section ("Social Associations" to "Social Exchange"), exchange and related processes of interpersonal relations and their rooting in primitive psychologic processes such as social attraction are analyzed. In the second section ("Differentiation of Power" to "Legitimation and Organization"), Blau examines how differentiation of status is derived from exchange under specified conditions: various aspects of differentiated group structure, adjustments that occur under changing circumstances, and the significance of the legitimation of superior power for stable organization of collective effort.

In the final section of Blau's book, he discusses opposition and other dynamics in complex structures. He states that these dynamics rest on the conception that a secondary exchange is superimposed on the primary one and that indirect transactions become substituted for direct ones as the results of normative expectations and value orientations in collectivities (Blau, 1964, p. 5).

Blau begins discussion of his theory by examining the structure of social associations stating that associations between individuals tend to become organized into complex social structures and that they often become institutionalized to perpetuate the form of organization far beyond the life span of human beings (Blau, 1964, p. 13). Blau next discusses the role of attraction of one individual to another. This attraction leads to a desire to please the other person, i.e., to engage in exchange transactions.

Social exchange provides the basis for a differentiation of status and power in the relationship. Blau postulates that this differentiation is the basis for legitimation or for opposition and change in social structures. Blau further explains how reciprocity in exchanges and the existence of balancing forces strains toward either equilibrium or imbalances in social life.

He states that these same imbalances give social structures their distinctive nature and dynamics (Blau, 1964, p. 14).

Social attraction for Blau is the force that induces human beings to establish social associations on their own initiative and to expand the scope of their associations once they have been formed. Blau identifies both intrinsic (love relationships) and extrinsic (neighbors helping each other) rewards in these associations. Mutual attraction maintains the association and this association reinforces social exchange or the obligation to reciprocate. Individuals also assess alternative associations by evaluating their expected experiences and thus determine which association is more desirable. The satisfaction that an individual experiences is contingent upon the actions of others. Therefore, this power, vis a vis, one individual's having something that the second individual wants is determined by the magnitude of that want. That is, the satisfaction that a man derives from exercising power over others requires that "these others" be willing to endure the deprivation of their personal wants. This deprivation results from subjecting their wills to the powerholder's will (Blau, 1964, p. 15). Blau (1964, p. 21) also states that if the individual feels that he has

nothing to offer, but needs the recurrent services of another individual, he may:

1. Force the other to give him the needed help
2. Obtain help from another source
3. Find ways to get along without help, or
4. Subordinate himself to the other and force himself to comply with his wishes, thereby rewarding the other with power over him as an inducement for furnishing the needed help.

These last two alternatives Blau borrows from Parsons. Blau goes on to say that unilateral services that meet basic needs are a source of power for an individual. The individual attains power over others by making the satisfaction of their need contingent on their compliance.

Blau further discusses the difference he sees between individuals and groups regarding power. He states that an isolated individual can either approve or disapprove of his superior. However, in a group the collective approval legitimates the leader's power. Legitimate authority is the basis for organization and allows for furthering the objectives of the organization. Conversely, collective disapproval engenders opposition, leads to division and reorganization along different lines (Blau, 1964, pp. 23-24).

Blau identifies macrostructures (structures of interrelated groups) and microstructures (structures of interacting individuals) as constituent elements of a more complex social structure. He then discusses their social processes. Individuals interact with each other in the microstructure. These same interactions and others occur within the macrostructure, that is, individual differences not only affect the individuals but also affect their intergroup relations. The processes of social attraction create integrative bonds between associates. These integrative processes also unite various groups in a community. In macrostructures, these same integrative bonds can lead to solidarity. Individuals have common standards and a media of exchange. The processes of integration, differentiation, organization, and opposition formation occur in the various substructures. The corresponding processes in the macrostructure all have repercussions for each other (Blau, 1964, p. 24).

Reciprocity and imbalance pose problems for the social structure. A principle which Blau postulates is that balanced social states depend on imbalances in other social states, that is, forces that restore equilibrium in one respect do so by creating disequilibrium in others. This paradox occurs in associations between

individuals, that is, as one attempts to make oneself more attractive to another in a relationship, reciprocity is disturbed by an imbalance in the exchange. Blau (1964, p. 30) states that the exercise of power may produce two different kinds of imbalance, a positive imbalance of benefits for subordinates or a negative imbalance of exploitation and oppression. Thus, Blau emphasizes the interrelationship between reciprocity and imbalances in social associations among individuals. He again stresses the importance of analyzing the associations between individuals as a basis for examining their associations within complex structures.

Blau proceeds from social associations to a discussion of the importance of social integration with other individuals and in social structures. He states that these integrative bonds between individuals unite them in their formation of cohesive groups. In individual relationships, social integration comes from the social attraction between two individuals. Some of the rewards of these associations are intrinsic and others are extrinsic. Various strategies are used to impress individuals and groups. These strategies are related to the values of individuals and groups. The individual must be willing to risk failure in his attempt to impress others. At the same time, some impressive

qualities of an individual, although appealing, may be a threat to other members of the group. Leadership in groups come from individuals' competition for social recognition and demonstration of their abilities; the integrative bonds in groups give rise to differentiation of status of individuals within the group at the same time reinforcing the need for continuance of integrative bonds between individuals. Those individuals who are able to contribute to the group achieve superior status in the group.

Blau discusses the problem of dependence experienced by some members of the group. An individual who displays superior qualities runs the risk of displacing other members from a superior status and thus having them dependent on him. Additionally, this superior display by one individual gives rise to ambivalence on the part of others. He may find the need to depreciate himself in order to gain the social acceptance of others. Blau refers to the paradox of an individual being both impressive and self-depreciating as the paradox of social integration.

This paradox of incompatible conditions is necessary for group cohesion. The solidarity of the group derives from the contribution of its members to its goals and from their integrative bonds. Problems

may arise because the members' contributions lead to the differentiations of status within the group which may lead to interference with their integrative bonds. The dilemma of incompatible conditions is the basis for the dynamics of social life according to Blau.

He cites as another facet of social processes, the feedback effects. Individuals anticipate the consequences of their social interactions based on their previous experience. They are able to do this because of the feedback or information received from previous experiences.

Individuals are attracted to each other because the association provides intrinsic or extrinsic benefits. Extrinsic benefits are useful in comparing and deciding upon associations. However, there are no comparisons for intrinsically rewarding associations. Rewards that come from associations are initially extrinsic and once they are fused with the association, they are said to become intrinsic. The extrinsic rewards of associations allow one to compare them and make choices regarding them. Established social relations then can be either supportive (intrinsic) or exchange (extrinsic) relations.

Blau proceeds from his discussion of social integration to a discussion of social support. He

identifies two related elements of social support. These elements are social approval and intrinsic attraction and they are used in gaining support for an individual's opinions and judgments and for his values and self-concept. Blau stresses that approval or shows of affection must be both genuine and given sparingly to be seen as important. The person who is less respected or desired must give approval and affection more indiscriminantly in order to establish his position. Paradoxically, this indiscriminate display serves to further weaken its value, creating an imbalance.

This same imbalance occurs when an individual is attempting to establish his social standing in the group. If his accomplishments are unknown, then he needs to advertise them. However, once his status is established, it becomes easier for the individual to make gains.

Social approval and attraction strengthen integrative bonds between individuals. The social cohesion which occurs from these bonds leads to group formation of individuals with common goals. This group cohesion then becomes a source of social support (Blau, 1964). Blau states that prestige and status rather than attraction are more important to individuals in a social

group, whereas attraction is more important to individuals in a relationship (Blau, 1964, p. 76).

Blau then proceeds to discuss social exchange. His use of the term refers to voluntary actions of individuals that are motivated by the returns they are expected to bring from others. This social exchange derives from social associations, that is, an exchange of activity between two individuals which is either rewarding and/or costly to them (Blau borrows from Homan). Blau goes on to state that social exchange is used to establish bonds of friendship and to establish superordination over others, i.e., power.

He differentiates between intrinsic, extrinsic, and unilateral rewards. Blau cross-classifies these rewards with spontaneous evaluations and calculated actions. Blau distinguishes rewards that are given at cost to the supplier. Examples are social approval, social acceptance, and instrumental services. Additionally, respect-prestige and compliance power are given with direct cost of subordination for suppliers. This reward system occurs between individuals as well as in groups. The giving of rewards to another person can lead either to establishing friendship bonds or in gaining superiority over the other individual. Thus, there is an attempt by the second person to "return favors" to

balance the relationship. Once superiority is established a person can extract tribute from other individuals and maintain his superiority over them. The issue of cost can lead one to associations with other individuals from whom he feels he can get help. The choice of alternatives may assist him in avoiding further obligations to one person. This standard for exchange transactions occurs also within the group and determines members' conformity toward the group norm. Exploitation by "superiors" within the group is controlled by the possibility of formation of coalitions by weaker group factions.

This desire for unilateral respect from other individuals is also evident in choices of group membership. However, most will accept giving respect to others rather than being excluded from the group. In exchange transactions, each individual hopes to gain the most with the least cost to him. This conflict between two individuals is usually resolved by obtaining both intrinsic and extrinsic benefits from other associates.

The occurrence of imbalances of obligations within social transactions leads to differences in power. If one individual cannot reciprocate recurrent favors this causes him to comply to the other's requests. This compliance gives power to the person who

bestows the favors. There are, however, four alternatives for the power subject:

1. He can provide services in return for those he receives

2. He can obtain the needed benefits from another source

3. He can secure the benefits he needs through force

4. He can renounce his need for benefits and overcome the need for them

Blau goes on to state that these four alternatives must be absent in order for one person to hold power over another. A person holds power by making fulfillment of another's essential needs contingent upon their compliance with his requests.

Differentiation of power arises in the course of competition for scarce goods. These scarce goods can be a variety of things from participation in a group to scarce means for livelihood. Initially everyone competes for these goods, then as success in obtaining them occurs, the attainment results in a differentiation of status among individuals. Eventually exchange relations become differentiated from an individual's competitive ones. Individuals who are not successful in attaining goods become exchange partners with the successful ones.

The exchange is their subordination and status support for instrumental benefits. The recognition of a person's ranking in a social stratum reinforces his social status.

Blau states that inducing a person to bestow a favor by rewarding him for doing so, does not constitute power over him. In contrast the person whose orders others follow, does exercise power over them. Thus, we see that one condition for existence of power is to comply with what someone else wants. Their compliance with his orders benefits him and thus discharges their obligations to him. Blau identifies this as an exercise of power which depletes power in the process.

Blau further describes power. He states that power can be invested at some risk to yield more power. A person who has power does not need to remind others to discharge their obligations. He uses his power to help them organize their activities to achieve their obligations. His effective leadership further obligates them to him. This risk of leadership is rewarded by further increments in his power.

Blau next discusses expectations as an important dimension of social associations between individuals and within groups. An individual's expectations determine whether he will be disappointed or satisfied in any

given association. An important factor then is the impact of past rewards that have been either received by that individual or his observation of others receiving them. The significance of various rewards differs according to their cost and usefulness to the individual.

Blau points out that an individual is influenced by his own attainments and those of his reference group and by the common standards and norms of society. He goes on to say that shared social experiences of groups exert a pronounced influence on their social expectations. Blau illustrates this in his example of factory workers placing higher expectations on the successor of a plant supervisor. He emphasizes that differences in the expectations that define the significance of given social transactions are a potential source of conflict. These same expectations and conflicts can be seen in comparison of individuals in social associations.

The concept of collective marginal utility as identified by Blau is that of the cost of receiving a benefit at the going rate of exchange. In exchange transactions people expect a fair return for their efforts. Individuals expect that those who receive greater rewards make a greater investment. This leads to supply and demand in groups, their influence on

exchange transactions, and on the going rate of exchange. Supply and demand affect the fair rate which in turn prevents many individuals from getting a fair return in their transactions. Blau states that a reason for this is that social attachments produce immobilities that prevent individuals from taking advantage of alternative opportunities.

Blau relates this problem to society. He states that the collective goals of organization require commitment from its members. This commitment reduces the members' mobility. Competition requires that some organizations cannot fulfill the needs of their members. Because of the members' lack of mobility, they cannot receive a fair return for the major investment of their lives. Blau feels that the recurrent problem with competitive processes will cause some men/women in our society to be alienated.

Blau next discusses the dynamics of changed adjustment in groups. He states that the need for advice leads to consulting relations where advice and help are exchanged for respect and compliance. He likens this relationship to a bilateral monopoly. The two parties involved negotiate how much advice and how much compliance to a point of optimum joint advantage on the contract curve. If there are a number of

consultants, then alternatives can be worked out. Blau points out that the consultant has a need to strengthen his status in the group and exert his power of influence over as many as possible within the group. Consultants attempt to increase the scope of their services which increases the differentiation of status within the group. Partnerships may evolve as a result of workers not being able to get the help they need without loss of their self-respect. Consequently, they give advice to each other and thus diminish the differentiation of status within the group. At the same time, they may create social strata if there are sharp differences in competence.

Blau states that power over others rests on services furnished to them. He does not address the morality of such situations. Some may receive an unfair return for their efforts. Blau considers this unfair return as part of the imperfections in the regulating mechanisms of social exchange.

Through sufficient power individuals may be able to monopolize resources and make others dependent on them. For example, consultants need to continue to provide some services to strengthen their power. This self-perpetuating element of power is evident in class structures in societies.

There is a difference between collectivities with a common goal and those where members are engaged in separate pursuits. Collectivities with a common goal evolve and accept leaders. The common objectives allow the individual to benefit all the members and evolve as a leader in exchange for his contributions to the group. Blau states that when hierarchies of power exist, processes of legitimation often transform them into hierarchies of authority.

Blau discusses legitimation and organization and their role in social life. Social standards set wide limits within which a range of permissible relations may exist. This range is true for exchange relations and power relations. Legitimate patterns of social conduct and social relations are determined by common values and norms that reinforce and perpetuate them. The community approves legitimate organizations and social relations.

Blau states that the exercise of power is judged in terms of social norms of fairness by those subject to it and by others who witness it. He discusses this in terms of legitimating the authority and fortifying the controlling influence of the powerful. A person who has a great need for power may abuse its use. A second factor that contributes to abuse of power is his lack of need for social approval. Therefore, legitimating

approval of power is needed for stable, organizing power. In formal organizations, Blau states, there is fairness in the exercise of power which obtains legitimate approval for it. Blau concludes that that is why power begets power.

Blau points out that the process for gaining power over others and of winning their approval may be in conflict. Consequently, the problem of leadership is that it requires both power and approval. Leaders mobilize their power first and then seek the approval of others by using the power to get them benefits. However, as Blau points out, not every potential leader succeeds in this endeavor. In formal organizations there is support for achieving this and having subordinates accept the legitimate authority.

Managerial authority and the sanctioning power of management contribute to the leader's success by providing recurrent rewards to the members. The formal position and powers make it easier for him to bestow benefits even if his leadership qualities are limited. Manager's contributions create obligations from the subordinates. These obligations find expression in group norms that demand compliance with his directors and legitimate his authority over them.

Blau states that power is the resource by which one individual or group can coordinate the efforts of others and that legitimate authority allows for stable organization of such a large coordinated effort. Blau illustrates the similarity between workers and shareholders who are both powerless and subject to control by the management.

The organization of collective effort mobilizes power. The leader's power over subordinates is the basis of power in other segments of society. Successful use of external power increases the power within the organization. The exercise of power can generate conflict and opposition both within the organization and its external relations. Blau (1964, p. 223) states that the commanding position is at the root of much social conflict and political opposition.

Blau discusses opposition. He states that for individuals, exploitation and oppression may cause them to be helpless, but in a group situation, they can produce a social surplus that becomes the source of opposition movements. Blau contrasts between power that is used in moderation for the benefits of others and the exploitative and oppressive exercise of power. The former use leads to social approval and the latter leads to social disapproval and hostility. Oppressed

groups are more effective in their retaliation than an individual. This is true because the collectivity are able to communicate their feelings into a noble cause to help their fellow men. Blau states that devotion to ideals makes men willing to sacrifice material rewards for the common cause.

In his discussion of mediating values in complex social structures, Blau states that commonly accepted social values serve as media of social transactions. They extend the range of social processes beyond the limits of direct social contacts through large collectivities and long periods of time. He distinguishes four types of mediating value:

1. Particularistic values are the media of social solidarity. They mediate bonds of social attraction and create a common unity. These values also produce segregating boundaries between the solidarity subgroups in the large collectivity.

2. Universalistic standards of social contributions and achievements give rise to differentiation of social status. These standards establish a medium of exchange in the form of status of a generalized reward which makes indirect transactions possible.

3. Legitimizing values act as the medium for the exercise of authority and the organization of social

endeavors on a large scale in the pursuit of collective objectives.

4. Opposition ideals are media of social reorganization and change. They inspire support for opposition movements and legitimate their leadership.

Blau goes on to describe the similarities and dissimilarities between the simpler structure of interpersonal relations, complex social structures that consist of subcultures, and social institutions. He states that the processes and structural features are similar but that the forms they take are different. For example, in face-to-face groups, processes of social integration depend on personal attraction, whereas in complex structures they arise from particularistic values that produce a common solidarity. Processes of social exchange and differentiation, which involve direct transactions in small groups, are mediated by universalistic standards of performance and achievement in complex structures.

Blau compares the informal and formal leaders of groups. The former is leader by virtue of social approval and the latter from legitimate authority. Blau also states that if there is social disapproval of the exercise of power then this leads to opposition and

change, formation of new ideologies and movements, and perhaps even new institutions (Blau, 1964, pp. 270-280).

Blau identifies as the most distinctive characteristics of complex social structures--direct social transactions that are impossible between most members of a large collectivity. Therefore, social processes are mediated by common values. Shared values play a more crucial role in complex structures than in small groups. These values partially institutionalize more complex structures of societies which then exert traditional constraints on other elements of community life. These components of social structures are also social structures.

Blau then describes the dynamics of subcultures. He states that a systematic theory of social structure must analyze the interrelations between attributes of a macrostructure and those of substructures on different levels. Particularistic standards integrate substructures and create segregating boundaries between them in the macrostructure. Blau goes on to say that universalistic values differentiating social strata in the macrostructure often become the basis of particularistic values that further social integration and solidarity within each stratum. Conflict arises between legitimate centralized authority and legitimate component parts of

organizations. This conflict may give rise to deviant opposition ideals and values. If the movement is successful, it will change the future (Blau, 1964, pp. 283-285).

In his discussion of opposition, Blau states that it is a regenerative social force. Opposition works against institutional rigidities and serves as a catalyst for change and reorganization. An opposition movement serves to revitalize a rigid social structure. Conflicts and opposition occur across many collectivities. There are interlocking memberships in them which are a continual source of social reorganization and change. These reorganizations have wide repercussions that create new problems and stimulate fresh oppositions and are therefore dialectic.

Dialectical forces are part of Blau's theory. As Blau states, these forces contradict each other. He cites such contradictory thoughts as balance and imbalance and reciprocal versus unilateral attraction. These thoughts, although contradictory, are involved in the establishment of social associations for individuals and are a basis of social structure.

Blau goes on to identify three facets of social structure as they occur in groups. They are integration (particularistic standard and emergent), opposition

(particularistic and goal-focused), and legitimation (universalistic and goal-focused). This classification of the structure of social associations is the basis of Blau's theory (1964, p. 313).

In summary, Blau's theory presents a developmental approach to the concept of power. He traces the beginnings of power in the social structure of individuals. Essential in his theory are the concepts of reciprocity, balance, and exchange. It is through their use of these (reciprocity, balance, and exchange) that individuals attempt to associate themselves with each other and with groups of individuals. Blau stresses that it is through the implementation of these concepts that differentiation of status and power are achieved by the individual.

This same kind of development can be seen in the evolution of the American Nurses' Association. The Association is composed of members whose social structures have developed in the various ways that Blau describes. In this study, an analysis will be done using Blau's theory and his definition of power. The various components of his theory will be used to describe and interpret the response of the leadership and membership of the organization to issues confronting the nursing profession. This analysis follows each

designated time period with an attempt to show how issues and responses are linked from one time period to the next.

CHAPTER III

LAYING THE FOUNDATION FOR THE DEVELOPMENT OF POWER (1893-1912)

Recognition of the Need to Organize

In the period between 1850 and 1900, changes occurred within society in the United States which impacted upon women's roles. Consequently, nursing (microcosm) as it was then known experienced changes that also occurred within the larger women's movement (macrocosm). The problems that nurses faced were part of the problems that women faced generally. These societal changes included social, economic and political gaps between men and women (Archer, 1982, p. 21).

Women were essentially relegated to the home. When the Industrial Revolution impacted society in the United States, women were able to and in some cases had to work outside the home. In the midst of all these changes several classes of women were emerging in urban American society: working-class women and middle- and upper-class women.

Affluent women were expected to live leisurely and quietly and not to indulge in any physical work or mental strain because of their innate frailties.

Working-class women were expected to do back-breaking work, to manage their homes, and to raise their children. (Ehrenreich and English, 1973a, p. 12)

The working-class woman of the New York City tenements in the 1870s struggled for honest employment (Riis, 1957). A graphic portrayal of her plight for survival was noted in the following vignette of a woman who had thrown herself from her attic window.

"I would have done any honest work, even to scrubbing," she wrote, drenched and starving after a vain search for work in a driving storm. She had tramped the streets for weeks on her weary errand, and the only living wages that were offered her were the wages of sin. (p. 177)

These divergent roles presented a conflict for women and helped to encourage the women's movement. Neither role allowed women to function independently or as equals to men.

Nursing was essentially dominated by the stereotypical roles assigned to women. They (nurses) transferred their subservient role in the home to their work in the hospital. "Nurses were expected to be ladylike at all times, to follow orders, to be obedient helpers, and to do all the menial tasks involved in total patient care" (Archer, 1982, p. 29). "Our subservience is reinforced by our ignorance, and our ignorance is enforced. Nurses are taught not to question, not to challenge" (Ehrenreich and English, 1973b, p. 1). Society both

defined and reinforced women's roles in the home and in the health care setting.

Additionally, nurses' roles were also affected by their heritage from religious and military influences. Women desiring to become nurses were said to be answering a "calling" and devoting themselves to a life of service to mankind. This calling negated thought of their own welfare or of remuneration for services. The focus of their service was the care of the patient and obedience to the doctor. Military influences further reinforced this calling and added to the idea of total obedience to the physician and supervisors. Discipline and enhancement of moral character were viewed as important aspects of the nurse's training and life (Nutting and Dock, 1907, 1:441-60).

"Nursing provided employment away from home that yielded an independent income and elements of an independent life-style, and at the same time, maintained the dominant social value and tasks assigned to women" (Baer, 1984, p. 34). These women were untrained as nurses. Prior to training schools, nurses were recruited from the working-class and lower socioeconomic classes. They came from a variety of backgrounds and had limited education.

In Martin Chuzzlewitt (1968), Dickens depicts this lower class of women in his fictional characters Sairey Gamp and Betsy Prigg. Despite their low moral standards and lack of training, they were hired to nurse the sick in their homes and public hospitals.

From the start of the Civil War which began in 1861, more women were leaving their homes to "nurse" the sick and wounded soldiers. These women were painfully aware of the need for training as a result of what they observed while engaged in nursing activities. This period marks the beginning of a concentration of women who were involved in public duties. During the Civil War there was an estimated 2000 women in this country engaged in nursing and hospital administration (Nutting and Dock, 1907, 1:357). One group was involved in reform of hospital systems and the other with selection and training of nurses.

As a result, there was an increased recognition of the value of and need for trained nurses. Women reformers worked at achieving improved nursing and sanitary conditions. The development of the Sanitary Commission was a step in this direction. This commission was the forerunner of the American Red Cross. Once established, the commission provided for the selection and training of women to nurse. Dr. Blackwell and a

committee of women selected these women and arranged for a one month course at Bellevue (Nutting and Dock, 1907, 1:361, 362). The one month training course, although meager, was an attempt to provide some kind of hospital experience for volunteers.

As a further recognition of the need for organized nursing, Dorothea Dix was appointed as Superintendent of Nurses. Her appointment was a landmark in the somewhat formless nursing department of the Civil War.

Following the war, the problem of untrained nurses who claimed the title "nurse" merely because they "nursed" continued. Reconstruction slowed down the inception of training schools. The formalization of schools of nursing did not occur in the United States until 1873 (Baer, 1984, p. 34). This formalization of training schools was built upon the work of Florence Nightingale.

The Nightingale Training School for Nurses was opened at St. Thomas Hospital in London in 1860. British citizens, as a reward for Florence Nightingale's efforts on behalf of soldiers during the Crimean War, contributed £44,000 to establish an institution for the training, sustenance, and protection of nurses and hospital attendants (Nightingale Fund Minutes in Seymer, 1960, p. 2). The Nightingale Fund allowed Nightingale's

representatives to contract for hospital room and board for her probationers, pay stipends to them and to their medical and nursing teachers, and to withdraw from hospitals that did not conform to the three fundamental requirements of the Nightingale system:

1. A trained matron who "was to have absolute powers over, and full responsibility for, the whole nursing staff."
2. Nurses who were to be ". . . completely sober, honest and truthful" and trained for their work with "the correct balance between theory and practice."
3. Nurses whose character was as important, if not more important, than their technical efficiency. (Seymer, 1960, pp. 31-35)

An important criteria for Nightingale's school was that it should be financially independent in order to carry out the program.

The establishment of training schools for nurses in the United States and England were attempts to provide some minimum standards for qualifications of applicants, for a uniform curriculum and for graduation from programs. There was a growing recognition that it was not enough for nurses to be of good moral character; they must also be trained.

Nursing leaders were aware of the problems facing the trained nurse and nursing. These emerging conditions then set the stage for the attempt to develop strategies for establishing minimum standards for nursing practice and the self-regulation of the profession.

All this was occurring within the greater context of the women's movement.

Formation of Nursing Associations

From the time of the first organized training schools for nursing in 1873 through the turn of the century, there was a proliferation of schools and graduates. This increase in the number of nurses, even though trained, introduced more problems to nursing. Recognizing the need for nurses to address these problems and for nurses to determine the future of nursing, visionary leaders pushed for the formation of associations of nurses.

The American Society for Superintendents of Training Schools for Nurses

The first organization to be formed was the American Society of Superintendents of Training Schools for Nurses. At the 1893 Chicago World's Fair, the International Congress of Charities, Corrections and Philanthropy was held. Dr. Billings of Washington was the chairman of the Hospital and Medical Congress section. At the request of one of the organizers of the International Congress, a Mrs. Bedford Fenwick of England, Dr. Billings established a subsection on nursing. He appointed Isabel Hampton, the

Superintendent of John Hopkins Training School, as chairman of this subsection (First Annual Report of the American Society of Superintendents of Training Schools for Nurses, 1894).

In June 1893, superintendents from training schools for nurses in the United States and Canada attended this first nurses' Congress. About 73 invitations had been sent out. Miss Isabel Hampton suggested a meeting among a small group of superintendents to discuss the possibilities for starting a nursing organization. A meeting was held the next day at the home of Miss K. L. Lett of Chicago. Eighteen superintendents attended and from this nucleus of unorganized women came discussion of ideas about education and nursing. These leaders believed that through the strength of their numbers, they could accomplish more collectively than individually. A committee was appointed with Miss Alston as chair. Their task was to frame resolutions to present to the superintendents on the following day. In the report of this committee, they suggested that the society be known as the American Society of Superintendents of Training Schools for Nurses. The objects or purposes of this society would be:

1. To promote fellowship of members

2. To establish and maintain a universal standard of training, and
3. To further the best interests of the nursing profession

The committee also proposed resolutions on the qualifications of members and officers, kinds of meetings, composition of an executive council, board council and suggested dues. The resolutions were unanimously adopted and it was moved, seconded and carried that a convention of training school superintendents be called for 10 January 1894, to be held in New York. Officers of the preliminary organization were elected with Miss Alston as President and the meeting was adjourned (First and Second Annual Reports of the American Society of Superintendents of Training Schools for Nurses, 1894 and 1895).

The original idea for this organization has been credited to Isabel Hampton. Her vision was shared and supported by other superintendents. Membership in the Society was limited to participants of the original organization and past and present superintendents of training schools connected with incorporated and well-organized hospitals.

These pioneer leaders had envisioned a second national organization which would be for all nurses.

They believed that another national nursing organization was needed to develop a code of ethics, to elevate the standards of nursing education, and to promote the interests of all nurses (Flanagan, 1976, p. 24).

Nurses' Associated Alumnae of
the United States and Canada

At the first (1894) and second (1895) annual meetings of the Society, the members discussed the importance of the formation and unification of Alumnae Associations. There were several identified purposes for such associations. For example, as a vehicle for the development of a code of ethics for nurses and a setting for social and educational activities. Isabel Hampton Robb¹ emphasized the importance of alumnae associations as a basis for the future formation of a national organization for nurses (First Annual Report of the American Society of Superintendents of Training Schools for Nurses, 1894, p. 17).

As a follow-up to this discussion, at the second annual meeting (Nursing Archives, ANA Collection, Box 39, File 10, p. 52), Miss Sophia Palmer presented a paper on a survey of training school alumnae associations. She was able to obtain a list of 164 training schools, twenty in Canada and 144 in the United States.

¹Isabel Hampton married Dr. Hunter Robb in 1894.

Responses from her inquiry indicated there were twenty-one training schools that had alumnae associations or clubs organized and in active operation with a printed constitution and another ten schools were in the process of organizing. Still another seventy-eight training schools had none but were interested in starting one. There was no attempt to classify these schools as to whether they were eligible for membership in the Society. She categorized the existing societies as: (1) Alumnae Associations (organized and managed by graduates), (2) Nurses' Clubs (pupils of the school and graduates of other schools), and (3) Religious Societies (with a number of officers, clergymen or members of the training school board) (p. 53).

Palmer cited as the stated purposes of the existing Alumnae Associations: the union of graduates of the respective schools for mutual help and protection; the promotion of social intercourse and good fellowship; the provision of friendly and pecuniary assistance in times of illness or death among members; and, the advancement of the interest of the nursing profession (ibid.).

The organization of alumnae associations in connection with training schools is comparatively a new movement and general interest has been stimulated by the agitation of the subject, both in Chicago in 1893 and at a meeting of this Society a year ago. (Ibid., p. 55)

Palmer stated that the object of her paper was to simply show the material available for a national alumnae. She urged the superintendent to take steps toward the organization of alumnae at their schools.

Organization is the power of the age. Without it nothing great is accomplished. . . . All questions having ultimate advancement of the profession are dependent upon united action of nurses for success. . . . The Directory question, the Uniform Curriculum, the Rejected Probationer, every subject that concerns individual graduates, as well as schools can only be reached through this channel. (Ibid.)

Palmer also stressed the importance of the superintendent, as the leader in the school, to call the first meeting. She pointed out that any size alumnae would be helpful to the cause and encouraged the further development of training school alumnae societies. "The power of the nursing profession was dependent upon its ability to maintain the cooperation of individual nurses who had the ability to influence public opinion" (ibid.).

The union of these alumnae was to be the basis of the formation of a national organization. A small committee of members of the Society of Superintendents was appointed to prepare a constitution and bylaws and was instructed to secure a number of delegates from among the oldest alumnae associations (from nine schools and the District of Columbia) to meet with them. Their first meeting was 2 September 1896.

The following year, the constitution and bylaws prepared by this group were accepted and the title of Nurses' Associated Alumnae of the United States and Canada was agreed upon. This title remained until 1901, when, upon the organization's incorporation, it was found that New York law prohibited foreign membership and reference to Canada was dropped. Isabel Hampton Robb was the first president from 1897 to 1901 (Christy, 1971, p. 1778).

Although alumnae associations were needed as the basic unit for the formation of the national organization, it soon became evident that another kind of local association and state associations was needed. The mobility of graduate nurses and the increasing recognition of the need for registration of nurses added to this reality.

Through discussion and investigation of the question of registration, other profession's methods of dealing with the problem were explored. Miss Dock made a careful study of the laws under which professional organizations could operate as well as how other national associations, particularly the American Medical Association, were formulated. She discovered that national bodies were policy making and that there had to be provision for systematic division and subdivision of

work and responsibility, with most of the real work being done locally (Third Annual Report of the American Society of Superintendents of Training Schools for Nurses, 1896). The Medical Society had county associations as their local organizations and these were part of the state association.

In order for registration to be accomplished, nurses needed to be organized under city or county associations which were part of a state association.

When we come to organize a state society the principal motive being to influence legislation, we take an entirely new departure from the motives actuating us in the organization of our association for educational and social purposes. We go to the legislature as citizens of the State not as graduates of any particular school. (Palmer, 1900, Proceedings Third ANA Annual Convention, p. 88)

Therefore, there was a gradual shift from alumnae associations to city or county and state associations as basic units to provide entry into the national organization.

International Council of Nurses

Nursing leaders, in addition to identifying nursing's needs for local, state and national associations, also recognized the need for international involvement with other nurses. The advantages of forming a union of nurses at an international level were also identified.

In order to accomplish this, the profession needed to be a member of the National Council of Women of its country. In addition to helping nurses unite, this move would have nurses participating with other women in discussing women's issues.

The idea of an International Council of Nurses was conceived by Mrs. Bedford Fenwick. At the second annual Meeting of the Matron's Council of Great Britain and Ireland in 1899, she proposed that steps be taken to organize an International Council of Nurses. Her motion was seconded by Miss Isla Stewart. A proposal was made for the appointment of a provisional committee to work on the formation of an International Council of Nurses. The goal of this provisional committee was to have national nursing associations affiliated with their National Council of Women. The International Council of Women would only be open to those societies primarily affiliated by national representation with the National Council of Women in their respective countries (Bridges, 1967, pp. 1-7).

In July 1900, the provisional committee drafted a constitution and bylaws and elected officers. Mrs. Bedford Fenwick was the founder and Miss Beray was elected honorary secretary. The provisional committee then accepted an invitation from the Buffalo Nurses'

Association to hold a meeting of the International Council of Nurses in Buffalo, New York in 1901. Having the meeting there was seen as a way to celebrate the new century (Bridges, 1967, pp. 1-7).

The Nurses' Associated Alumnae had received an invitation to join the National Council of Women in 1898 (Second Annual Proceedings of the Nurses' Associated Alumnae, 1898).

The spirit of the age is combination. The National Council of Women is the engine of combination offered to women's organization. . . . With a view to combining effort and uniting and economizing forces toward common ends and purposes, the National Council of Women invites you to join with it and give it the benefit of your council along your own line of work, and to extend your sympathy and co-operation to other organized efforts which the Council may present for your consideration or hearing--A council of women composed of all national organizations could move the nation by its voice. (Nursing Archives, ANA Collection, Box 33, File 10, p. 109)

At the 1900 annual convention a resolution was passed for the Nurses' Associated Alumnae to affiliate with the American Society of Superintendents of Training Schools for the purpose of applying for membership in the National Council of Women. The decision was made to delay the acceptance until the association was incorporated in 1901.

The American Federation
of Nurses

Since only one national body could be affiliated with the International Council of Nurses, it was necessary for the two national nursing organizations to create one affiliative national body. From 1901 to 1904, there was an informal union between the two associations. In 1904, they formalized this union under the name, the American Federation of Nurses. That same year, the American Federation of Nurses, the National Council of Nurses of England and the German Nurses' Association were invited to join the International Council of Nurses.

At a 3 May 1905 meeting of the American Federation of Nurses, a constitution and bylaws were adopted. Membership was withdrawn from the National Council of Women and the Federation organization joined the International Council of Nurses. M. Adelaide Nutting was elected its first president and she served in that capacity until 1913 when the organization was dissolved and the American Nurses Association became the official national representative body for American nurses to the International Council of Nurses (Flanagan, 1976, pp. 50-52).

The Nurses' Associated Alumnae changed its name to the American Nurses' Association in 1911. The

American Society of Superintendents of Training Schools for Nurses became the National League for Nursing Education in 1912.

ANA had completed the chain of organization of nurses--local, state, national and international--assuming the role of national and international spokesperson for the nursing profession of the United States.

Identification of Problems

Lack of standardization of educational programs

The various nursing organizations had been established to address specific needs and goals of the profession. Nursing had moved from untrained nurses to nurses being trained in a variety of programs. Once the training of nurses was seen as profitable, a number of hospitals recognized the advantage of opening "schools." Many institutions started schools for economic reasons solely. The number of hospital schools of nursing rose from sixteen in 1880² to 1,129 in 1910 and graduate nurses from 157 in 1880 to 8,140 in 1910. With the increase in the number of schools, the inferior schools

²According to Wendell W. Oderkirk, original accounts of the number of nurse training schools were reported inaccurately. Therefore, the number of schools have been corrected with his revised statistics for the years 1879 to 1900 only (Oderkirk, Journal of Nursing History, 1985, pp. 30-37).

preparation (Burgess, 1928, pp. 35, 36). These "weak" schools added to the lack of standardization of programs.

Women reformers returned from the Civil War and were eager to take on the task of reforming the American hospital system. Mrs. Woolsey, one such reformer, had served as a volunteer nurse during the Civil War and started the movement for hospital and nursing reform in this country. She was a member of the Visiting Committee and had toured European hospitals to study their systems. Mrs. Woolsey reported:

Whenever we have followed the historic line and have found progress in hospital reform, we have found concurrent with it an effort to devise the best means of attracting and of retaining in the nursing service, women of good character and acquired fitness in their work. (Woolsey, 1950, pp. 111-12)

Dr. Gill Wylie, a physician at Bellevue Hospital, had visited England and obtained information on the Nightingale School. He supported the work of the Visiting Committee to reform Bellevue through the training of intelligent, competent modern nurses (Woolsey, 1950, p. iv).

The investigations of Mrs. Woolsey and Dr. Wylie, along with the formation of the State Charities Aid Association in 1872, set the stage for the development of schools of nursing as part of the hospital system.

The Association was initiated to improve the public charitable institutions in New York. Miss Louise Schuyler was elected president of the Visiting Committee which was formed to investigate public institutions (Woolsey, 1950, pp. 111-12).

Hobson (1950, p. 147), who was also a member of the committee, was asked to report on the cleanliness, diet, and finally upon "the character of the nursing service" at Bellevue Hospital. She reported (1950, p. 149) "they [conservative doctors] preferred nurses 'who would do as they were told'; the intelligent, educated women we proposed to introduce 'would not be amenable to discipline'; and they were 'utterly opposed to our interference.'" This resistance did not come from all the doctors and some helped them in their reform.

Inception of training schools

One of the key factors that emerged as a result of their investigations was the identification of the need for trained nurses. The transition from untrained nurse to trained nurse was slow. Late in the nineteenth century three models of training schools for nurses emerged. The original reform model of Nightingale, which was initiated at Bellevue in 1873, kept nursing separate from the hospital and medical domination but left it supervised by Boards of Lady Managers.

A second model espoused by Linda Richards, America's first trained nurse, was implemented by her at Boston City Hospital in 1878. This model subjected nursing to medical control and was the system under which she was trained.

The third model advanced by Isabel Hampton at John Hopkins, toward the century's close, advocated self-determination and self-regulation for nursing (Baer, 1984, p. 32).

There were problems inherent in each of these models. The problem with the modified Nightingale model was that the superintendent had to report to a non-nurse board which dictated nursing policy, selected nursing leadership and established nursing routines. Additionally, the students received minimal supervision on the wards (Baer, 1984, p. 35).

The Richards model "subjected the head of the nursing department to the larger coordinating medical control." "There was no pride of authority, no thought of personal sacrifice." By the end of the century, the Richards model dominated nursing and hospital organization (Dock in Hampton, 1949).

The Hampton-professional model sought uniform educational standards for schools, a professional organization, and registration and licensure for nurses

(Baer, 1984, p. 36). Hampton attempted to have nursing proceed along scientific lines similar to what medicine was embracing.

However, more trained nurses embraced the first two models. This fact plus the fact that there were still a large number of untrained nurses continued to have an adverse effect on nursing's autonomy. The competition between small versus large school graduates was reinforced by who was allowed to join the professional organizations (Nursing Archives, Mugar Memorial Library, ANA Collection, Box 34, Folder 16). The diversity and division among nurses increased the recognition by the nursing leadership of the need for educational uniformity.

Lack of uniformity of programs

At the second annual meeting of the Society of Superintendents, papers were presented discussing existing and proposed curricula for training schools. Miss Snively's paper on a uniform curriculum dealt mainly with the two year programs. She discussed the desirability of uniformity and possible strategies to be used toward this end.

. . . the ideal organization would call for state recognition with its fixed curriculum, its board of examiners, appointed and paid by the government, its centers where at fixed periods examinations would be

held, and degrees in qualifications both in theoretical and in practical work obtained. (Second Annual Report of the American Society of Superintendents of Training Schools for Nurses, 1895, p. 27)

Miss Snively urged the Society to take some initial action toward uniformity of curriculum in training schools. She advocated the following:

1. A uniform matriculation examination to be required before admission
2. A uniform period of training be required in certain hospitals recognized by a central committee or association, and
3. That certain examinations (primary at end of first year and final at end of second year) shall be passed by a nurse subsequent to matriculation, and before receiving a certificate

Miss Snively's paper was followed by one delivered by Isabel Hampton Robb advocating a three-year curriculum with an eight-hour practical day of work. Mrs. Robb also urged the society to establish a standard of education that would be common to all training schools and to unite to develop the three-year course of instruction. Components of such a course would include:

1. Specification of the necessary qualifications of applicants
2. A curriculum for teaching and study, and

3. A proper grading in tests and in final examinations (Second Annual Report of the American Society of Superintendents of Training Schools for Nurses, 1895)

She stated that "under the present system there is no opportunity for the pupil to learn administrative duties until they have undertaken it." The third year in her proposal would allow for the pupil to have an experience in teaching, administration, or more theory for private duty work. Robb advocated the three-year curriculum only if the eight-hour day were part of it. Otherwise, she felt they should stay with the two-year curriculum. She was concerned about the health of the pupils, if they were "overworked."

Additionally, Robb recommended that pupils not receive remuneration, stating that this would put the school on a scholastic basis. The change was intended to attract refined and intelligent women. Scholarships could be founded for poor but competent women. Robb also suggested that the association move slowly over the next five years to implement any agreed upon changes.

As a result of these papers and the ensuing discussions, the Society members agreed upon the appointment of two committees. The first one was to study and propose a two-year curriculum. A second committee was appointed to study the three-year, eight-hour-day

curriculum proposed by Robb. Both committees would submit their reports for the next annual meeting (Second Annual Report of the American Society of Superintendents of Training Schools for Nurses, 1895).

The importance of the role of training schools in solving problems was noted by Mottus (1981, p. xvii):

. . . Although national associations decided upon professional standards, it was necessary for the training school to place them in practice. It was at the training school level that many battles were fought for the professionalization of nursing.

"The training schools expanded and upgraded their curricula to keep pace with medical progress and raised their standards to elevate nursing to a professional status" (Mottus, 1981, p. 64).

The superintendents of training schools recognized the lack of uniformity in programs regarding admission requirements of applicants, preliminary course content and length, and curriculum including theory and practice. The problem of training schools connected to specialty hospitals and need for affiliation with larger and general hospitals was also noted. Additionally, nursing leaders recognized the lack of preparation and experience for teaching or administrative positions.

Lack of legislation for
registration of nurses

There was a growing recognition among the leaders of the nursing profession of the need for legislation to accomplish the goals of uniformity and standardization. Palmer (1900, p. 166) summed the first quarter of the nursing profession with:

The controlling power of the training schools is in the hands of physicians and laymen . . . the trained nurse is a recognized factor . . . the public are woefully ignorant in regard to education and requirements of the modern trained nurse . . . need for organization and higher education . . . nurses graduated from all kinds of schools.

She also stated that nursing needed to proceed in such a way as to secure the assistance of all nurses and the medical profession. The two great principles of registration were: (1) giving a better training to nurses of the future, and (2) protecting the public and the regular graduate.

Some state associations were being formulated to assist nurses in their attempts to have legislation enacted that would set minimum standards. Nursing followed the model that the medical profession provided.

Each profession attempted to persuade state legislatures to pass registration and licensing laws which granted state examining boards composed of professionals with the power to establish minimum standards both for practitioners and schools. (Mottus, 1981, p. xiv)

Nurses in the various states were working to obtain legislation to establish minimum standards that "registered" graduates from a school with an approved program. The graduate would have to satisfactorily pass a required examination. In order to enforce these standards, the nursing leadership sought to have established Boards of Nurse Examiners with a nurse inspector of training schools.

The first four states to obtain Nurse Practice Acts were: North Carolina in March, 1903; New Jersey and New York in April, 1903; and Virginia in May, 1903. The state associations that had obtained registration shared their strategies with other states. Leaders of the registration movement worked against opposition from within nursing and from without. One of the main attacks dealt with whether the state associations truly represented all nurses. The leaders in the New York State Nurses' Association's Legislative Committee countered that any registered nurse would be able to join the association.

Augustus Downing, the first Assistant Commissioner of Education in New York State (Downing, 1912 p. 187) stated that, "New York led in standardizing of the general preliminary, the professional, the examination and the registration requirement. Now twenty-nine

states and territories have laws regulating nurse training." With registration there was now a definite distinction between a "nurse" and a legally sanctioned nurse.

The major weakness of most of the existing statutes was that they were permissive rather than mandatory. Even though the statutes were permissive, training schools were raising their standards and were seeking approval through the Boards of Nurse Examiners. Additionally, schools were requesting curriculum guides. Nursing was making progress in its movement toward self-regulation. As Downing (1912, pp. 196-97) stated, "It is time to amend the Nurse Practice Acts so as to absolutely protect the word 'nurse' and to license nurses by registration, that is, the license of a nurse shall be her certificate of registration."

American nurses were supported by other countries whose nursing associations were also seeking legislation to register nurses.

It is the opinion of the International Congress of Nurses, in general meeting assembled, that it is the duty of every country to work for suitable legislative enactment regulating the education of nurses and protecting the interests of the public by securing state examinations and public registration with the proper penalties for enforcing the same. ("Editorial Comment," 1901, p. 234)

Need for Journal

The recognition of the need for an official organ as a mark of profession dated back to 1893. Edith Draper, at the nursing subsection of the International Congress of Charities, Correction and Philanthropy, stated, "There is need for an American Nurses' Association which would encourage creation of a publication pertaining to nursing needs and the exchange of ideas" (Flanagan, 1976, p. 35). This idea of publishing a magazine was an objective of both of the nursing organizations and was discussed at the first two meetings of the Society. Since the sentiment was that this journal should represent the entire profession, actual work on it was delayed until a representative body (ANA) was formed in 1897.

At the first annual convention of the Nurses' Associated Alumnae in 1898, a committee was appointed to establish a nursing magazine (Flanagan, 1976, p. 36). This committee investigated possible circulation and possible means of financing such a journal. At the proceedings of the second annual convention of the Nurse' Association Alumnae, a committee on ways and means of producing a magazine was reorganized with Miss E. P. Davis as the chairman. In January 1900, the committee organized a stock company and shares of \$100 each were

sold only to nurses or to nurse alumnae associations, thus ensuring professional control of the magazine.

At the annual convention in May 1900, the committee acknowledged it had overstepped its authority by establishing a stock company. Davis asked the delegates to entrust the committee with the power to act on the recommendation that the business of actually publishing the journal be turned over to a publishing company which would furnish a business manager. The delegates approved and the J. B. Lippincott Company was chosen. The American Journal of Nursing was adopted as the name. Sophia F. Palmer was appointed the Editor-in-Chief, a position she maintained until her death in 1920 (Flanagan, 1976, p. 36).

The first publication of the Journal³ was 1 October 1900. Palmer and Davis had personally mailed out the first copies. Since the Journal was not incorporated there was no provision for mailing. In October 1902 the stockholders were incorporated and a board of directors was elected.

Thus, one of the profession and nursing leaders' goals was attained. All the stocks were secured by 1912 and the Journal was officially owned by the ANA.

³The American Journal of Nursing will be referred to as the Journal for the remainder of the paper.

The Journal was used as a vehicle to disseminate information regarding state registration. For a quarter of a century the Journal published new items under the title, "Progress of State Legislation" (Roberts, 1954, p. 73). The Journal was seen not only as important for communicating progress regarding state legislation, but also for other exchange of ideas. The nursing leaders hoped that nursing practice would improve concomitantly and used the pages of the Journal to publish early clinical papers concerning nursing procedures and techniques (Christy, 1971, p. 1780).

Wheeler (1985, p. 24) in her review of the early Journals noted that they presented monthly useful facts, progressive thought and the latest news that the profession had to offer. In 1908, "R.N." was used after the nurse's name. She noted from a 1910 editorial, ". . . registration in twenty-three states, with the standards which the Journal advocated practically uniform . . . chief guide and inspiration of the workers" (Wheeler, 1985, p. 27). Nurses were encouraged to both subscribe and write articles, so that the Journal could be truly a publication of the profession.

Few Dedicated Women

There was a distinct group of women who had dominated the nursing leadership during the last quarter

of the nineteenth century and the first decade of the twentieth century. The pivotal character in this group has been identified as Isabel Hampton Robb. Her leadership and personal qualities have been extolled by her contemporaries (McIsaac, 1910, pp. 9-38). Mrs. Robb's ability to lead and influence others was best described by a young nurse. "She was the radiant center of the magnetic force which brought the two national organizations into existence before 1900" (Roberts, 1954, p. 26).

Robb was able to share her visions and gain support of other key nurses of the time. Together these leaders orchestrated what was then the current nursing scene. Their ideas and visions were not only in response to the profession's present needs and problems, but rather they were plans for the future development of nursing. As Robb noted:

The objects as outlined in our constitution may seem simple and few in reading: and yet concealed in each there lies folded up the seed of many a plan and purpose that can only come to maturity in the fullness of time (Flanagan, 1976, p. 5)

These "seeds" included the formation and refinement of the nursing organizations, the standardization of educational programs through legislation, the development of a code of ethics, and a collegiate program for graduate nurses.

The development and implementation of these future plans was built upon the leaders' skills and ideas. In referring to Robb's idea regarding the course for graduate nurses at Teacher's College, Dock described Robb's ability to conceptualize: "I saw it dawning in her eyes at breakfast; at dinner it was nearing completion and at suppertime it was completed in all its details" (Dock, 1909, p. 955). It was this ability to conceptualize ideas and then enlist the aid of other leaders in the development of them which was so characteristic of Robb.

The appreciation that these women had for each other's abilities was a binding force among them. Their constant common goals were legitimizing nursing as a self-controlled profesison and generating reform in nursing and society at large (Wheeler, 1985, p. 20).

This small band of women recognized that with the existence of trained nurses as a reality, there were concomitant problems. Through the sharing of their ideas, plans and strategies began to take form. They were able to utilize their positions as superintendents of training schools to both identify problems facing nursing and to suggest directions to take to solve these problems. These leaders also used their organizational positions and often held positions in a couple of

organizations at the same time. For example, Miss Dock was secretary for the Superintendent's Society and at the same time secretary for the International Council of Nurses and editor of the Foreign Department of the American Journal of Nursing. These positions gave her a channel for communication on the national and international levels (Houggard, 1983). Several of the leaders held positions in the state and national associations. E. P. Davis and Sophia F. Palmer were examples of this (Doona, 1984, p. 5). Robb and Nutting at various times were elected to positions or committees in the Society and Associated Alumnae. These positions enabled the leaders to communicate their ideas, receive input from nurses and perhaps influence their thinking over a period of time.

Other kinds of influential positions such as: Board of Managers (Robb), Board of Nurse Examiners (Palmer), Nurse Inspector (Goodrich) and Director of the Hospital Economics Course at Teacher's College (Nutting) were used to advance the profession's goals.

Another demonstration of their organizational skill was the use of the Journal as a means of communicating ideas and goals while working toward uniformity. The development of this magazine was yet another example of their ability to work together and share goals.

It was a drama of women who dared an enterprise armed only with faith and common sense, who matched sound business judgement with sure knowledge that the time had come for the young profession to establish a journal. (Leone quoted in Roberts, 1954, p. v)

The nursing leaders assessed each situation and carried their plans to fruition. They successfully obtained the support of other non-nurse women, some physicians and administrators. Their ability to achieve organizational goals, have nursing legislation enacted before women had the vote, and at the same time maintain their employment positions was impressive.

Annie Goodrich, in her report as the Inspector of Training Schools of New York State presented at the New York State Nurses' Association, identified the contributions of those pioneer leaders:

We owe these efforts [registration] to the beloved women who fought so for what we have attained, who are no longer with us, Miss Allerton, to whom we greatly owe our recognition by the state, and Mrs. Robb, who never rested till she secured a firm foothold for us in Columbia University. We owe them to the splendid women who have worked for so long for us, Miss Palmer, our legal advisor, our historian, our teacher in the broadest sense of the word; Miss Dock, who has united us to our nurse sisters throughout the world; Miss Damer, who as president of the Associated Alumnae for so many years, worked for us in every state; Miss Alline, our pioneer instructor in the college and inspector in the state, to whom we owe a great debt, patiently, courageously, and alone establishing us under difficulties of which we have never heard and never will hear from her; Miss McIsaac, who has once more placed the yoke upon her shoulders and many others. But above all and because of all that has been done for us, we owe it to those who will come after us--

the children of the profession. (Goodrich, 1911, pp. 307-8)

Wheeler (1985, pp. 28-29) described the characteristics that enhanced the early nursing leaders in their shared mission:

. . . revered, deeply loved, and respected for their diversity and non-conformity . . . they encouraged one another in open discussion, supported conflict, and invited critique . . . dedicated to one goal: to move nursing forward onto a solid foundation . . . they did not discredit one another on the basis of noncompliance with a specific line of thought. Emphasis on membership in the professional organization as a true moral duty for the practicing nurse. . . . early nursing leaders were not isolated from their community and were leaders in the women's movement.

Power Analysis of the American Nurses' Association

The conception of the American Nurses' Association was born from the acknowledgement of the need for nurses to unite to obtain self-regulation. As Blau had described in his theoretical formulation of the development of power, the beginnings are derived from basic social attraction. Early nursing leaders were drawn to each other by common problems and interests. From these associations or contacts there emerged leaders and followers who were agreed upon a common goal. This solidarity of purpose bound them together.

Nurses were used to their role of being subjected by virtue of being women (socialized to be subservient) and nurses (socialized to a "calling" and selfless service). However, the control of nursing by non-nurses led to opposition of this control and reorganization. Thus, we have the development of nursing associations (NLN and ANA) and the movement for state registration of nurses.

The trade-off of social exchange for membership in ANA was that nurses could work together toward stated mutual benefits. Nurses elected leaders who demonstrated their ability to lead the group forward to the stated goal, e.g., uniformity of educational programs, registration or protection for graduates of approved programs, and the general welfare of nurses. As long as these were mutually agreed upon goals, members were willing to subject themselves to their new leaders.

An imbalance in the reciprocity of social exchanges occurred whenever there were differences in stated goals or the method in attaining these goals. For example, the emergence of three models of training schools: the modified Nightingale model, the Richards model and the Hampton model; the two-year versus the three-year curriculum; the eight-hour or longer work day for pupils; and, the subjects to be taught presented

conflicts among the ranks. The leadership attempted to maintain its power through publication of information and papers in the Journal, work with delegates at the association meetings (development of policy and positions), and by recommending former pupils for superintendent positions. Inasmuch as there were meaningful benefits to the members they chose to subject themselves to the leadership.

However, there were other nurses who were in opposition because they did not share the same common goals of the organization; did not feel that registration would get them a job; and were not willing to subject themselves to the leadership. Unfortunately, there were a number of nurses who had not come to share the value of organizing and uniting for their own common good.

Nevertheless, the solidarity of leadership had provided a foundation upon which to strengthen the organization. ANA still in its infancy was growing and making changes to both address the needs of nurses and the profession. The legitimation of its power had begun with the growing number of states enacting legislation to register nurses. All this before women had the vote.

CHAPTER IV

STRUCTURING ORGANIZATIONS: SOLVING PROBLEMS

(1913-1946)

Issues and Responses

The early developmental phase of the organization led the way to a focus on refining the organizational structure of ANA to continue to address the various issues which were problems for nursing. Ongoing issues concerned nursing education, nurse practice acts and the working conditions of nurses.

Nursing Education

Standardization of educational programs

One predominant issue was a continual need to work toward the standardization of basic educational programs. The burgeoning of schools to "train" nurses produced a number of nurses who were educated in a variety of programs. Hospitals equated student nurses with profit and "trained" them at an incredible rate. Between 1900 and 1929, the number of nursing schools soared from 549¹ to 1,885. The increase in the number

¹See footnote, Chapter III, p. 74.

of graduate nurses being turned out by the increased number of training schools schools was judged by nursing leaders to be more than what was needed. In 1920, for example, there were 149,128 nurses, yet by 1930 there were 294,263--a ninety-seven percent increase while the population had increased by only sixteen percent (Wagner, 1980, pp. 273-74). Additionally, "untrained nurses" achieved "degrees" through correspondence schools, unlicensed programs and fraud. There was an increased awareness within the profession of the value of standard criteria for a uniform curriculum. This awareness was intensified through discussions at joint meetings of the ANA and NLNE and through articles published in the Journal ("Nursing News and Announcements," 1914, pp. 1000-04).

NLNE Curriculum Committee

Through the appointment of a committee on curriculum at the nineteenth annual convention of the NLNE in July 1913, an attempt to present a guide for standardizing curriculum of schools of nursing was initiated ("Nursing News and Announcements," 1914, pp. 1000-04). Since the NLNE was now affiliated with ANA, the work of this committee had the approval and cooperation of ANA. In 1912, through changes in its bylaws, NLNE became an integral part of the American Nurses' Association,

although retaining its individuality and purpose (Noyes, 1913, p. 498).

The Committee on Curriculum was chaired by Adelaide Nutting, the secretary was Isabel M. Stewart and it functioned as the Education Department for ANA. NLNE's committee worked on the curriculum for three years and presented their results in a report at the joint meeting of ANA, NLNE and NOPHN in July 1917 ("Report of the Committee on Legislation," 1917, pp. 918-925). The Standard Curriculum (Committee on Education of the National League for Nursing Education, 1917) was formulated as a suggested curriculum which could be used as a national standard for training schools. However, the authors cautioned that it was a suggestion and not a model.

The Standard Curriculum firmly established the League as the authoritative source of information on nursing education. This curriculum reinforced the good work of the better schools and set a standard for other schools to work toward. Boards of Nurse Examiners welcomed The Standard Curriculum as a tool, which could be used to evaluate training programs (Roberts, 1954, p. 100).

Although the development of this curriculum was hailed as a major accomplishment, the committee

recognized the need to continue studying the curricula of schools of nursing and, according to changes in society, make adjustments in their proposals. The committee submitted their recommendations for curriculum revision in their report at the joint meeting of the three national nursing organizations in 1927. The revised edition was entitled, A Curriculum for Nursing (Committee on Education of the National League for Nursing Education, 1927).

The committee continued its work on setting standards for curriculum in schools of nursing. The changing needs of society as well as the needs of the profession necessitated that the committee on curriculum of the NLNE, under the able chairmanship of Isabel Stewart, continue to work on the development of yet another new curriculum. In 1937, the committee published A Curriculum Guide for Schools of Nursing. The committee had input from the various state leagues. In order to make the profession aware of their ongoing work, they published several articles in the Journal. Additionally, the committee had input from experts in the field of education, representatives of nursing school faculties, members of state boards of nurse examiners, and other persons interested in the project (Committee on Curriculum of the National League for

Nursing Education, 1937). The continued intent of the committee was that the curriculum be used as a "guide" for nursing schools in the development of their own curriculum. The work of the curriculum committee and the impact that it had on improving educational standards of school nursing demonstrated its power on influencing the nursing scene.

Nursing Education Studies

Throughout this period of time, 1912 through 1946, various studies were conducted by groups outside the professional organizations, to assess the efficacy of educational programs. These assessments were concerned with the needs of nurses, nursing and society.

"Educational Status of Nursing"

In 1912, an extensive study of nursing schools in the United States was conducted by M. Adelaide Nutting. The results of the study were published in the U.S. Bureau of Education Bulletin. The study provided a comprehensive overview of nursing education as it was then. This was the first major study on nursing education.

Nutting's study identified negative as well as positive aspects of these programs. For example, some identified problems were: minimal admission requirements

for applicants to nursing schools, few paid instructors, and low occupancy of patients in hospitals with attached schools of nursing. The study pointed out many of the problems in the poorer schools. Despite all of the problems that were identified, it had little impact on changing the conditions in nursing education (Nutting, 1912, pp. 60-91).

Nutting's study was not widely publicized and received little attention. The fact that it was published in a bulletin not widely read by nurses helped to maintain its obscurity. Other nursing studies had received more publicity in the Journal. Her study clearly did not have the same impact on nursing education that Flexner's 1910 report had on medical education.

Nursing and nursing education in the United States

In 1923, another study on nursing education, the Winslow-Goldmark report on Nursing and Nursing Education in the United States was published. This broad scale study was based on firsthand observations of nurses at work as public health nurses, teachers and administrators of schools of nursing. The report identified shortcomings of nursing education and public health nursing. There was nursing representation included on

the committee. Ten conclusions were reported from their study. Among these conclusions, the committee identified the need for educational preparation beyond the basic program for public health nurses, teachers and administrators. The committee also advocated that university schools be developed and strengthened and that high educational standards be maintained (Committee for the Study of Nursing Education, 1923, pp. 1-36).

The grading report

Another major study undertaken during this period was initiated by the committee on grading of schools of nursing, named the Grading Committee. The work and findings of the committee were widely publicized in the American Journal of Nursing. This eight-year project was begun in 1926 and concluded in 1934. The committee had two representatives from the American College of Surgeons, the American Hospital Association, the American Medical Association, the American Nurses' Association, the American Public Health Association, the National League of Nursing Education, and the National Organization of Public Health Nursing and seven members at large. The goals of the committee were to investigate the supply and demand for nursing services; to do a job analysis of nursing and nurse-teaching; and, to

explore the grading of nursing schools (Roberts, 1954, pp. 234-37).

Mary Ayres Burgess, the director of the committee, reported the findings of her study on nursing economics at the 1928 ANA convention. In her report, Nurses, Patients and Pocketbooks, she identified four main problems which were confronting the nursing profession. These were the need to: reduce and improve the supply of nurses, replace nursing students by graduate nurses, assist hospitals to meet the costs of graduate nurses and attain public support for nursing education (Burgess, 1928). This report on the economics of nursing served as the basis for the remaining studies of the committee on nursing education.

The Grading Committee published two reports in 1934. The first, An Activity Analysis of Nursing was written by Ethel Johns and Blanche Pfefferkon. This study reported the findings made by nurse educators on the job analysis of nursing and nurse teaching. The purpose of doing the study was to identify all the activities related to nursing care. These lists were believed to be helpful in curriculum development. As a part of the report, a list of eight conclusions defining the functions of professional nurses was included (Johns and Pfefferkon, 1934, pp. 40-41).

The final report of the committee entitled Nursing Schools Today and Tomorrow provided a basic overview of the eight-year study. The report discussed the knowledge and skills of the professional nurse, the essential elements of a professional school of nursing, and courses for graduate nurses (Committee on the Grading of Nursing Schools, 1934, pp. 15-21).

The committee's reports and the discussions of the activities of committee members with nurses and nursing leaders emphasized the need for further study of nursing services. The three national organizations established a Joint Committee on the Distribution of Nursing Services in 1928. ANA, in 1932, assumed responsibility for the work of the committee. A two-year project to develop standards of hourly and group nursing and to organize councils to study the nursing needs of the community was undertaken (Flanagan, 1976, pp. 86-87).

In addition to the focus of the needed changes in nursing services, there was also the identification of needed changes in nursing education. With the development of the NLNE curriculum guides and the various studies on nursing education, the nursing profession and society responded in several ways.

Registration of Nurses

As educational programs became more standardized, nursing leaders also worked on obtaining better legislation. The period following 1912 saw a proliferation of Nurse Practice Acts. There were attempts with varying degrees of success to change permissive registration to mandatory registration. The thinking of the time was that some form of legislation was better than none. The greatest emphasis on mandatory registration occurred after 1938. There were forty-five states, the District of Columbia and Hawaii that had some type of registration (Christy, 1971, p. 1781). In 1939, ANA adopted a policy favoring "licensure of all who nurse for hire" (Roberts, 1954, p. 665). The movement was toward demanding that the person who nursed for hire be required to register. The increased number of states with registration demonstrated the growing power of the association. In the Journal there was a regular section entitled, "Progress of State Registration."

The State Nurses' Associations were sharing their successful strategies used to obtain registration of qualified graduate nurses. The ANA through its office of the Interstate Secretary was also assisting the states in their struggle for registration ("Nursing News and Announcements," 1914, pp. 99-100). In 1914, a

Central Bureau of Legislation and information was created by ANA. The purpose of the bureau was to be a clearinghouse for information related to nurse registration for the states.

Another factor identified in the association's movement toward registration of all practicing nurses was the importance of the women's vote. "The vote is a great factor in individual progress as well as in state affairs and western women have shown how well they can use their vote" ("Progress of State Registration," 1916, p. 625). There was a call for nurses to push for the women's vote and in the meantime to continue to influence the men's vote. In the United States women obtained the vote in 1919. The fact that ANA had taken so long to take a stand on the women's vote diminished their power base with many members of the association.

Improvement of Nursing Schools

In 1915, the first list of schools approved by the Boards of Nurse Examiners was published ("Report of Education Committee," 1914, pp. 930-31). Improving nursing school programs and strengthening nurse practice acts were dominant themes of the profession and the association. Boards of Nurse Examiners had a stronger basis upon which to hold schools responsible for improving their standards of education. As a result of the

curriculum guides, they now had criteria to evaluate schools of nursing. Weak or poor programs were slowly forced to close and the remaining programs were helped to improve.

The need for nurse inspectors of training schools was again emphasized, as well as the importance of nursing regulating its own practice. At the ANA's twentieth annual convention in April 1917, the report of the legislative committee chaired by Anna C. Jammé, was presented describing the minimum curriculum for an accredited school of nursing program ("Report of the Committee on Legislation," 1917, pp. 918-25). A universal standard of nursing school programs was identified as a basis for reciprocity.

With the standardization of curricula, there was a recognition to do something about improving the educational programs offered in the small or specialty hospitals. One way to implement improvement was through the concept of a central school such as the one at Illinois Training School which was gaining popularity among superintendents. The central school concept involved having students from various programs engaged in the same basic theoretical program at one institution and then affiliating at various hospitals for their clinical experience. This model was seen as an answer to small

programs. The central school provided a uniform education for a number of programs and at the same time was economical. Standardization was a consistent topic at the annual conventions of the organizations ("Editorial Comment," 1913, pp. 85, 249-54; "Editorial Comment," 1916, p. 1068; "Editorial Comment," 1917, pp. 1042-48).

New Concepts in Education

Another result of the findings of these studies was a growing interest in endowing universities to experiment with schools of nursing. Several experimental programs were established. One such program was opened at Yale University. Annie W. Goodrich, who assisted in starting the program was appointed its first dean. Opened in 1924, the Yale School of Nursing was the first in the world to be established as a separate university department with an independent budget and its own dean (Kalisch and Kalisch, 1978, p. 338). In 1926, the baccalaureate degree in nursing was conferred upon its first two graduates. A second school was opened in Cleveland, Ohio and named the Frances Payne Bolton School of Nursing. Mrs. Bolton had endowed the program. Carolyn E. Gray was the first dean. The school was later renamed Western Reserve University School of Nursing. Another school was opened in 1930. Shirley C.

Titus was appointed dean of the newly established Vanderbilt School of Nursing in Nashville, Tennessee.

By 1923, eighteen colleges and universities were offering the combined academic and professional course of four or, more frequently, five years. There were ten state or municipal universities with nursing programs. The majority of these municipal universities also had three-year programs in which most of their students were enrolled (Roberts, 1954, pp. 180-82).

Problems with Graduate Nurses' Work Conditions

At the start of the second decade of the twentieth century, most practicing nurses were still untrained. The increasing number of nurses, trained and untrained, and the limited number of nursing positions created a problem for the profession. As was described in the Grading Report of 1934, there were "too many but too few," that is, there were many nurses but few who were well prepared educationally (Committee on the Grading of Nursing Schools, 1934, pp. 22-60). The public did not know what it was "buying" when a nurse was hired. Even nurses who were trained came from a variety of programs with extremely diverse educational standards. This lack of uniformity of training programs was noted from the medical community as well as the nursing community. Registration where it was in existence was

mostly permissive or not enforced. This situation presented a dilemma for both the graduate nurse and the public. Nursing leaders such as Annie Goodrich believed that because of this lack of uniformity there was a need for orientation of graduate nurses following employment (Goodrich, 1913, pp. 335-42).

As basic training became more standardized, other problems of nurses became more evident. Graduate nurses sought advanced preparation to become teachers of student nurses. Prior to this time teaching in schools of nursing was done by physicians or the superintendent or principal of the school who had no teacher's training. Programs such as the courses offered at Teachers College at Columbia University were turning out a better educated and more knowledgeable nurse teacher. This nurse was proficient not only in the practice of nursing but in teaching also. With the advent of better educated nurses, not only were they hired as teachers, but as head nurses on the wards. This was a position originally filled by senior nursing students (Goodrich, 1913, pp. 335-42).

Expanding Roles for Nurses

The primary work setting for the graduate nurse was still private duty nursing in the home. In 1930, between seventy and seventy-five percent of all

registered nurses were self-employed as private duty nurses (Wagner, 1980, p. 272). This group of nurses, however, was subjected to seasonal unemployment and was isolated from other nurses. The private duty nurse worked long hours, often by her own choice. This often resulted in a decrease in the number of jobs available. Consequently, a number of private duty nurses sought jobs in hospitals despite the poor working conditions.

In the community, in addition to private duty nurses, there were also visiting nurses and some school and industrial nurses. The firm basis for the role of the visiting nurse had been initiated by the work of nursing pioneers like Lillian Wald who had established the Henry Street Settlement. Over the years, there were more nurses being drawn into this field of nursing.

Even the role of the visiting nurse had not remained static. The visiting nurse's role had expanded under the umbrella of a new identification known as the public health nurse. As Edna Foley (1914, p. 803)

wrote:

Public health nursing is a product of evolution from district/visiting nursing and now includes the school nurse, infant welfare nurse, tuberculosis nurse, hospital social service nurse, a sanitary inspector, a truant officer, a social worker, a visiting dietitian and even a mid-wife.

These additional roles reinforced the need for national standards. The expansion of roles stressed the

importance of advanced educational preparation beyond the basic program. At Teachers College courses were offered to help prepare the public health nurse to fulfill her role (Roberts, 1954, p. 88).

Another community role for the graduate nurse was as a member of the American Red Cross Nursing Service. The Red Cross nurse had to be registered and be a member of ANA. These nurses were prepared to do disaster nursing. Their role had expanded to include rural nursing. The demands placed upon this service over the years became so extensive that it broadened into the Town and Country Nursing Service of the American Red Cross in 1912. Providing public health nursing services was a large component of their work (Roberts, 1954, pp. 87, 193; "Town and Country Service," 1916, p. 745). The American Red Cross Nursing Service also maintained its close ties with the Army Nurse Corps and the Navy Nurse Corps and during World War I was the mechanism whereby nurses were recruited for military service.

All of these expanded roles for the graduate nurse emphasized their need for advanced educational preparation beyond basic educational programs. Previously, the offering of electives in the senior year was encouraged to fill this need. Expansion of the role of the graduate nurse beyond private nursing in the home

led to the increased emphasis on advanced preparation following graduation ("Editorial Comment," 1917, pp. 1042-48).

In 1916, the NLNE and NOPHN initiated a joint effort to develop recommendations for basic curriculums upon which any type of specialization could be built, as might be required by changing medical and social needs (Roberts, 1954, p. 97). The Nursing Department at Teachers College and programs in Boston and Cleveland offered advance courses for public health nurses.

Formal advanced training in the field dates back to 1906, when the Boston District Nursing Association first offered a course in practical training. In 1910, Teachers College began its course offering. In the next year, 1911, Cleveland offered a public health nursing course under the Visiting Nurse Association. Philadelphia, in 1913, gave a course by Phipps Institute. In 1914, a course was established by the New Haven Visiting Nurses Association. Except for the Teachers College courses all the courses organized prior to 1917 were organized by visiting nurse associations or other public health organizations. During the year 1919-20, there was in existence in the United States twenty schools offering courses in public health nursing (Committee for the Study of Nursing Education, 1923, pp. 500-01).

There were also post-graduate courses offered for other areas of nursing, such as operating room, communicable diseases, care and feeding of infants and obstetrics. The positive reception of these courses by both nurses and teachers reinforced the need for education beyond the basic generic programs.

In the 1940s, the largest number of employed practitioners was the hospital-based general staff nurse (Christy, 1971, p. 1781). In 1929, only about 4,000 nurses were employed by hospitals for salaries. By the end of World War II, the majority of registered nurses were "staff" or "general duty" nurses employed in wards of hospitals. This period also marked

the development of modern hospital personnel policies; the emergence of division of labor between registered nurses, practical nurses and aides; and the growth of hospital programs to inculcate their work forces with an institutional and professional loyalty. (Wagner, 1980, p. 272)

Deteriorating Conditions

The general staff nurse often was working in poor to deteriorating conditions. The eight-hour working day did not become a reality for the graduate nurse until 1938. Obstacles to the attainment of this goal came from resistance within nursing as well as from without nursing. Problems with staff scheduling (cost to hospitals), "unionism" and the desire of the private

duty nurse to work longer hours were cited as reasons for not limiting the working day of the nurse (Jammé, 1919, pp. 525-30). As Dock stated, these nurses deserved education, shorter hours and a living wage. Also that their positions should bear some relationship to the working world (Dock, 1913, p. 971). The eight-hour day also made it possible for more nurses to obtain work.

Hospital administration seeking to control both costs and nursing was advocating the use of the hospital attendant in 1919. Once again little thought was given to the need for training or the distinction between roles of the two groups. Supervision was lacking as was their job description. This was particularly true in the smaller hospitals. The Journal published articles on the importance of trained attendants and their registration by state boards of nurse examiners ("Editorial Comment," 1919, p. 415). For the most part this group of workers was only used during World War I and they were not widely incorporated into nursing. In fact, there was overt movement to exclude them from nursing and of nursing's leadership only Jane Delano was in overt support of them.

In 1936, a committee of the NLNE and the Division on Nursing of the Council of the American Hospital

Association published a Manual of the Essentials of Good Hospital Nursing Service (Flanagan, 1976, p. 110). A section in the manual stressed the importance of supervision and control of the subsidiary or auxiliary worker. Between 1936 and 1947, statements regarding the role of the subsidiary worker in the care of the sick were periodically published in the Journal. In 1942, the National Association for Practical Nurse Education was organized to develop courses for vocational workers. By the end of 1947, the work of the three national nursing organizations had resulted in the establishment of over fifty recognized schools of practical nursing, and a degree of legal control of practical nurses in twenty states (Flanagan, 1976, pp. 110-12).

Impact of Societal Conditions: Industrialization, the Depression and the Two World Wars

During the first half of the twentieth century, a number of societal conditions greatly impacted the American scene. These included increased industrialization, the Great Depression and two world wars. Each of these conditions had definite effects upon nursing as well as upon society. Industrialization resulted in a period of great productivity. People moved from rural areas to urban areas in ever increasing numbers. Women

moved outside the home to find employment. People in general were more mobile.

Additionally, these and other societal changes affected health care delivery. There was the formation of the Children's Bureau and Food and Drug Administration. In addition, laws were enacted regarding child labor laws, mandatory education and quarantining for infectious diseases. All these changes in health care delivery led to an increased need for public health nurses.

World War I presented a whole new set of challenges for nursing that had to be met by the profession if extrinsic forces were not to interfere. Congress declared war on Germany and President Wilson signed the declaration on 6 April 1917. The direct involvement of the United States necessitated the increased enrollment of nurses in the Red Cross. Adelaide Nutting's Committee on the Nursing of the General Medical Board on the Council of National Defense asked the ANA president, Annie Goodrich, to make a survey of national nursing resources and a survey of nursing in military hospitals. This survey provided a basis for wartime and postwar planning. It was important that a survey of nurses in the United States be taken, since all states did not have registration and there was no record of the total

number of nurses available (Roberts, 1954, pp. 130-37). There needed to be a list of nurses who were available for civilian as well as military service. Military hospitals were established on bases throughout the United States. The Red Cross recruited nurses for military service. Their high standards and the requirement for nurses to be Red Cross nurses first, in turn affected the quality of nursing education. The Red Cross had sent nurses overseas even before the United States actually declared war ("Editorial Comment," 1917, pp. 469-74). Nursing resources were further depleted by nurses who went overseas on their own to serve in Red Cross hospitals.

In the spring of 1918, as a result of the military hospital survey, the committee recommended the establishment of the Army School of Nursing. In May 1918, Miss Goodrich was appointed as its dean. The school was centralized in the Surgeon General's office. Training units and teaching staffs were in many camp hospitals. The student was offered a three-year diploma course and had to meet requirements for state registration. Miss Goodrich believed that the care given by a student trained in such a program would be superior to care given by trained aides plus providing an ongoing supply of registered nurses (Kalisch and Kalisch, 1978,

p. 308). The Army School of Nursing was established and flourished despite the controversy and opposition surrounding it. Under Annie Goodrich's able direction, the school was hailed as an outstanding demonstration of the application of the principles of administration, teaching and organization. The three national nursing organizations supported its development. It stayed in existence until the early 1930s.

Another accomplishment for nursing was the Vassar experiment. During the summer of 1918, the Committee on Nursing attempted to recruit female college graduates into nursing through an experimental program. A twelve-week intensive preliminary course in nursing was offered to graduates of approved colleges on the Vassar campus. At the end of the course the students chose from a list of thirty-three cooperating hospital schools of nursing from which they would receive the rest of their training lasting two years and three months. The standard of teaching at Vassar was noted to be higher than that in other nursing programs. This experiment was sponsored by the Red Cross and the Council of National Defense and functioned much like the central school concept (Roberts, 1954, p. 135; Kalisch and Kalisch, 1978, pp. 303-04).

The proposal of the use of Red Cross aides to alleviate the demands for nurses was opposed by both Miss Nutting and Miss Goodrich. This issue was debated at the joint convention of the three national nursing organizations in 1918. Miss Delano graciously conceded and proceeded to enroll thousands of nurses for the military service (Christy, 1971, p. 1782). Nursing leaders demonstrated the use of their power through their obtaining the support of other nurses in this endeavor.

On the heels of the end of World War I came the influenza epidemic of 1918. Not only did this catastrophic event increase the number of nurses needed but it was problematic in that a number of nurses died as a result of contracting the flu (Roberts, 1954, p. 223). Influenza, complicated by pneumonia, was a major health problem of that time.

Following the war and the influenza epidemic, the nation attempted to return to its peacetime efforts and focus on the economy and societal conditions. Between 1924 and 1934, disease prevention and health maintenance were emphasized.

Unfortunately during this period, "The Great Depression" occurred. The public, financially limited, could not afford health.

The social consequences of unemployment were quickly registered in the clamor for relief in the great industrial centers. A survey of 126 cities, made in 1932, representing 56 per cent of the urban population of the United States, reported relief aid to 823,894 families in May, 1932, as against 386,151 families of the previous year. Relief expenditures of New York City set at approximately one million dollars in October, 1929, rose to nine and a half million dollars in February, 1933. The Committee on Costs of Medical Care reported "appalling" conditions in the South where the incomes of the people in ten southern states were so low that they were unable to purchase adequate treatment. (Beard and Beard, 1939, pp. 64-65)

Among the unemployed were also nurses. The hardest hit group was the private duty nurses. The public, unable to pay for health care, sought needed care in public health agencies (Roberts, 1954, p. 223).

With the rise in unemployment, ANA established a committee on Distribution of Nursing Services in 1932. This committee sent letters to Boards of Trustees of Hospitals, Hospital Administrators, and Directors of Schools of Nursing. The committee encouraged use of graduate nurses instead of student nurses and the decrease in the numbers of schools producing ill-prepared nurses. Although the replies were essentially positive, only 115 out of 6000 responses were received. As a result of the depression, more graduates were hired and there was a decrease in the number of schools (Christy, 1971, p. 1783). These results demonstrated

the ability of nurses working through organizational structure to effect positive changes.

Some major developments which contributed to the increased employment of nurses were: the National Recovery Act of 1933, the Federal Emergency Relief Administration of 1934 and the Works Progress Administration of 1935. The American Nurses' Association and the National Organization for Public Health Nursing shared major roles in these projects. ANA was working for the welfare of nurses and NOPHN was concerned with administrative problems related to the administration of public health programs (Christy, 1971, p. 1783). The involvement in these projects brought nursing out of isolation and had the profession working together through the national nursing organizations. Nursing was also involved in collaborating with other agencies, official and voluntary (Roberts, 1954, p. 231). Once again nursing had worked together to achieve desired goals and strengthened their role as a contributor to society.

At the start of the Second World War, nursing was better prepared to meet the demands placed upon it. In 1940, ANA proposed and became a constituent member of the Nursing Council on National Defense. In 1941, ANA participated with the United States Public Health

Service in a survey to identify nursing resources. They prepared with NLNE a Digest of Nurse Practice Acts and Board Rules which was used to speed up the process of licensure by reciprocity. A study was done on the vacancies of nurses in domestic hospitals (Christy, 1971, p. 1784).

In 1943, the Bolton Bill created the Cadet Nurse Corps. Graduates were needed for military service and increased the number of students needed for the nation's schools of nursing. Passage of laws providing commissioned rank to Army and Navy nurses were finally achieved. Despite the involvement of nurses in the military effort--one out of three nurses were in the armed forces and 125,000 cadets in training--there was talk of the conscription of nurses. In 1945, there was a proposal to draft nurses. The position of ANA, as stated through its president Katharine Densford Dreves, was that any draft would include all women. As a result, the draft was delayed until a definite need could be established. In the meantime, the war in Europe ended (Schutt, 1971, p. 1792).

By 1946, the war was over and nurses were returning to and being absorbed in the domestic scene. Individually and through their nursing associations, nurses had served a vital role for their country. Julia

Stimson was the president of ANA and the superintendent of the Army Nurse Corps (Christy, 1971, p. 1784). The American Nurses' Association was celebrating its fiftieth anniversary and becoming involved, as were all Americans, in the Reconstruction period.

ANA Structural Changes

The American Nurses' Association, in an attempt to address the needs of standardization and registration for nurses and nursing, looked to the structure of the organization. As a result, several structural changes were initiated.

ANA was already affiliated with NLNE, through a change in NLNE's bylaws in 1912 allowing it to become a member of ANA. Both organizations had encouraged the formation of the National Organization for Public Health Nurses (NOPHN) as a means of providing a forum for the standardization of visiting nurses. In 1913, there was an amalgamation of the three national nursing organizations (Noyes, 1913, pp. 498-504). These organizations held joint meetings beginning in 1912 in order to coordinate their efforts to move nursing forward. The meetings facilitated their communication and working together. They were held annually through 1920 and biennially until 1952 (Roberts, 1954, p. 98).

Basic entry unit

A second structural change was from the alumnae association being the basic unit of entry to the state association becoming the basic unit of entry into the national association. This new structure provided representation for the individual nurse at all levels-- alumnae (gradually being phased out), district, state, national and international. ANA through the state association was able to work more effectively for state registration (reciprocity). Also, since nurses were extremely mobile, having state associations allowed them greater ease in maintaining their membership in the national association. The district, state and national levels of the organization provided a more equitable and realistic structure for the distribution of work to address the issues impacting upon the profession ("Report of the Nineteenth Annual ANA Convention," 1916, pp. 787-962).

Committee on revision
of bylaws

The ANA committee on revision of bylaws was hard at work restructuring the organization from 1916 to 1922. A main element in the restructuring focused upon strengthening the state nurses' associations. This movement culminated in the Federation of the State

Associations in 1922. The presidents of the state associations met annually and reported the summary of their meetings at the annual meeting. In 1916, ANA initiated an Advisory Council ("Report of the Nineteenth Annual ANA Convention," 1916, p. 830). The composition of the council included the presidents of the state associations, ANA officers, chairmen of the sections and the editor of the Journal. The council was kept informed of Board actions and problems which required action by the Board. Their meetings were held in connection with the biennial conventions of the association. ANA also broadened its executive committee to include the presidents of the NLNE and the NOPHN as ex-officio members (Nursing Archives, Mugar Memorial Library, ANA Collection, Box 10, Folder 5).

Another change that occurred at the 1916 convention was the establishment of the House of Delegates as the voting body of ANA. At the same convention the first two sections of the organization were initiated. These were the private duty and mental hygiene sections ("Business Section--Nineteenth ANA Annual Conventions," 1916, pp. 829-32).

Due to the various kinds of membership, ANA could no longer be legally incorporated under New York State laws. Therefore, the revision committee proposed

other possibilities for the incorporation of the association. ANA attempted to obtain a national charter through Congress. Although the process was begun there were many delays due to the legislature's occupation with the problems of World War I ("Business Section," 1916, pp. 830-31; "Business Session--Twentieth Annual ANA Convention," 1917, pp. 1005-08). Consequently, the decision was made to stop proceedings for a national charter and instead incorporate under District of Columbia laws. This was accomplished in 1917 and became effective in 1918. The NLNE also incorporated under the District of Columbia laws in 1918. In order to assist the state associations in changing their charters to comply with the national, the ANA Interstate Secretary corresponded with state officials and attended their meetings (Nursing Archives, Mugar Memorial Library, ANA Collection, Box 14, Folder 1).

Registries

Another issue addressed by the ANA concerned the necessity of the formation and standardization of central registries for nurses. Registries were initiated to assist in the employment of private duty nurses. Early registries were operated by physicians, hospitals or by training schools under a variety of rules and regulations. ANA appointed a committee on Central

Directories in 1916 to study this issue ("Business Section--Nineteenth ANA Annual Convention," 1916, p. 824). Two other studies were done in 1929 and again in 1942 (Flanagan, 1976, pp. 104-6). There were also articles published in the Journal on the need for registries to be organized by registered nurses, appointed by local nursing organizations and administered by registered nurses. In 1932, the Board of Directors of the ANA adopted the following definition for the "nurses' professional registry":

The nurses' professional registry in a given community is that registry which has been so designated by the local nurses' association and has been approved as such by the state nurses' association. Where there is no district nurses' association, the state nurses' association is to designate and approve the nurses' professional registry. (Quoted from Flanagan, 1976, p. 104)

The importance of having registries standardized was identified. Between 1932 and 1934, ANA's Committee of Distribution of Community Nursing Services studied ways to improve and standardize the registries. In 1934 the ANA house of delegates adopted recommendations to organize registries as community agencies, functioning as community programs (Nursing Archives, Mugar Memorial Library, ANA Collection, Box 34, Folder 10).

Professional counseling and placement services

A focus of the ANA 1936 convention was on the role of the association in establishing a guidance and placement service for nurses. This was in response to the high unemployment rate and job insecurity that resulted from the depression. Following a feasibility study on the need for a professional guidance and placement service and its operation through state associations, an experiment was initiated at the Nurse Placement Service in Chicago in 1944. With the approval of the plan by state associations, in May of 1945, the Professional Counseling and Placement Service, Inc., of the American Nurses' Association was officially organized and incorporated in the State of New York as a subsidiary corporation, wholly-owned by the American Nurses' Association. The Service functioned as an employment agency for nurses and as a disseminator of information related to nurses and the kinds of nursing service needed in a specific geographic location (Flanagan, 1976, pp. 107, 108).

Formation of bureaus

ANA was also attempting to provide a broader base of services through its establishment of various bureaus. In 1916, a committee on a Central Bureau was

formed. This committee was to provide verifying lists of accredited schools given out by the Boards of Nurse Examiners. They were also charged with the necessity for developing a uniform method of training school records ("Editorial Comment," 1914, p. 944). In 1934, the Nursing Information Bureau of the ANA was established by the American Journal of Nursing Company. In 1935, the bureau published its first Facts About Nursing. In 1943, the ANA Bureau of State Boards of Nurse Examiners was established. This was another attempt to coordinate and disseminate information between ANA and other agencies (Roberts, 1954, p. 656).

National Headquarters Office

Another method for ANA to provide service was through the study made by the committee on a central headquarters. The committee identified an increasing need to have a central location for all nursing interests. Cost and size as well as location of such a headquarters was investigated. In 1921, the National Nursing Headquarters was established in New York City. With the establishment of the central headquarters came the appointment of a Director, Agnes C. Deans ("Editorial Comment," 1914, p. 947).

All of these changes in the ANA structure served to strengthen its role in pushing the profession

forward. In so doing it was more firmly establishing its power base.

Power Analysis of the American
Nurses' Association

Nursing leaders of the American Nurses' Association were continuously examining the structure of the organization to determine how adequately the needs of the profession and nurses were being met. Early leaders had laid a sound foundation for the organization to continue to grow. During the period, 1913 to 1946, a number of changes were needed to meet and maintain professional goals.

A major demonstration of this examination of structure was in the evolving power relationship between the state associations and the national association. In order to obtain registration of all practicing nurses, ANA had to work through the state associations. The national association provided information and strategies and the states obtained some form of registration. Eventually the "trade-offs" between the state and the national associations moved the profession toward more standardization of registration of nurses throughout the country.

The state associations in addition to responsibility to the national association, were also

responsible to its members. Bylaws of the state associations had to comply with ANA's. The ANA Board set policy and with the assistance of the state and district associations implemented the policy. State nurse associations participated in determining policy through the membership of their presidents on the ANA Advisory Council.

With the establishment of the house of delegates as the voting body of ANA, the members themselves gained some control over the direction that the association took. They (the delegates) were elected by their sections and served as representatives of the entire membership.

There existed a reciprocal relationship between the officers of the association and the house of delegates. Once the delegates voted on issues, the Board was empowered to carry out these policies during the following biennium. A number of trade-offs occurred among the delegates and between the delegates and the Board. An example of an issue around which trade-offs occurred was the debate on the Red Cross aides. There was division among nursing leaders as to the use of aides. Following debate the leaders who had more power prevailed and the members worked together to have more nurses enrolled in the military service.

The ANA in response to the power given it by the membership, provided services through structural units and programs such as: sections, bureaus, employment services, etc., as the social exchange for the support from the membership. ANA also worked to combat the poor working conditions of the graduate nurse through the use of the skills of nursing leaders and their positions within and without the organization.

Increased membership in the organization presented a problem in moving from a homogenous to a heterogenous group, thus making it difficult for democratic participation. There was more representation from the rank and file who had different interests and different priorities than the association leadership. The membership was willing to subject themselves to the leadership when the payoff was in their interest. When opposition to leadership occurred, the members pushed for change within the organization or dropped out of the organization. Other members were willing to give the leadership legitimation to run the organization.

Despite all the problems of this period, ANA maintained a large membership (176,307) and worked for the general welfare of nurses while upholding the standards of the profession.

CHAPTER V

MATURING: FURTHER EVOLUTION OF THE ORGANIZATION (1947-1960)

The duplication of efforts by the various nursing organizations to address the problems confronting nursing was discussed at the 1946 ANA biennial convention. The House of Delegates adopted as its first platform plank, the improvement of nursing service and the welfare of nurses. Delegates voted to begin work on these two issues immediately rather than delay action on them until after completion of the structure study (Proceedings of the Thirty-Fifth ANA Convention, 1946).

This study will be discussed later. The adoption of the 1946 platform plus the organization's initiation of the structure study set the framework for the work of the profession during the late 1940s and 1950s.

Following this convention, the professional organization continued to evolve. This evolution was in response to ANA's growing recognition of needed professional changes related to societal changes.

Issues and Responses

There were increased demands for nursing service from both the civilian and military sectors. During the 1940s, these demands reinforced the professional organization's need to re-examine nursing's role in relation to society. Some of the needed changes had already been identified in the late 1930s and early 1940s (Schutt, 1971, p. 1785). However, work on the solution to these problems needed to be deferred until after the war.

National Nursing Council

Following the war, the whole country was engaged in a reconstruction effort. Nurses and nursing took their place within this movement. ANA through its membership on the National Nursing Council collaborated with the other national nursing organizations and some allied health groups to identify problems of nursing education and nursing service. This council had been previously named the National Nursing Council for War Service. The National Nursing Council had been formed in 1945 and the "jointness" of the council membership as well as its effectiveness reinforced the need to study the existing nursing organizations (Schutt, 1971, p. 1785).

Three major activities that the council was involved in were: the inception of the school

accreditation program under the direction of the NLNE, the initiation of a socioeconomic study conducted by the Department of Labor, and the initiation of Esther Lucile Brown's "school study." In 1948, with the completion of the Brown Report, the National Nursing Council went out of existence (Brown, 1948). Once again, the responsibility for over-all leadership reverted to the national nursing organizations. The joint boards of the six national nursing organizations, the National League of Nursing Education, the American Nurses' Association, the National Organization for Public Health Nursing, the National Association of Colored Graduate Nurses, the Association of Collegiate Schools of Nursing and the American Association of Industrial Nurses, worked together on these issues.

The collaboration of the council members had demonstrated the ability of and need for the six nursing organizations to work together toward common goals. The nursing groups also showed that they could collaborate effectively with non-nursing groups, such as allied health and governmental groups. Thus, nursing was able to demonstrate its power (Schutt, 1971, p. 1785).

Welfare Issues of Nurses

In addition to the problems of nursing service, nurses continued to be confronted by issues related to

their own welfare. These issues included the eight-hour work day, adequate minimum wages and employment conditions. There were other problems related to racial issues in the employment and organizational settings and the need to better prepare nurses to function within changing nursing services. ANA had previously focused upon the employment problems of the private duty nurses. With the increased numbers of general staff nurses employed in hospitals, ANA focused upon their needs. In 1946, three/fifths of the 280,000 active nurses in the United States were general duty nurses, earning \$2000 a year (Schutt, 1971, p. 1786).

ANA Programs

Professional Counseling and Placement Services

ANA attempted to respond to these issues through its programs. One such program which had been in existence since 1936 was the Professional Counseling and Placement Services (PC&PS). ANA sought to strengthen this program by assisting the state associations in developing local offices to provide services for nurses. By 1952, one half of the state constituent associations had established such a service. In addition to the state offices, the main office was in New York City and

there was also a branch office in Chicago (Schutt, 1971, p. 1786).

ANA was concerned with finding "the right nurse for the right job." PC&PS was offered as a free service to ANA members. The stated primary purposes of the program were to provide educational, vocational and professional counseling for nurses and to promote a better distribution of qualified nursing service (Nursing Archives, Mugar Memorial Library, ANA Collection, Box 10, Folder 12).

Intergroup Relations Program

Another program developed by ANA to address racial and inter-group problems of nurses was the Intergroup Relations program. The problem of representation of Negro nurses within the organization had been in existence for many years. In a number of states Negro nurses were prohibited from joining their local association. Consequently, these nurses formed the National Association of Colored Graduate Nurses in 1908. In an attempt to address the issue of discrimination against minorities within the organization, the 1946 House of Delegates instructed the ANA Board of Directors to do something "concrete" about the situation (Nursing Archives, Mugar Memorial Library, ANA Collection, Box 82, Bylaws). At the 1948 convention, the House of Delegates

Delegates voted to adopt a bylaw change to allow for direct membership to the national association for Negro nurses living in states that restricted their membership (Proceedings of the Thirty-Sixth ANA Convention, 1948). At that time nurses became members by joining through their state associations.

In 1949, the ANA Board of Directors authorized a study of the functions of the National Association of Colored Graduate Nurses (NACGN) as they related to ANA's total program. Between 1950 and 1951, the functions and responsibilities of the NACGN were absorbed by ANA (Flanagan, 1976, p. 167). At the 1952 ANA Convention the fourteenth plank of the Association's program recommended: "promoting the inclusion and full participation of minority groups in association activities, and eliminating discrimination in job opportunities, salaries and other working conditions" ("Editorial: The Platform," 1952, p. 953).

The Association continued in its efforts to have all the constituent associations integrated. As ANA President Elizabeth K. Porter stated:

The bold and forthright action of 1946 recommending that all state and district nurses' associations eliminate racial bars to membership, and the subsequent record of progress, has earned for nursing the proud right of enlightened leadership among the professions. Indeed, our action has been a real contribution to the entire nation in our present world-wide struggle for ideologies. And I might

add, not only is the integration of colored graduate nurses into the association a deserved recognition but, the American Nurses' Association will, as the years pass, continue to be enriched by their contribution. (Porter, 1952, p. 979)

Government Relations Program

Through its Government Relations Program, ANA attempted to meet the legislative needs of nurses. During the 1950s, ANA strengthened its emphasis on legislative activities and promoted: (1) state laws that would provide for mandatory licensure for the practice of professional nursing, (2) desirable social legislation including those labor measures that would benefit nurses, and (3) inclusion of nursing benefits in prepaid hospital and medical care plans.

In 1951, ANA opened its Government Relations office in Washington, D.C. The government relation's staff were responsible for reviewing bills, disseminating legislative information and preparing testimony on behalf of nurses and nursing (Flanagan, 1976, p. 164).

Economic Security Program

The Economic Security Program, although controversial, was a major program that had gained a great deal of support from the membership of ANA by 1946. The original purposes of the ANA was "to promote the usefulness and honor, the financial and other interests of the

nursing profession." ANA leadership believed that the adoption of the economic security program in 1946 fit in with these purposes and merely represented a new means of achieving this goal (Flanagan, 1976, p. 169).

For more than forty years, ANA had made recommendations on policies governing nursing personnel and distribution of nursing services. In 1934, ANA had pushed for the eight-hour working day which had received slow acceptance. Studies conducted during this time, the 1930s and 1940s, identified one of nursing's problems as not being able to recruit qualified young women into the profession because of the poor working conditions. Graduate nurses were also leaving nursing for the same reasons. Nurses were beginning to insist on satisfactory working conditions that they believed were compatible with service ideals (Flanagan, 1976, p. 169).

Nursing was moving toward collective bargaining following the lead of other groups in the United States. In 1926, the Railway Labor Act established collective bargaining as the normal mode of industrial relations in the railroad industry. Related Labor Acts adopted during this period established collective bargaining as an accepted mode of negotiation in employer-employee relations with respect to wages, hours and working conditions (Flanagan, 1976, pp. 170-71).

In the late 1930s, the struggle for the nursing profession had centered on two questions: (1) Is collective bargaining consistent with professional ethics? and (2) Should collective bargaining be controlled by professional societies or by unions? ANA supported nurses' right and responsibility to protect their economic security and stated that the professional nursing association should represent them, since the professional organization stands for the fulfillment of all professional obligations (Flanagan, 1976, p. 171).

In 1938, the ANA Board of Directors adopted a resolution that:

Through the state nurses' association, the district nurses association be made more cognizant of their strength and assume their responsibility for certain problems in their communities. Such problems are standards of nursing care and employment conditions for nurses, particularly as the latter relate to hours of duty and fee schedules. (Quoted in Flanagan, 1976, p. 171)

In 1941, California nurses began to work actively for better salaries and improved working conditions. The California State Nursing Association (CSNA) was the pioneer in moving actively forward on solving nurses' working problems. CSNA proceeded to implement a total economic security program and in 1942 established a set of personnel and salary standards. Gradually nursing leaders were able to accept a program of

collective bargaining based on the California experience as separate from unionism (Wagner, 1980, p. 228).

California's success prompted ANA to go for a more extensive national program in 1946. The stated purpose of the national program was:

to secure for nurses, through their professional associations, reasonable and satisfactory conditions of employment which, in turn, will enable the public to secure top quality nursing service in sufficient quantity to meet the demands for such services. (Fact Sheet on Economic Security Program quoted in Flanagan, 1976, p. 172)

At the 1946 Thirty-Fifth biennial convention, the House of Delegates adopted fourteen planks, four of which were related to the economic conditions of nurses. These were: (1) hours and living conditions of nurses, (2) increased participation of nurses in planning and administration of nursing services, (3) greater development of nurses' professional associations as spokesperson for nurses, and (4) removal of barriers that prevent full employment and professional development of nurses belonging to minority racial groups. President Densford concluded her address by stating:

If the nursing profession is ready to take decisive action on hours, salaries, economic advancement, enlargement of nursing resources while maintaining standards and the possible reconstruction of its own organizational structure, we shall this week be making nursing history. (Proceedings of the Thirty-Fifth ANA Convention, 1946, p. 13)

The House of Delegates at several conventions voted to adopt measures that strengthened the economic security program. In 1948, they voted that the ANA Committee on Employment Conditions of Registered Nurses be authorized to draw up criteria for the evaluation of economic security programs of state nurses' associations. The ANA Economic Security Program was becoming a major professional activity and as such contributing to contemporary society ("Criteria for the Evaluation of State Programs in Relation to Official National Policy," 1949, pp. 656-57).

The 1950 House of Delegates voted to adopt a no-strike policy, stating that because nurses had relinquished their basic right to strike, then, employers had a special obligation to bargain with them. Nurses expected that through their authorized representatives employers would deal justly in all matters affecting their employment conditions. However, the American Hospital Association (AHA) was opposed to ANA's program. Their state associations fought this movement and were successful in obtaining an amendment to the Taft-Hartley Labor Act. The amendment excluded hospitals from having to bargain and consequently seriously impacted on ANA's program (Schutt, 1971, p. 1788).

At the 1952 convention a resolution supporting the states in their attempts to establish minimum salaries and a forty-hour week was approved. The relationship of the ANA to their state constituents was supportive and advisory. ANA conducted workshops for state representatives and developed manuals to assist them (Proceedings of the Thirty-Eighth ANA Convention, 1952). In 1954, ANA financed a demonstration project to test certain techniques.

By 1958, ANA's Economic Security Program was labeled a success and had achieved a new status in employer-employee relations. As President Porter stated: "The economic security program means that the nursing profession is saying to all groups concerned that the only way to get superior nursing service is to recognize it, emphasize it, honor it, and reward it" (Proceedings of the Thirty-Sixth ANA Convention, 1948, p. 748). Despite all the good feelings about the program, there remained controversy over this issue and how it impacted on other ANA programs. On the one hand economic security strengthened the association by meeting the needs of the members; on the other hand it pointed out the division among its members.

Reports of Studies of Nursing Service
and Nursing Education

At the May 1947 homecoming of the Division of Nursing Education of Teachers College, through discussions faculty and alumnae attempted to diagnose the major problems confronting the nursing profession and explored alternative means that might be used to solve them. The Division in its effort to prepare future teachers of nursing, initiated a post-war revision of its curriculum. For this revision, they sought input from other health and social welfare professions, concerning the structure of the nursing profession and the medical needs of the community (Committee on the Function of Nursing, 1948, pp. vii-xi).

A Program for the
Nursing Profession

In the Fall of 1947, Professor L. Louise McManus, Director of the Division of Nursing Education of Teachers College, formed the Committee on the Function of Nursing with Eli Ginzberg as its chairman. The report of this committee was published as A Program for the Nursing Profession. The task of this committee was to review a group of selected problems related to the current and projected shortages of nursing personnel (Committee on the Function of Nursing, 1948).

Since this committee, by design, was not engaged in a comprehensive study, the members limited their focus to an examination of the following areas: the requirements for and recruitment of student nurse applicants, the specialization of nursing functions, education of nursing personnel, the nurse's role on the health team and career incentives for nurses.

Some of the committee's data revealed that following World War I, during the 1920s and 1930s, thousands of nurses were dissatisfied with the nursing profession. The emergence of the current and projected shortage of nursing personnel crystalized these problems. Evidence indicated that the shortage was permanent and would get worse. The annual recruitment of young women for schools of nursing for the period 1936-40 averaged only 35,000. Even with the emotionalism of the war effort and the financial advantages offered by the USPHS Cadet Training Program, recruitment never exceeded the 67,000 nurses attained in 1944 (Committee on the Function of Nursing, 1948, pp. 19-20).

The committee concluded that the contributing factors to the shortage were: minimal economic incentives, competition with other professions and occupations, increased demands for medical and health care services which included nursing, more prepayment for

hospitalization and medical care, hospitals reliance on cheap labor (students) and gifts, and finally the inefficient use of nursing personnel (Committee on the Function of Nursing, 1948).

In addition to looking at current problems, the committee chose the year 1960 to project future needs. This was the same year chosen by the Department of Labor for their study. Ginzberg's committee estimated the need for 625,000 registered nurses based on the decrease in the number of private duty nurses and the partial replacement of student nurses by hired professional and practical nurses. The Department of Labor had projected a need for only 500,000 registered nurses because their estimate was based on a lower withdrawal rate of student and graduate nurses than the committee had estimated (Committee on the Function of Nursing, 1948).

Consequently, the committee made the following recommendations: (1) that relations be clarified between nurses and other members of the medical and health team, (2) that suitable relations be established among various groups of nursing personnel, (3) that the professional nurses be graduates of a four-year course in a college or university affiliated school of nursing, (4) that practical nurses be graduates of a nine-eighteen month course in an approved school, (5) that a

goal of 200,000 professional nurses and 400,000 practical nurses be set for 1960, (6) that conditions of pay and work for nurses be substantially improved with differentials in rewards and (7) that research in nursing should receive a heightened emphasis (Committee on the Function of Nursing, 1948, pp. 105-6).

The report strongly supported the need for two groups of nurses, the professional and the practical. The committee members emphasized that the professional nurse should be educated in an institution of higher education and that the practical nurse should be trained in an approved school for practical nurses. Each group was to have different functions, with the professional nurse supervising the practical nurse. The development of these two groups would preclude the need for the current registered nurse. This nurse (RN) would evolve into the professional nurse who had received improved education and clinical experience (Committee on the Function of Nursing, 1948).

As a result of this study and its recommendations, the nursing profession and its organizations attempted to further investigate and implement some of the recommendations of this committee.

The Brown Report

Nursing leaders for a quarter of a century, with minimal results, had attempted to create a sound and socially motivated form of nursing education. These leaders believed that an apprenticeship type of education was no longer adequate to prepare nurses for complex institutional nursing or for the developing community nursing. The Goldmark report of 1923, Nursing and Nursing Education concerned itself with the problem of reorientation of professional practice to meet new health and social goals and made specific recommendations for education under such reorientation (Brown, 1948, pp. 7-24).

In 1926, the Committee on the Grading of Nursing Schools attempted to eliminate weak nursing schools and to raise the educational standards in the remaining schools. Concurrently, NLNE and NOPHN conducted smaller specialized studies and sought to elevate the practice of, and preparation for, nursing. The nursing profession had more success in determining the direction nursing should take than in the initiation or acceleration of that movement. The profession was, however, successful in several attempts which included: closing many poor training schools, opening some university or collegiate schools, persuading many hospitals to

substitute graduate staff nurses in considerable numbers for student nurses and in encouraging hospital schools to lengthen and improve their preclinical period of instruction and to provide more and broader clinical instruction. Even with these improvements the nursing profession remained inadequate to produce the required supply of nurses with necessary preparation for such essential functions as specialized clinical nursing, public health nursing, supervision, planning and administration, research and writing (Brown, 1948, pp. 7-24).

The nursing profession concluded that there was something chronically wrong with a system of education which could not meet the demands either for quantitative or qualitative services. Consequently, nursing leaders decided to commission a study under the auspices of the National Nursing Council. Esther Lucile Brown was asked to be the director of the study with a professional advisory committee, representative of the public interest. Later a group of hospital administrators and physicians who were charged by various organizations with planning for future nursing services asked to share in the report. The council members requested financial support from the Carnegie Corporation of New York (Brown, 1948, pp. 7-24).

The focus of the study was "the examination of the question who should organize, administer and finance professional schools of nursing?" Since a comprehensive study was too costly, the committee under the leadership of Esther Lucile Brown decided to: (1) view nursing service and nursing education in terms of what is best for society, (2) tour (the director take an extended field trip) the United States, so that a broader picture could be obtained, and (3) attempt to answer the question of who should organize, administer and finance professional schools of nursing through examination of the probable nature of health services in the second half of the twentieth century, and of nursing services likely to be demanded by those evolving health services. They also decided that inquiry into the kinds of training and of academic and professional education requisite to prepare nurses to render those various kinds of nursing service would be essential (Brown, 1948).

The Brown Report of 1948, Nursing for the Future, identified that the problems within nursing were chiefly due to the problems related to nursing education. Dr. Brown recommended as a goal to work toward during the next decade,

that effort be directed to building basic schools of nursing in universities and college, comparable in number to existing medical schools, that are sound in organizational and financial structure, adequate

in facilities and function, and well distributed to serve the needs of the entire country. (p. 178)

Other recommendations in the report included: official examination of schools, publication and distribution of lists of accredited schools, campaign for public support for accredited schools, periodic re-examination of all schools, and that the public assume responsibility for a substantial part of the financial burden for schools of nursing; if nursing committed itself to this undertaking of major social significance (Brown, 1948, pp. 138-73).

National Committee for the
Improvement of Nursing Services

The Committee for the Improvement of Nursing Services (NCINS), originally named the Committee on the Implementation of the Brown Report, was formed in 1948. According to its director, Marion Sheahan, "every activity of the committee will be used as an opportunity to bring about a better understanding of the problems of nursing as they affect interprofessional groups and of the avenues open for communication." The committee was awarded \$200,000 to prepare a three-year plan to coordinate nursing and related professions by national, state and local groups. NCINS was enlarged to include forty representatives from dentistry, social science, industry, labor, public health, government agencies and

consumers of nursing services as well as the original representatives from nursing, medicine, hospital administration and general education (Sheahan, 1950, pp. 794-95).

The plan developed by the committee was to focus upon the improvement of nursing service, the improvement of nursing education and the promotion of relationship between nursing and the public. In 1952, after the restructure of the national nursing organizations, NCINS became the Advisory Committee to the Nursing Division of the National Leagues for Nursing (NLN) (Roberts, 1954, p. 504).

Community College Education For Nursing

In the early 1950s, associate degree educational programs in nursing were initiated via Mildred Montag's project, Community College Education for Nursing. This new concept in nursing education was introduced as a result of the, by then, chronic shortage of nurses. The program was seen as a more effective way of educating nurses than was currently being done in hospitals, thereby getting them into the mainstream of nursing sooner (McManus in Foreward of Community College Education for Nursing, 1959, p. viii).

National Nursing Organization's
Structural Studies

During the late 1930s and early 1940s, the leaders in the nursing profession had recognized the need to investigate possible areas of duplication among the national nursing organizations. This need was confirmed by various studies being conducted on nursing education and nursing service. The impetus for the formation of a committee to study the possibility of consolidating the three organizations came from a request from a state nurses' association to the ANA Board of Directors in 1939 ("ANA, Digest of Minutes of the Meeting of the Board of Directors," 1940, p. 82). A year later a committee was appointed to study the structure of the organization.

In 1944, the boards of the ANA, NLNE and NOPHN voted to undertake a joint survey of their "organizational structure, administration, functions and facilities to determine whether a more effective means could be found to promote and carry forward the strongest possible program for professional nursing and nurses." A joint committee was established by the three organizations. In late 1944 and early 1945, they asked the National Association of Colored Graduate Nurses (NACGN), the Association of Collegiate Schools of Nursing (ACSN),

and the American Association of Industrial Nurses (AAIN) to join the committee (Nelson, 1950, p. 4).

In April 1946, the Raymond Rich Associates were employed to conduct a study on the national nursing organizations. Their report entitled, "Report on the Structure of Organized Nursing" was presented at the 1946 ANA Biennial Convention. At the same convention the Joint Committee on the Structure of National Nursing Organizations presented their report (Nelson, 1950, p. 5).

Rich Report

The purpose of the Rich Associates study was to discover needed revisions to enhance expansion of the organizations. As part of their study, they reviewed "A Comprehensive Program for Nationwide Action" prepared by the National Nursing Council ("A Comprehensive Program for Nationwide Action in the Field of Nursing," 1945, pp. 707-13).

They recommended five principal structural requirements: (1) all nurses must be united in one body to gain maximum effect in furthering the above purposes; (2) the new structure must allow each specialty group enough autonomy to pursue its own interests as well as have an adequate voice in decision-making on common interests; (3) the new structure must be able to bring

together the needed "tools and interest" to make informed decisions and take actions on nursing problems as well as serve nurses and the public; (4) the need to use democratic process and encourage as well as train new leaders from the ranks; and (5) the need to facilitate the cooperation and assistance from allied professions and interests, nursing auxiliaries, and the general public to achieve major nursing goals (Raymond Rich Associates, 1946, pp. 648-61).

The Rich Report presented two alternative plans for organizing. Plan I provided for complete incorporation and maximum participation of lay members with professional nurses. Plan II provided for a large group reserved for professional nurses only and another area for nurses and non-nurses to work together on an equal basis. The two groups were to be linked together by a "National Nursing Center." Plan II was seen as less revolutionary and as a transition stage in working toward the development of one organization.

As part of their report, the Rich Associates recommended the establishment of several structural units (see Appendix B). These structural units were proposed as a vehicle for members to carry out their interests, activities and functions.

Major operational recommendations and goals that were suggested included: (1) development of high standards on nursing practice by the specialist sections and enforcement of them through legislation and state board recommendations; (2) improvement of curricular and educational facilities through accreditation; (3) improvement of social and economic welfare of nurses and recruitment of better students; (4) ensurance of adequate qualified nursing service by studying facilities, their administration, finance and distribution and making recommendations on better ways to finance nursing care; (5) development of public relations to ensure that nursing will be included in the councils where issues important to nursing and health are being considered, and (6) continuance of a periodical which reflects the policies of the organization, and possibly a future journal devoted to nursing science and technical questions related to various specialities (Raymond Rich Associates, 1946, pp. 648-61).

1946 Convention

At the 1946 convention, the ANA House of Delegates voted to adopt the following recommendations: (1) that ANA, through its constituent associations, complete a detailed analysis of the Rich Report and the feasibility of its proposals, (2) that the ANA because

of the organization's large membership be represented on the Joint Structure Committee by twelve members; these representatives to include proportionate representation from private duty, federal government, institutional, industrial, and men nurses' sections of the association, (3) that the authority granted ANA's twelve representatives be restricted to receiving the report as analyzed and interpreted to the members of the joint structure committee, and (4) that, before ANA approval shall be given in regard to the general structure report, it must be approved by the House of Delegates at a special session to be called no later than 1 October 1947 (Proceedings of the Thirty-Fifth ANA Convention, 1946, pp. 224-26).

This analysis and interpretation was based on a belief that ANA needed to study the report in relationship to its own organization and interpret it to the membership. ANA representatives functioned merely as auditors and consequently their role on the joint committee was greatly restricted.

As a result of their limited role, ANA was unable to participate in the formulation of the committee's proposals which were submitted to all six organizations in August 1947. The joint committee made the following recommendations: (1) the appointment of a

joint subcommittee to study the possibility of combining the programs of the NLNE, NOPHN and the ACSN as "a practical beginning toward a comprehensive organized effort for better nursing service"; (2) the appointment of a joint subcommittee to study and plan ways in which the ANA could absorb the functions of the NACGN; (3) the formation of a joint subcommittee to analyze the functions of the existing nursing organizations as they relate to industrial nursing and to formulate recommendations aimed at unification of these interests; and (4) a new or revised organization structure to include provision for non-nurse members who would be restricted from participation in decision-making activities regarding strictly professional matters (Proceedings of the Thirty-Fifth ANA Convention, 1946, pp. 224-26).

1947 Special Convention

In September 1947, a special session (the first ever in the history of the association) of the ANA House of Delegates was convened to take action on the proposals of the Rich Associates and the recommendations of the Joint Committee on the Structure of the National Nursing Organizations. Some 1,500 ANA members had assembled to consider the future directions of the organizations (Flanagan, 1976, p. 142).

The fundamental question, as stated by an ANA member, to be addressed was: "Shall the ANA continue to conduct its own study independent of the Joint Committee?; or shall the six national organizations do the job jointly and democratically share the expenses, with all representatives free to exercise voice and vote?" (Nursing Archives, Mugar Memorial Library, ANA Collection, Box 83, Transfile 16, p. 3). There was much discussion and debate regarding the proposals for restructuring the associations. After two days, the House of Delegates voted to reject both Plan I and Plan II of the Rich Associates and referred it to the Joint Structure Committee (p. 34).

Miss Densford, ANA President, concluded her statements at the final session by stating, "Stripped of everything but essentials, your discussions indicate that there is a difference of opinion on the method to bring about unity--a unified organization" (Nursing Archives, Mugar Memorial Library, ANA Collection, Box 83, Transfile 16, p. 159). Delegates were faced with two alternatives: (1) Should the ANA assume responsibility as the central unified front organization, integrating within itself the constituent associations as well as other nursing organizations? or (2) Should a new organizational structure be built through the

cooperative efforts of the six existing nursing organizations?

The ANA Board of Directors recommended to the House of Delegates that:

the ANA take the leadership in the endeavor; the ANA be preserved in its essential structure as to district, state, and national associations; the ANA must remain the national organization representing all graduate professional nurses and that it retain its status in an expanded form in any unified action which may be undertaken. Since there are many methods of achieving unity, all requiring further study, it be the sense of the house that the matter be diligently pursued by its authorized representatives. (Nursing Archives, Mugar Memorial Library, ANA Collection, Box 83, Transfile 16, p. 84)

However, the delegates chose to postpone any action on this resolution until the 1948 biennial convention.

ANA's House of Delegates voted to support the activities of the joint structure committee and empowered ANA representatives to participate and vote in the deliberations and studies which the joint structure committee might conduct. This action directly conveyed the desire of the association that all six organizations work cooperatively. The House of Delegates also voted that:

the ANA Board of Directors request a joint meeting of the boards of directors of the six national professional nursing organizations not later than November 15, 1947, to consider ways and means of implementing a program of united action, which meeting would consider the areas of activities and interests peculiar to each organization and the areas of activities and interests common to more than one of the organizations. (Nursing Archives,

Mugar Memorial Library, ANA Collection, Box 83,
Transfile 16, p. 100)

Tentative plan for one
national nursing organization

This structure study was sponsored by the Board of Directors of the six national nursing organizations. The tentative plan was released to the nursing profession on the basis for discussion and further development. This proposal was based on four major premises: (1) a majority of nurses favor a single nursing organization, (2) structure problems should be approached from the standpoint of function, "of work that organized nursing is doing now, should be doing now or in the future," (3) first consideration should be given to local organizations, their function in relation to nurses. State and national organizations must be built upon the local unit (Committee on the Structure of National Nursing Organizations, 1948, pp. 321-28).

The tentative plan included sections for nurse members and divisions for non-nurse, agency and school members as well as nurse members. Only nurse members could be elected to the House of Delegates and board of governors. A major problem with this plan was the concern by many nurses regarding non-nurse involvement in what they considered to be the province of nurses only, such as the economic security program. Additionally,

there was the issue of membership in the International Council of Nurses. Therefore, the delegates made a motion to refer the issue to the joint structure committee for further study (Proceedings of the Thirty-Sixth ANA Convention, 1948, p. 290).

The 1949 alternate plans

The Structure Committee published the 1949 Handbook on Structure of Organized Nursing for the consideration of the profession. This proposal also had as its premise that the state and national organizations be built upon the local unit and "must be shaped so as best to meet the needs of the local unit" (Flanagan, 1976, p. 150). Two alternate plans were prepared by the committee. The two-organization plan had one organization to which only nurses would belong and another to which nurses, non-nurses, schools of nursing, and nursing services would belong. Joint services would be provided cooperatively to and by the two organizations (Nelson, 1950, pp. 6-7).

The one-organization plan of 1949 offered the same features for nurse members as the professional organization in the two-organization plan. All services would be conducted by it. A major difference between the two alternate plans proposed by the committee was that non-nurses, schools of nursing, and nursing

services were offered membership in discussion forums attached to the nurses' organization ("The Structure Study," 1949, pp. 236-41).

Under the two-organization plan, ANA would remain the organization for professional nurses only. It would be composed of the House of Delegates (the voting body), a Board of Governors, Councils, Committees, Sections and ANA Service Bureaus. The second organization would be called the Nursing League of America. It would be composed of a Membership Body (nurse and non-nurses), Board of Directors, Committees, Division of Nursing Service, Division of Nursing Education and NLA Service Bureaus (Nelson, 1950, pp. 8-63).

There was a Joint Board between the two organizations composed of the presidents of each organization and six members from ANA's Board of Governors and six members from NLA's Board of Directors. Cooperative projects were to be coordinated through this board as were joint services for business services, accreditation, tests and measurements, public relations, publications, and research and studies (Nelson, 1950, pp. 59-63).

At the 1950 ANA Biennial Convention delegates made a careful study of the 1949 alternate plans. The delegation voted to adopt the two-organization plan with the three recommendations made by the ANA Board of

Directors: (1) that the existing ANA corporation be retained and the proposed new functions and sections as approved by all six national nursing organizations be provided for by amendments to, or revisions of, the present ANA bylaws, (2) that the joint board become a subsidiary corporation, jointly owned by the ANA and NLA,¹ and its name be changed to more clearly indicate the functions which it will assume, and (3) that the creation of councils be delayed for the present and, so far as possible during the interim, council functions be assumed by the appropriate sections (Proceedings of the Thirty-Seventh ANA Convention, 1950, p. 185).

The two-organization plan was accepted by the other five national nursing organizations, provided that the ANA retain its corporation and that any changes in ANA functions be accomplished through revision or amendment to the ANA Bylaws. Following legal counsel, the six national nursing organizations agreed that the second association be built upon an existing charter. They decided that it should be established by amendment

¹The Nursing League of America was the name offered in 1949 for the organization, in the two-organization plan, through which nurses should seek support for their efforts to improve nursing education and nursing service (Nelson, 1950, p. 39). At the 1952 biennial convention the name National League for Nursing was selected as the name most representative of the work of that organization.

to the current NLNE charter which had provision for nurse and non-nurse members. The other organizations were being dissolved (Flanagan, 1976, p. 158).

In order to effect a transition, a joint coordinating committee was established. This committee was composed of the chairman of each organization's structure committee, together with the president and executive secretary of each organization. Between the late 1950s and summer of 1951, the joint committee reviewed and coordinated all the plans for the two national nursing organizations--ANA and NLN. Professional nurse functions were assigned to ANA and those functions shared with the consumer and any allied professional worker to NLN. The Organizational Charts are in Appendix D (Proceedings of the Thirty-Seventh ANA Convention, 1950, p. 185).

At the 1952 Convention, ANA delegates approved the general plans for the ANA and NLN and adopted revisions to the bylaws of the association. Under the new structure ANA would:

1. Define and promote the implementation of the functions, standards, and qualifications of nursing practitioners in the various occupational and clinical fields.

2. Promote the economic and general welfare of nurses which directly affect the recruitment and efficiency of nursing personnel.

3. Work to provide like opportunities in nursing for men and women of all racial and religious groups.

4. Provide professional counseling and placement referral service to individual nurses and to employers in regard to employment opportunities and available personnel.

5. Promote legislation and speak for nurses regarding legislative action for general health and welfare programs.

6. Work closely with the various state boards of nursing in the interpretation of nursing practice acts and the facilitation of interstate licensure by endorsement.

7. Survey periodically the nurse resources of the nation and finance research in nursing functions.

8. Represent and serve as national spokesman for nurses with allied professional and governmental groups and with the public.

9. Implement the international exchange of nurses program and assist other nurses who immigrate to the United States.

10. Serve as official representative of American nurses.

The National League for Nursing (NLN) would:

1. Define standards for organized nursing services and education.

2. Stimulate communities, nursing services, and educational institutions to achieve the standards defined.

3. Provide consultation, publications, cost analysis methods, data, and other services to individuals, nursing services, schools, and communities.

4. Offer comprehensive testing and guidance services to institutions with practical, basic, or advanced nursing education programs.

5. Offer consultation to institutions for nursing education upon request and accredit nursing programs.

6. Carry out and promote continual study and research about nursing services and educational curricula as related to changing needs. Encourage similar studies and research by nursing services, schools, and communities and provide assistance in these studies.

7. Provide, in cooperation with state licensing authorities, examinations and related services for use in licensing professional and practical nurses.

8. Conduct a national student nurse recruitment program co-sponsored by ANA, NLN, AHA, and AMA.

9. Represent nursing services and nursing education units with allied professional, governmental, and international groups and with the public. This was the conclusion of the six-year structure study which was labeled as "one of the most significant experiments in democratic action" (Flanagan, 1976, pp. 161-62).

As Hortense Hilbert stated in her forward to the structure committee report: "Nurses are to be congratulated on the widespread interest in the study now in progress, and the numbers who are participating in it."

Another committee member reflected:

Never in the history of the nursing profession, probably have so many nurses taken the time to study seriously the "where" and "why" and "how" of their organization activities. Your committee has confidence that all the thinking and discussion which have taken place and are continuing will bear fruit in genuine progress for the profession. (Quoted in Nelson, 1950, p. xvii)

The profession had indeed been engaged in a long period of self-examination. Through discussions and open debates it was moving towards a united front.

Between 1948 and 1958, the association concentrated on three broad objectives outlined in the platform: (1) to provide health protection for the American people, (2) to aid nurses to become more effective and more secure members of their profession, and (3) to

promote better health care for the peoples of the world (Flanagan, 1976, p. 163). The profession was indeed moving toward a united front.

Power Analysis of the American
Nurses' Association

The period from 1947-1960 was one of major restructure within the nursing profession and the national nursing organizations. There was a continual evolution within the professional national nursing organization and as part of this evolution ANA was attempting to strengthen its power base. This was being done in several ways.

ANA through its reciprocal relationship with the state associations was involved in a number of trade-offs. In exchange for national membership and support, the state constituents were implementing national policies and programs. State associations were able to effect some of their needs, through the membership of their presidents on the Advisory Council and their members being elected to the national House of Delegates. At the same time, the national organization was able to establish and coordinate desired programs throughout the states.

The various programs offered by ANA served to strengthen the bond between the state and national

associations. Individual states deferred their wants in order to attain a more unified and strong national organization.

The very fact that most nurses polled wanted one single organization demonstrated the amount of power that the national association had developed. The delegates in their vote to adopt the two organization structure, with ANA being maintained as the professional nursing organization, legitimized the national association's authority and power.

In return ANA established structural units that allowed the members to carry out their interests. This was in exchange for commitment and support from the state organizations.

The two national nursing organizations were to be connected through a Joint Board. Together these organizations would work to meet the needs of nurses, nursing and society. ANA, as the organization representing all nurses, in exchange for the support from the membership was attempting, through its various programs and studies, to solve the problems that were facing nurses in both the educational and nursing service settings. The organization was doing this within the changing societal conditions.

ANA and its membership within its new structure was pushing forward to a new era with continuing problems and a renewed spirit. Unity of goals and united action was the mainstay.

CHAPTER VI

CONTROLLING: DIRECTION OF PRACTICE AND THE PROFESSION (1960-1979)

A central issue for the sixties was the improvement and control of nursing practice. The American Nurses' Association once again looked to its structure to assist the development of the nursing profession in this area. The Association continued to work on fulfilling its responsibilities to nurses, the profession and society.

At the 1958 convention the House of Delegates called for a study to investigate how the Association was meeting the responsibilities of a professional organization. The ANA Board of Directors appointed a Committee on the Study of the Functions of the American Nurses' Association (Proceedings of the Forty-Second ANA Convention, 1960, p. 110). The role and the results of the work of this committee will be discussed later.

Issues and Responses

There were a number of issues of concern to nurses and to the profession. Nurses continued to be in

disagreement over the solution to such issues as the entry level into professional nursing and economic security for nurses. The conflict over these two issues that was present among nurses, generally, was also evident within the Association. ANA's response to these issues was seen as crucial in its demonstration of power and in its role as spokesman for nurses. The Association responded through appointment of committees to study issues and through the development of structural units to implement programs. There was an emphasis on the development of standards for nursing education, nursing practice and nursing service.

Standards of Nursing Education

The focus upon the educational preparation of nurses was a recurrent theme within the Association. There was a recognition of the need for sound basic preparation of nurses, improved and increased graduate education, and continuing education for all practicing nurses. Association members stressed the importance of ANA's enunciation of standards for all areas of nurses' education as well as the profession's control of credentialing in these areas. Throughout the 1960s and 1970s, the Association through the board of directors, the house of delegates, the Committee on Nursing Education and subsequently the Commission on Nursing Education

articulated, refined and implemented standards of nursing education.

Basic nursing education

There had been an ongoing recognition of the need to have basic educational preparation for nurses in institutions of higher learning. Mrs. Bedford Fenwick of Great Britain in an address presented at the International Congress of Nurses in 1901 spoke of nurses' need for ". . . endowed colleges, chairs of nursing, university degrees and state registration . . ." (quoted in Bridges, 1967, p. 20). The need for higher education was also articulated in the Goldmark Report of 1923, the Ginzberg Report of 1948 and the Brown Report of 1948.

In 1948, ANA helped support a study of the organization, administration and financing of schools of professional nursing. Initiated by the National Nursing Council, this study strove to define the term professional nurse, describe the professional nurse's role in society and the type of education required to prepare for that role. This report pointed the way toward a plan for education for professional nurses which would: ". . . attract women with ability, education and interest necessary to serve the more complex needs of people, whether sick or well" (Proceedings of the Forty-Second ANA Convention, 1960, p. 54).

Entry level into professional nursing was a controversial issue in the 1960s and 1970s. During this period, there were in existence three types of basic educational programs preparing individuals for licensure as registered professional nurses: college and university programs leading to the baccalaureate degree, junior college programs leading to an associate degree, and hospital programs leading to a diploma (Flanagan, 1976, p. 239).

The initiation of the work on setting standards for nursing education was being done through the ANA Committee on Current and Long-Term Goals. The committee pointed out that, "assumption of responsibility for standards of competence cannot be divorced from a concern for the standards of education" (Reilly, 1960, p. 212). At the ANA convention in May 1960, the committee presented a proposal to the House of Delegates which was viewed by ANA membership and the nursing profession as a crucial issue facing the Association. The committee recommended:

To insure that, within the next 20 to 30 years, the education basic to the profession, shall be secured in a program that provides the intellectual, technical, and cultural components of both a professional and liberal education. Toward this end, the American Nurses' Association shall promote the baccalaureate program so that in due course it becomes the basic educational foundation for nursing practice. (Hanson, 1960, p. 55)

This proposal for the Association's Goal III was accepted and adopted by the House of Delegates for continued discussion and study.

The Committee on Current and Long-Term Goals had also formulated twelve principles for nursing education from generally accepted theories of professional education:

- 1) The determination of standards for professional education is the responsibility of the nursing profession.
- 2) All graduates of professional educational programs in nursing shall have mastered that core of basic and applied knowledge essential for effective practice.
- 3) The requirements for curricula and methods of teaching shall be flexible in order to stimulate experimentation and to permit revision and expansion of subject matter.
- 4) Professional education should provide the student with an opportunity to develop the capacity for independent judgment in the application and advancement of nursing knowledge.
- 5) The educational program should include an opportunity for the student to expand intellectual and cultural horizons through acquiring a broad liberal education.
- 6) Responsibility for the total educational experience should rest with the faculty of the educational institution.
- 7) The standards governing the organization, faculty and facilities of a nursing education program should be comparable to those of other professional programs within an educational institution.
- 8) The nursing faculty should have responsibility for developing and implementing the professional education program.
- 9) Responsibility for financing professional education rests with the entire society.
- 10) Adequate and stable financial resources should be provided for the programs of professional education.
- 11) The requirements for admission to programs in nursing education should be comparable to those of

other professional programs within an educational institution.

12) Graduation from undergraduate professional programs in nursing should qualify students for entrance to graduate programs in nursing with, generally, no further academic experience. (Hanson, 1960, pp. 57-61)

These principles were presented with accompanying explanatory statements. On the basis of these principles, the committee concluded that only baccalaureate programs in nursing met all the essential requirements for professional education.

The work of the committee was supported by the House of Delegates through its adoption of a plank to continue to elevate standards for nursing education by formulating principles of the education essential to effective practice (Hanson, 1960, pp. 57-61). In June 1961, the ANA Board appointed a Committee on Nursing Education. In January 1962, the Committee was charged with the following responsibilities:

- 1) To study and make recommendations for meeting the association's specific responsibilities in nursing education.
- 2) To formulate basic principles of the education essential for effective nursing practice.
- 3) To study the effect of federal and state legislation in terms of its effect on nursing education and make appropriate recommendations. (Reiter, 1964, p. 102)

The 1962 House of Delegates identified, "Enunciation of standards of nursing education" as one of the Association's primary functions (Proceedings of the

Forty-Third ANA Convention, 1962, pp. 23-25). As further evidence of their support of ANA's role in setting educational standards, at the end of the 1964 convention, the house approved the recommendation that the American Nurses' Association work toward baccalaureate education as the educational foundation for professional nursing practice (House of Delegates Reports, 1964-1966, 1966, p. 67).

The delegates at that convention requested that the Committee on Nursing Education work with "all deliberate speed to enunciate a precise definition of preparation for nursing at all levels." From the information presented during the various convention sessions, it was apparent to ANA members that current and pending changes in patterns of demand for health services, the structure of health care services, licensure, and the scope of nursing practice warranted practitioners who were more comprehensively prepared to assume greater responsibility and to adapt to fast-changing techniques and approaches to practice (House of Delegates Reports, 1964-1966, 1966, p. 67).

In May 1965, NLN passed a resolution advocating community planning to implement the orderly transition of nursing education into institutions of higher learning. Additionally in September of 1965, the ANA Board

of Directors endorsed the Association's first definitive statement on nursing education--Educational Preparation for Nurse Practitioners and Assistants to Nurses: A Position Paper (Flanagan, 1976, p. 242).

Two events which contributed to the publication of this paper were: (1) the Surgeon General's Consultant Group's study, Toward Quality in Nursing: Needs and Goals, and (2) the Nurse Training Act of 1964 (Schutt, 1971, p. 1790).

In 1961, the Surgeon General recommended that a study be made immediately of the system of nursing education in relation to the responsibilities and skill levels required for high-quality patient care and that the study be funded by private and governmental sources. This study published in 1963 as Toward Quality in Nursing: Needs and Goals identified the need for more and better prepared nurses (U.S., Department of Health, Education and Welfare, 1963).

Subsequently, ANA's Committee on Nursing Education proposed the establishment of an autonomous commission which would design and spearhead a comprehensive study and prepare a report for the profession and the public to consider. ANA's Committee on Nursing Education recommended that this commission be composed of professional nurses, educators, and people drawn from

other health disciplines, economics, sociology, and communications. Both the ANA and the NLN appropriated funds to establish a joint committee to investigate ways to conduct and finance the study. ANA's Board of Directors believed that the Association's position paper on nursing education would serve as useful material to the commission (Flanagan, 1976, p. 243).

On 1 September 1964, President Lyndon B. Johnson signed into law the Nurse Training Act. This was the first federal law to give comprehensive assistance for nursing education. It authorized appropriations of \$283,000,000 over a five-year period for construction grants to collegiate, associate degree, and diploma schools of nursing for new facilities or for rehabilitation or replacement of existing facilities; for teaching improvement grants to diploma, collegiate, and associate degree schools; for payment to diploma schools for traineeships for professional nurses; and for loans to student nurses (Flanagan, 1976, p. 244).

Both of these events, the report of the Surgeon General's Consultant Group and the Nurse Training Act, reinforced the need for ANA to articulate its position on the direction that nursing education in the United States should take. In December, 1965, ANA published its position paper on the direction for nursing

education in pamphlet form under the title, Educational Preparation for Nurse Practitioners and Assistants to Nurses: A Position Paper. It was also printed in the American Journal of Nursing as "American Nurses' Association's First Position on Education for Nursing" (December 1965, pp. 106-11). The delineation of specific goals for the direction of nursing education and the identification of professional and technical levels of practice had a profound effect upon the diploma and associate degree nurses (Educational Preparation for Nurse Practitioners and Assistants to Nurses: A Position Paper, 1965, pp. 1-9).

At the time of publication of the 1965 position paper, seventy-eight percent of the practicing nurses were graduates of hospital schools of nursing. Concern was expressed regarding the impact of the document on the status of these nurses. In an attempt to alleviate this concern ANA published, A Date with the Future, a brochure which interpreted the meaning of the 1965 position paper for graduates of hospital schools of nursing. The brochure was intended to alleviate the concerns of the diploma nurses and reduce the schism created by the Position Paper. According to the brochure:

The position paper addresses itself to the future of the nursing profession to insure that nursing will exercise its rightful voice and influence in the health care complex of tomorrow. As the American

Nurses' Association plans for the future ANA members are assured that: 1) There is no change in legal status for the diploma nurse. Nurses graduated from and enrolled in state approved diploma programs are eligible upon graduation to become licensed as registered nurses. 2) The position paper does not in any way affect what nurses have already achieved but rather it focuses on the impending and long overdue changes in the system of nursing education. (Quoted in Flanagan, 1976, pp. 244-45)

"The position paper reflected the association's best judgment on the nature of nursing practice, the characteristics of the nurse practitioner, and the preparation needed to practice nursing and to assist nurses"

(Flanagan, 1976, p. 244). However, there remained great concern among nurses:

The identification of "professional" nursing practice with baccalaureate education, and the new term "technical" nursing practice with diploma and associate degree education . . . the discussion and correspondence which persisted even in later years indicated that it was one of the most controversial actions, internally, the ANA had ever taken (Schutt, 1971, p. 1790)

At the 1966 ANA convention, the chair of the Committee on Education pointed out to the delegates that implementation of the position paper called for immediate attention in two areas: "continued interpretation and clarification of the association's position and collaborative planning by all groups involved in health care" (Ritter, 1966, p. 48). In June of that year, the board of directors of ANA and the NLN approved a joint statement on community planning for nursing education:

In recognition of the many changes taking place in the health field and the need for appropriate education for nursing personnel to meet present and future requirements, both in quantity and quality of nursing services, the ANA and NLN believe that sound community planning for nursing education is essential and should be begun or accelerated promptly. (Quoted in Flanagan, 1976, p. 245)

Between 1966 and 1967, there was an increase in campus-based nursing education programs as noted in the rise in the associate degree programs, from 218 to 281, and baccalaureate programs, from 210 to 221. There was a concomitant decrease in the number of diploma hospital schools of nursing from 797 to 767 (Flanagan, 1976, p. 245).

In March 1967, the Committee on Nursing Education was dissolved and ANA's Commission on Nursing Education was initiated. The functions of the Commission were:

- 1) To evaluate relevant scientific and educational developments and changes in health needs and practices, with reference to their implication for nursing education.
- 2) To establish the scope of the association's responsibility for nursing education.
- 3) To develop standards for nursing education and devise methods for gaining their acceptance and implementation through appropriate channels.
- 4) To encourage and stimulate research in all areas of nursing education.
- 5) To formulate policy and recommend action concerning federal and state legislation in the field of education. (Schlotfeldt, 1968, p. 87)

In 1968, the House of Delegates adopted three platform planks relative to nursing education including

support for community planning for "the sound and orderly transition of nursing education into institutions of higher learning" (Schlotfeldt, 1968, p. 90).

During the 1968-70 biennium, the ANA Commission on Nursing Education spelled out criteria for all new nursing programs in a communication to state boards of nursing and SNAs. The Commission outlined the following minimum requirements: control by an educational institution (college or university), adequate numbers of competent faculty with graduate preparation in nursing and education, adequate financial support, and provision of clinical learning laboratories for the projected number of students (Proceedings of the Forty-Seventh ANA Convention, 1970, pp. 38-39).

During the 1970s the Commission on Nursing Education continued to work on entry level into professional nursing. The Commission worked within ANA structural units. Concern was expressed by the student association, NSNA regarding ANA's 1965 position paper as it related to the diploma and associate degree graduates.

The Commission on Nursing Education worked with the ANA Board of Directors in interpreting and supporting the position paper to ANA membership and other nursing groups. The Commission's task force was getting

input and developing guidelines for the implementation of the baccalaureate degree as the basic preparation for entry into professional nursing practice and related work on titling, competency statements and career mobility for nurses (Flanagan, 1978, pp. 6-12).

As a result of the mandate from the 1976 House of Delegates to the ANA Board of Directors, the Commission on Nursing Education's task force assumed responsibility for convening a national conference on entry into nursing practice in 1978. The purpose of this conference was to provide the opportunity for selected representatives of the nursing profession to:

(1) debate the issue related to entry into nursing practice; (2) explore and discuss methods that can be used to implement ANA's statement on educational preparation; and (3) propose recommendations for further plans and activities regarding entry into nursing practice (Proceedings of the Fifty-First ANA Convention, 1978, pp. 67-73).

The National Conference on Entry Into Nursing Practice held 13-14 February 1978, in Kansas City was a working conference planned for 400 participants. Invited participants were selected from groups which included nurse legislators, representatives from the Division of Nursing, and educators from each type of

nursing program. Each State Nurses' Association (SNA) was requested to send three representatives from the following categories: SNA president, SNA executive director, chairperson of education or legislative committee or chairperson of entry into practice committee, and staff nurse. Representation was also requested from the following organizations: NLN, AACN, NSNA, Western Interstate Commission on Higher Education (WICHE), National Federation of Licensed Practical Nurses (NFLPN), AHA Assembly of Hospital Schools of Nursing, AHA Society for Nursing Service Administrators, Federation of Specialty Nursing Organizations and ANA, Southern Regional Education Board, Midwest Alliance of Nursing, and National Association of Practical Nursing Education and Services (Flanagan, 1978, p. 13).

As a result of the reports and recommendations of the small groups at the conference, the Task Force on Entry Into Practice submitted three resolutions which were adopted as amended by the House of Delegates at the 1978 convention. Those resolutions served as a beginning framework for the education of nurses of the future. The three resolutions concerned the following areas:

- 1) Identifying and titling the two categories of nurses entering nursing practice.

- 2) Establishing a mechanism for deriving competency statements for the two categories.
- 3) Increasing accessibility of career mobility programs in nursing. (Proceedings of the Fifty-First ANA Convention, 1978, p. 67)

The Commission on Nursing Education delegated the task of providing mechanisms for implementation of these resolutions to the Task Force on Entry into Practice. In September 1978, the task force and the Commission on Nursing Education formulated initial plans for implementation of the resolutions adopted by the 1978 House of Delegates.

The task force was divided into three working groups: (1) the Titling Work Group, (2) the Competency Work Group, and (3) the Career Mobility Work Group. The Titling Work Group met twice in 1979 and developed a preliminary draft report. The Competency Work Group met four times in 1979 and completed a report delineating broad entry-level competencies for the two categories of nurses who will enter nursing in the future. The Career Mobility Work Group met once in 1979 and once in 1980 and formulated general guidelines (House of Delegates Reports 1978-1980, 1980, pp. 115-16).

The Commission on Nursing Education continued to gather information from various nursing groups and worked towards the implementation of the 1978 resolutions so that by 1985 the minimum preparation for entry

into professional nursing practice would be the baccalaureate degree in nursing.

Graduate education

In addition to the focus on basic preparation for nursing, the Commission on Nursing Education issued statements regarding graduate education ". . . The Commissioners deplored the fact that so few graduates of masters programs were being employed in hospital nursing services, where they would have an impact on upgrading student experiences" (House of Delegates Reports 1966-1968, 1968, p. 90).

The ANA Board of Directors approved a statement on graduate education in nursing in 1969. This statement was considered one in a continuing series to comprise a comprehensive philosophy of nursing education. On the basis of an examination of the traditional goals and values of graduate education and an analysis of the expanding responsibilities of nurses, the Association declared, "the major purpose of graduate education in nursing should be the preparation of nurse clinicians capable of improving nursing care through the advancement of nursing theory and science" (House of Delegates Reports 1968-1970, 1970, p. 13).

The Commission on Nursing Education stated that two of the primary criteria of a profession are:

(1) The use in its practice of a well-defined and well-organized body of specialized knowledge on the intellectual level, and (2) Constant enlargement of the body of knowledge it uses and constant improvement of its techniques of education and service, through systematic inquiry (Flanagan, 1976, p. 248).

In the Executive Director's report for 1970 House of Delegates the future of nursing education was discussed.

. . . Predicting "dynamic" development of clinical specialization, the Commission on Nursing Education pointed out that nursing education must be geared to the future in which nurses will move freely among a variety of formal and informal health care settings far different than those we know. . . . But whatever roles or functions these nurses may assume, the core knowledge needed is that of the science and practice of nursing. (House of Delegates Reports 1968-1970, 1970, p. 13)

The Commission identified the need for more masters and doctorally prepared nurses to assume leadership roles.

In 1978, the Commission on Nursing Education issued a revised statement on graduate education.

This new statement on graduate education focuses upon the preparation of highly competent individuals who can function in diverse roles, such as clinical nurse generalists or specialists, researchers, theoreticians, teachers, administrators, consultants, public policy makers, system managers, and colleagues on multidisciplinary teams. All such persons will be prepared through master's, doctoral, and postdoctoral programs in nursing that subscribe to clearly defined standards of scholarship. (ANA, Commission on Nursing Education, 1978, p. v).

This ANA statement also noted that: ". . . The continued revision, expansion and improvement of professional practice is dependent upon the research and leadership of those prepared in graduate programs" (ANA, Commission on Nursing Education, 1978, p. 1). The statement identified future needs for the profession and society:

. . . In essence, graduate education is education for the future; it must be characterized by pluralism, diversity, and flexibility to address the multitudinous health care needs of society. New and changing concepts about nursing, health care, and the delivery of health services can be expected. Increasingly complex preventive, therapeutic, restorative, and rehabilitative modalities and changing roles of health professionals will demand scholarly preparation for nurses. Individual nurses, the institutions in which they practice, teach, and conduct research, the agencies that provide financial assistance, and the nursing organizations must collaborate in order to increase the number and kinds of nurses prepared through graduate education. If this nation is to realize its stated goal of optimal health care for all its citizens, priority must be given to graduate education in nursing. (ANA, Commission on Nursing Education, 1978, p. 5).

Continuing education

The third area of focus for the Commission on Nursing Education was continuing education. ANA launched a campaign to involve nurses in continuing education activities. Continuing education was noted as being important in nurses' maintaining their competency

and meeting standards of nursing practice (Welsh, 1962, p. 23).

Since its inception in 1896, the professional organization gave priority to the promotion of basic and continuing education as the basis for nursing's professional growth and development. Early formation of alumnae associations was for social and educational purposes and have been credited with providing the first continuing education for nurses. Continuing education has been defined by the Association as "planned learning experiences beyond a basic nursing educational program" which are designed to promote "the development of knowledge, skills and attitudes for the advancement of nursing practice" (Flanagan, 1976, p. 252).

At the 1962 convention, the House of Delegates for the first time formally discussed continuing education. The discussion was triggered by the report of the Committee on Nursing Practice's statement on clinical practitioners (Welsh, 1962, p. 23). The committee proposed the presentation of clinical papers at ANA conferences. The stated purpose of the papers was to describe clinical issues and to offer suggestions for the improvement of nursing practice. The most up-to-date information affecting the delivery of nursing care would be presented (Welsh, 1962, p. 23).

In 1967 ANA made its first definitive statement on continuing education in its publication, Avenues for Continued Learning. Three categories of continuing education were identified: (1) formal--baccalaureate or higher, (2) short-term courses by higher educational institutions, and (3) independent and informal study carried on by practitioners including inservice education programs and self-study.

In the pamphlet was stated:

No program of basic education, whatever its type or quality could possibly encompass all that the practitioners will need to know for skilled practice through a lifetime career. . . . Continuing education is a necessity for each practitioner--teacher, engineer, doctor or nurse--to keep skills and competencies current with the growth of knowledge in each field. . . . The obligation to obtain continuing education is upon the nurse and the profession. (ANA, 1967, p. 5)

ANA, in September of 1971, was awarded a \$42,000 grant for a project entitled, "Identification of Need for Continuing Education for Nurses by the National Professional Organization." The project was completed late in 1972 and identified the diversity of subject matter, location and sponsorship of existing programs (Flanagan, 1976, p. 255).

The Council on Continuing Education was formally established in 1971 to determine the scope of ANA's role in continuing education and to develop standards and

program guidelines for continuing education in nursing (Flanagan, 1976, p. 255).

During ANA's 1974 convention, the House of Delegates adopted several resolutions pertaining to nursing education. Of special significance for continuing education was the adoption of the following resolutions:

1) (Continuing Education)

Resolved, that ANA express its strong support for establishing participation in continuing education approved by SNAs as one prerequisite for continuing registration of a license to practice the profession of nursing, and be it

Resolved, that ANA assist SNAs in developing systems for implementing this requirement, which will ensure interstate mobility of licensed practitioners, and be it

2) (Accreditation of Education Programs in Nursing)

Resolved, that this House of Delegates direct the ANA Board of Directors to move with all deliberate speed to establish a system of accreditation of continuing education programs and move just as expeditiously to examine the feasibility of accreditation of basic and graduate education programs, and be it further

Resolved, that this House of Delegates recommend that the ANA Board of Directors seek the cooperation and assistance of SNAs as is appropriate and necessary in this critical effort. (Proceedings of the Forty-Ninth ANA Convention, 1974, pp. 36-38)

In October 1974, the Board of Directors went on record as agreeing to the ongoing plans and activities of the Commission on Nursing Education regarding the feasibility study on accreditation mandated by the 1974 House of Delegates. In 1974 ANA published, Continuing Education Guidelines for State Nurses Associations. The

pamphlet stated ANA's belief that: "Continued learning is essential for maintaining competency in nursing practice." However, ANA took a neutral stand on continuing education for relicensure (ANA, Commission on Nursing Education, 1974, p. 1).

In the pamphlet, the following principles and responsibilities were identified:

- 1) Continuing education is essential to continued competence.
- 2) Continued competence in practice is an individual responsibility.
- 3) The public holds the profession accountable for the competence of its practitioners.
- 4) The profession carries responsibility for establishing standards for continuing education activities in which the practitioners of that profession participate; and for establishing a climate and the mechanisms to facilitate continued learning. (ANA, Commission on Nursing Education, 1974, pp. 1-3)

The stated rationale for the professional association's assumption of responsibilities was that:

- 1) The Association carries responsibility for establishing the scope of nursing practice, developing and continuously updating standards of practice.
- 2) The Association keeps abreast of trends in health care services and has general working knowledge of the increasing complexity of health care.
- 3) The Association has means for assessing consumer expectations.
- 4) The Association has the capacity to minimize unnecessary duplication of programs, to foster effective use of funds, and suggest alternative sources of funding. (ANA, Commission on Nursing Education, 1974, p. 3)

In 1975, appointments were made to an ANA National Accreditation Board for Continuing Education Programs and an ANA National Review Committee for

Expanded Role Programs, as well as five review teams and five regional accrediting committees (Flanagan, 1978, p. 10). In 1975, the Council on Continuing Education developed a model and mechanism for accreditation of continuing education in nursing, revised standards for continuing education in nursing and published guidelines for staff development (Flanagan, 1976, p. 260).

During the 1970s ANA through its structural units continued to work on the refinement of standards for nursing education. In 1974, the House of Delegates adopted priorities for 1974-1976 biennium which included the following statement:

Improving the quality of education (basic, graduate and continuing) in nursing through implementation of standards enunciated by the association and through development of a system of accreditation of continuing education offerings in nursing. (Flanagan, 1978, p. 8).

In June 1975, the Commission on Nursing Education issued Standards for Nursing Education. Contained in the Association's publication are standards for programs leading to graduate, baccalaureate, and associate degrees and diplomas from hospital schools of nursing. Standards for continuing education in nursing were also included (ANA, Commission for Nursing Education, 1975, pp. 4-5).

Nursing Studies

At the same time that ANA structural units were examining the basic educational preparation for nursing, other projects and studies were being conducted. One such study was the investigation of the development of the associate degree program in nursing.

Community College Education for Nursing

During the 1960s and 1970s Mildred Montag's Community College Education for Nursing impacted the nursing education scene. The initial study and experimentation extended through five years and involved the cooperation of seven junior and community colleges and one hospital school throughout the United States.

Few nurse educators sensed in 1952 that the junior and community college movement, rapidly being extended across the country, would attract an increasing proportion of youth, including many needed in nursing who would be lost to this field unless nursing programs became an integral part of the junior college curricula. Both nurses and educators questioned the possibility of shaping the technical education characteristics of these colleges into an accelerated new type of program to prepare young people for licensure as registered nurses and for what has been named the associate degree in nursing. (McManus, 1959, p. vii)

The development of this program challenged the senior colleges and universities to examine their programs in terms of the principles of professional education and their graduates as registered nurses whose competence and functions should be above and beyond those of nurses prepared through diploma and associate degree programs. Adequate education for

the leadership group needed to be provided by the universities if the nation was to have satisfactory health services. (Montag, 1959, p. x)

The profession must recognize too the differences between professional and semi-professional or technical functions and between professional and technical education (Montag, 1959, p. 367).

Montag's project was initiated as an experiment to respond to the shortage of nurses and the decrease in the recruitment of application for nursing. The intent as stated throughout the study was to prepare the nurse with the technical skills needed for bedside nursing. Although initially designed to address the shortage of nurses, the "mushrooming" of these programs throughout the country led to conflict within the profession and within the association.

National Commission for
the Study of Nursing and
Nursing Education

Another study on nursing was conducted during the late 1960s. A desire for follow-up to the work of the Surgeon General's Consultant Group on Nursing led the ANA and the NLN to initiate action toward the establishment of an independent commission for a national study of nursing. The study was financed by both organizations, the Kellogg and Avalon Foundations and an anonymous benefactor. Findings of the National

Commission for the Study of Nursing and Nursing Education were reported in An Abstract for Action (Lysaught, 1970).

Completed after two and one-half years of investigation, the report stated that nursing's educational system should be centered in collegiate institutions to insure enlarged social, economic, and educational opportunities. In the report was also stated that the recommendations for change in nursing could be seen in terms of four priorities:

- 1) Increased research into the practice of nursing and education of nurses;
- 2) Improved educational systems and curricula based on the results of that research;
- 3) Clarifications of roles and practice conjointly with other health professions to ensure the delivery of optimum care; and
- 4) Increased financial support for nurses and for nursing to ensure adequate career opportunities that will attract and retain the number of individuals required for quality health care in the coming years. (Lysaught, 1970, p. 155)

The commission from the study formulated four central recommendations:

- 1) The federal Division of Nursing, the National Center for Health Services Research and Development, other government agencies, and private foundations appropriate grant funds or research contracts to investigate the impact of nursing practice on the quality, effectiveness, and economy of health care.
- 2) Each state have, or create, a master planning committee that will take nursing education under its purview, such committees to include representatives of nursing, education, other health professions, and the public, to recommend specific guidelines, means for implementation, and deadlines to ensure that

nursing education is positioned in the mainstream of American educational patterns.

3) A National Joint Practice Commission, with state counterpart committees, be established between medicine and nursing to discuss and make recommendations concerning the congruent role of the physician and the nurse in providing quality health care, with particular attention to the rise of the nurse clinician; the introduction of the physician's assistant; the increased activity of other professions and skills in areas long assumed to be the concern solely of the physician and/or the nurse.

4) Federal, regional, and local governments adopt measures for the increased support of nursing research and education. Priority should be given to construction grants, institutional grants, advanced traineeships, and research grants and contracts. Further, we recommend that private funds and foundations support nursing research and educational innovations where such activities are not publicly aided. We believe that a useful guide for the beginnings of such a financial aid program would be in the amounts and distribution of funds authorized by Congress for fiscal year 1970, with proportional increases from other public and private agencies. (Lysaught, 1970, pp. 156-161)

The report also identified that their recommendations were similar to those of other studies, Goldmark (1923) and Brown (1948). They pointed out that these recommendations were discussed but never enacted (Lysaught, 1970, p. 161).

In meetings in 1970 and 1971, the ANA Board of Directors reviewed and endorsed its (the report's) principal recommendations, pointing out that these recommendations were closely allied to ANA's long held objective for nursing education. The board urged SNAs to study the report and to intensify their efforts to advance

implementation of the recommendations (Flanagan, 1976, p. 248).

In May 1970, the House of Delegates endorsed the report of the commission. Between 1970 and 1972, the Association worked to implement the commission's recommendations. Special attention was placed on securing of federal aid for nursing education (Flanagan, 1976, p. 249).

Standards of Nursing Practice and Nursing Services

The initial work on standards in the association was done through the Function, Standards and Qualification Studies. ANA has defined "standard" as "an authoritative statement by which the quality of practice, service or education can be judged" (Flanagan, 1976, p. 219). During the 1960s and 1970s, ANA through its structural units and programs was engaged in developing and refining standards for nursing practice for the purpose of affecting and controlling nursing practice.

In 1960, to implement the House of Delegates resolution on nursing practice the ANA Board of Directors appointed an ad hoc committee to investigate an appropriate course of action to be taken. The absence of professional standards for nursing service was a deterrent to the efforts of SNAs to improve nursing

practice (Proceedings of the Forty-Second ANA Convention, 1960, p. 119).

In June 1961, the Board appointed the Committee on Nursing Services. As a result of the work of this committee in 1965, ANA published, Standards for Organized Nursing Services to serve as guidelines for the development of a nursing care system relevant to contemporary health care needs. In 1966, when ANA reorganized its structure, nursing practice was given top priority through setting standards for all areas of nursing practice. The Joint Commission on Accreditation of Hospitals, in 1968, upgraded its regulations and incorporated ANA standards into the Commission's specifications (Flanagan, 1976, p. 220).

In October 1967, the Council of Division Chairmen (replaced by the Congress of Nursing Practice in 1968) developed guidelines for standards committees with descriptions, rationale and significant factors for practice. In February 1968, the first meeting of the standards committee was held. The five committees accepted the council guidelines and worked through 1969 to complete their standards. In 1969, the format for the standards included a statement of the standard, the rationale for including the standard, the assessment factor or the nurse behaviors to judge the

practitioner's use of the standard (Flanagan, 1976, p. 221).

Work on the standards was temporarily halted in 1970 due to ANA's financial crisis. ANA staff undertook a one-year study of the issues and referred their results to an ad hoc committee composed of members of the Congress for Nursing Practice plus the chair or representative from each standard committee. The key issue was related to the number of sets being developed. In January 1971, the committee recommended the formulation of one generic set of standards while others were being studied. The committee concluded:

- 1) that standards were necessary for the practice of nursing,
- 2) that one set of generic standards should be developed for uniformity among the divisions,
- 3) that the preliminary work on the standards should be used, and
- 4) that specialized sets of standards would be formulated for each division after the generic set was published. (Flanagan, 1976, p. 223)

By the end of 1971, there were eight generic standards for nursing practice identified.

In April 1973, the Congress for Nursing Practice decided to publish the developed standards as working documents. In June 1974, at the ANA convention, the House of Delegates voted that the implementation of ANA's standards of nursing practice be given major priority.

The majority of nurses now practice in organized services which are essential components of health care facilities . . . inherent in the statements of Function, Standards and Qualifications and the approved legal definition of practice and other policy statements of ANA. The essential elements in a nursing service that would meet the standards of the nursing profession should be identified in order that there be guidelines to the establishment of conditions under which nurses may perform their professional functions to the satisfaction of themselves and the public they serve. (Proceedings of the Forty-Second ANA Convention, 1960, p. 119)

At the 1962 convention, the House passed a resolution on the critical practice of nursing necessary to meet the increased scope and complexity of health care in this country. The resolution identified the need for increased numbers of professional nurses who are being prepared to further develop and maintain a high degree of clinical judgment and competence in their practice and to extend their services through other personnel and function in a primary role as a clinician. The House also called for collaboration with the American Medical Association and the American Hospital Association to promote the recognition, development and utilization of clinical practitioners in nursing in hospitals and thus improve the quality of care for the public (Welsh, 1962, pp. 24-25).

The Association continued to work on the further development of the clinical nurse practitioner. In the

report of the ANA Executive Director the progress to date was identified:

Ways and means are being devised to advance the clinical competence of practitioners of nursing. Standards, recognition and working relationships are being further developed and maintained within the Association and with related professional, governmental and community groups as appropriate.

The staff of the Nursing Practice Department have devoted considerable time to thinking through and planning how to proceed judiciously, but with "deliberate speed" to carry out the Association's program for the advancement of nursing practice, with priority to the Committee on Standards. . . . Statements on standards will improve nursing practice throughout the country and will tend to unify the profession behind such statements by the Association. (House of Delegates Reports 1966-1968, 1968, p. 20)

Certification

The work on standards was related to the Association's work on the development of a certification process.

At the 1958 Convention, the House of Delegates upon recommendation of the Committee on Current and Long-Term Goals, adopted what was to be known as Goal II of the Association: that ANA establish ways to formally recognize members who demonstrated exceptional accomplishment in the practice of nursing, contributed to the development of the profession, advanced nursing knowledge, and served both society and the profession by their contributions. The responsibility for the development of this goal was delegated to the Intersection

Committee on Recognition of Superior Performance. This committee was composed of representatives of the Committees on Functions, Standards and Qualifications for Practice which was created in 1954 by the eight occupational sections of the association (Proceedings of the Forty-First ANA Convention, 1958, p. 74).

In 1962, the Intersectional Committee on Recognition of Superior Performance reported that their work was interrelated with the Study Committee on the Functions of the ANA. It was decided that further study needed to wait until membership consideration and the eventual decision on proposed rearrangements within the association were completed (Welsh, 1962, pp. 23-25).

In 1966, the Study Committee on Functions of the ANA delegated to the divisions on practice, the work on certification. Certification boards within each division were established to develop criteria. The functions of these boards were to: (1) develop specialized criteria; (2) review credentials of those applying, (3) certify division members who meet special criteria, and (4) endorse certified practitioners for appointment as Fellows in the American Academy of Nursing (Proceedings of the Forty-Fifth ANA Convention, 1966, pp. 87-88).

In 1968, the five interim certification boards held their first meeting. In January 1969

questionnaires were mailed to various professional organizations to obtain data on formal or informal recognition of excellence. Early in 1969, the Congress on Nursing Practice submitted fifteen tentative guidelines to the interim certification boards. The Congress on Nursing Practice developed definitions for two kinds of practice--professional nursing and technical nursing. In September 1969, the Congress in response to reactions from the interim certification boards revised their guidelines. They recommended three types of certification: (1) professional general practice, (2) professional specialty practice, and (3) technical general practice (Proceedings of the Forty-Seventh ANA Convention, 1970; Flanagan, 1976, p. 231).

Through 1970 and 1971 work on the guidelines continued and on 15 October 1971, the Congress on Nursing Practice distributed a revised set of guidelines for one level of certification with consideration of the following questions:

1. What are the steps in the certification process?
2. Who is eligible for certification? and
3. What are the criteria for certification?

They also stated that ANA certification was based on three factors:

1. Assessment of knowledge
2. Demonstration of competence in clinical practice, and
3. Endorsement by colleagues.

In May 1973, ANA formally announced the initiation of its nationwide certification program to recognize excellence in practice. A contract with the Educational Testing Service of Princeton, New Jersey was obtained. In June 1973, the Congress for Nursing Practice shared information with specialty groups and together they explored ways of cooperating to develop a system or systems that complement and support the activities of all nursing organizations (Flanagan, 1976, pp. 236-37).

During the 1972-74 biennium, the Congress for Nursing Practice appointed an ad hoc committee to study certification for the specialty practice of nursing. Two recommendations received top priority: (1) certification for excellence in practice as a specialist is needed, and (2) documentation of proficiency in a specialty area is based on continuing education beyond basic nursing education (Flanagan, 1976, p. 238). Concomitantly other organizations began to certify practitioners considerably "molding" the certification process.

In January 1975, ANA conducted formal ceremonies for nurses who were certified. Three hundred and four nurse practitioners were awarded ANA certification (Flanagan, 1976, p. 238).

American Academy of Nursing

As the result of a study conducted between 1964 and 1966, the revisions to the ANA Bylaws, presented at the forty-fifth convention, included a provision for an academy of nursing "for the advancement of knowledge, education and nursing practice" (ANA Bylaws, as amended June 1966, p. 29). In presenting the proposal for an academy, the chairman of the Study Committee on the Functions of ANA stated:

Established for the purpose of advancing knowledge with election as a fellow therein being a high honor in recognition of substantial achievement and contribution to nursing, the academy envisioned by the study committee would enhance in great measure the authority and effectiveness of the ANA. In other fields such bodies are often formed outside the professional association. The study committee proposes that ANA encompass the academy for the nursing profession within itself. (Proceedings of the Forty-Fifth Convention, 1966, p. 29)

The House of Delegates adopted bylaw provisions which designated academy members (fellows) as individuals selected by the Academy's governing council "from among those members of the association who have been certified and endorsed by division certification boards

and otherwise deemed qualified by the Academy" (ANA Bylaws, as amended June 1966, p. 29).

After many years of debate on the criteria for membership and functions of the Academy, the American Academy of Nursing was initiated on 31 January 1973. This was accomplished through the adoption of a resolution by the ANA Board of Directors which designated thirty-six charter fellows, named pro tem officers, and directed that specific action be taken to establish the Academy. The House of Delegates at the 1974 convention adopted bylaw revisions which clarified the purposes and objectives of the Academy. The bylaws stated that Academy fellows

shall be selected by the governing council of the academy from among those members of the association who have made a significant contribution to the advancement of knowledge, education, practice in nursing, or to the profession of nursing. (ANA Bylaws, as amended June 1974, p. 25)

Criteria for selection of members included: five years of professional experience beyond basic nursing education, evidence of outstanding contributions to nursing, and evidence of potential to continue contributions to nursing.

The Academy was viewed as

a working body which would operate in a climate in which current systems, ideas, and practices may be challenged, new ideas in nursing and other fields explored, and experimentation and innovation in

nursing encouraged. (House of Delegates Reports 1968-70, 1970, p. 103)

Thus another step in the recognition of excellence of nurses was taken by the Association. ANA continued to work on helping the profession improve and control nursing practice.

Credentialing

In January 1977, ANA announced the award of a contract to the School of Nursing at the University of Wisconsin at Milwaukee to undertake a comprehensive, twenty-two month study of credentialing in nursing. Initiative for the study grew out of action taken by the 1974 House of Delegates which charged the Board of Directors "to move with all deliberate speed to establish a system of accreditation of basic, graduate, and continuing education programs in nursing." The project was launched in September 1976 after two years of preliminary planning and in response to recommendations from three individual conferences sponsored by ANA. Participants in those conferences were selected from the nursing profession, governmental agencies, other disciplines and public members with expertise in the area of credentialing. Based on the recommendations made at the conferences, the purposes of the credentialing study were: (1) to assess current credentialing mechanisms in

nursing, including accreditation, certification, licensure, and, where indicated, to suggest ways for increasing the effectiveness of credentialing; and (2) to recommend future directions for credentialing in nursing. Although ANA was the sole sponsor of the study, a significant role had been identified for other nursing organizations designated as cooperating agencies and the State Nurses' Associations (SNAs) in implementing this study (Flanagan, 1978, pp. 10-11).

The project identified three forms of credentialing mechanisms for health care workers:

- 1) licensure (minimal),
- 2) accreditation (schools) recognizes the educational institution's ability to impart a certain level of knowledge to students, and
- 3) certification or recognition--3 types:
 - 1) voluntary or mandatory for entry into practice
 - 2) voluntary or mandatory certificate of competence which serves as validation of educational attainments and continuing education activities
 - 3) voluntary or mandatory--serves as recognition of professional achievement, e.g. ANA--recognition of excellence in the clinical practice of nursing. (Flanagan, 1976, p. 231)

The specific aims of the study were:

- 1) To critically examine, compare and evaluate current credentialing in nursing.
- 2) To develop alternative models for a credentialing system for individuals involved in nursing and for nursing education and nursing service agencies, and to evaluate those models in relation to specific criteria which are deemed essential for such a service.
- 3) To recommend a credentialing system for nursing and plans for systematic implementation of the proposed system, and

4) To make other recommendations for future directions as deemed appropriate. (Flanagan, 1976, p. 231)

In March 1979, the Board of Directors adopted a motion that: (1) a task force be established, (2) the ANA Board of Directors request the American Nurses' Foundation to establish a distinctive fund to receive and administer money to carry out functions of the Task Force on the Credentialing Study, and (3) the ANA Board of Directors solicit nominations for membership on the task force from the cooperating groups.

The study committee's report was published in two volumes. Volume I of the study, The Study of Credentialing in Nursing: A New Approach, the Report of the Committee, contained five basic recommendations. The report made recommendations on: (1) Principles of Credentialing, (2) Positions on Credentialing Issues, (3) Credentialing Definitions and their Applications in Nursing, (4) Nursing Credentialing Center, and (5) Structure of the Professional Society (ANA, Study of Credentialing in Nursing, 1979, pp. 82-92). The second volume was published entitled, The Study of Credentialing in Nursing: A New Approach, Staff Working Papers (House of Delegates Reports 1978-1980, 1980, pp. 118-19).

Economic and General Welfare Program:
Continued Growth

During the 1960s and 1970s ANA's emphasis on the Economic and General Welfare Program continued to grow. The program was expanded to meet two objectives: (1) To achieve employment status for nurses commensurate with their preparation and qualification 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).

The Committee on Economic and General Welfare, at the 1966 convention, reported to the House of Delegates that

the nursing profession has very little control of how salaries are actually set and administered and only limited control over the level of preparation an individual must have before she is employed to carry a certain level of nursing functions and responsibility. (Nordin, 1966, p. 61)

A report on the current salaries of registered nurses prompted the House to adopt the following national salary goal: "In 1966, a registered nurse should enter the profession at a salary of not less than \$6,500." The pronouncement was viewed as a method for both retention and recruitment of nurses. During the 1966-1968 biennium, substantial improvements in nurses'

salaries were noted across the country (Flanagan, 1976, p. 268).

In 1966, the Commission on Economic and General Welfare was established. Throughout 1967 and early 1968, the newly formed Commission on Economic and General Welfare conducted an extensive study of the association's approach to economic security for nurses. The Commission concluded:

A unique combination of circumstances has created a favorable climate for expansion of state nurses' association programs: the advent of medicare, arousing a wide national salary goal, focusing public attention on the economic needs of the profession; the dramatic salary increases won by nurses in New York City and San Francisco, demonstrating the effectiveness of group action to nurses throughout the country. As more and more nurses turned to their professional association for economic security assistance, the needs of state constituents for direct and immediate aid became increasingly apparent. (Zimmerman, 1968, p. 74).

The Commission outlined a plan based on two essential considerations: (1) The need for a program of sufficient scope and concentration to achieve a significant change in the number of nurses represented, within a relatively short period of time, and (2) the need to provide state nurses' associations with direct assistance by qualified staff (Flanagan, 1976, p. 263).

In 1968, ANA's House of Delegates endorsed a proposal that additional staff be assigned to specific projects in various parts of the country where SNAs had

requested assistance in implementing their economic and general welfare programs (Proceedings of the Forty-Sixth ANA Convention, 1968, p. 33). The additional staff were assigned to specific projects in various parts of the country where SNAs requested assistance in implementing their economic and general welfare programs. It was proposed that there would be shared funding of these programs by ANA and the SNAs. The services provided by ANA included assistance in preparing briefs, developing educational programs, conducting workshops, giving advice on collective bargaining legislation, analyzing surveys, and recruiting memberships (Flanagan, 1976, p. 263).

At the 1968 convention the House of Delegates also voted to rescind the eighteen-year-old no-strike policy. The House adopted a motion that:

The American Nurses' Association support the efforts of the state nurses' associations acting as bargaining representatives for members in taking necessary steps to achieve improved conditions, including concerted economic pressures which are lawful and consistent with the nurse's professional responsibilities and with the public's welfare. (Proceedings of the Forty-Sixth ANA Convention, 1968, p. 33)

In 1970, the House of Delegates voted to rescind ANA's neutrality policy as adopted in 1950. The policy referred to labor management relations between their employers and non-nurse employees:

The Commission on Economic and General Welfare redefined the neutrality policy as a position on relations with other employee bargaining groups that urges nurses, in the event of a dispute between their employer and other employee groups, to continue to perform their distinct nursing duties, but to press for action in the interest of safe patient care, to reduce the patient census by curtailing admissions or by expediting discharge and transfer to other facilities, and to coordinate activities through the local unit organizations in the SNA (Proceedings of the Forty-Seventh ANA Convention, 1970, p. 36).

Between 1966 and 1971, there were increased activities in the economic security programs of SNAs. However, due to ANA financial difficulties there was a suspension of economic security programs in the spring of 1970. Between 1970 and 1972, ANA staff services to the state nurses' associations were sharply reduced (House of Delegates Reports 1970-1972, 1972, pp. 43-44).

In January 1972, the Board of Directors approved and funded a modified program of specialized field service. The Commission on Economic and General Welfare was asked to develop long-range, five-year projections for the field service program. The Commission identified several significant trends:

- 1) Increased unionization of health care employees,
- 2) Proliferation of collective bargaining laws covering health care employees,
- 3) Increased organization of other professionals,
- 4) Increased awareness of nurses of the need for organized action,
- 5) Growing use of contracts to provide mechanisms for implementing nursing standards, and

6) A growing lack of ability of many SNAs to implement an economic and general welfare program. (Poulin, 1972, p. 77)

Between 1972 and 1974, emphasis was placed on educational training for SNA staff members and local unit members through workshops, seminars and conferences. In December 1973, ANA announced that it would commit substantial financial resources to assist the fifty-two constituent nurses' associations to expand collective bargaining activities in health care facilities (Flanagan, 1976, p. 264).

In 1974, the Association launched an aggressive campaign to assist the state nurses' associations to organize the nation's 800,000 active registered nurses for the purpose of professional collective action. Because of the passage of the amendments to the National Labor Relations Act, which extended the right of collective bargaining to nurses in nonprofit hospitals, the ANA, working through the state nurses' associations, has intensified its efforts:

- 1) To secure conditions of employment and a climate for practice that fostered a lifetime career attachment to nursing.
- 2) To secure conditions of employment that will attract able persons to careers in nursing.
- 3) To involve nurses actively in determining the conditions of employment under which they practice, through collective action.
- 4) To represent nurses at their place of employment utilizing collective bargaining.

- 5) To attain wide understanding and recognition of the scientific and social contribution of nurses to the health and welfare of the community.
- 6) To achieve an employment status for nurses commensurate with their preparation and qualifications and with the intellectual and technical nature of their services.
- 7) To promote social, economic and health legislation beneficial to the economic and general welfare of nurses. (Flanagan, 1976, p. 266)

In 1975, ANA intervened in several unit determination cases and urged the National Relations Board (NLRB) to sanction a separate unit of professional registered nurses as appropriate. In a landmark decision, Mercy Hospital of Sacramento, Inc, the NLRB ruled that,

registered nurses possess, among themselves, interests evidencing a greater degree of separateness than those possessed by most other professional employees in the health care industry. These distinct interests derive not only from the role and responsibilities of registered nurses but also from an impressive history of exclusive representation and collective bargaining. (ANA, Commission on Economic and General Welfare, 1981, p. 7)

In 1976, the House of Delegates reaffirmed the multipurpose nature of ANA and the right of participation of directors of nursing in ANA (p. 7). The Board of Directors was mandated to study the structural relationships of the collective bargaining activity as it applied to the multipurpose nature of the ANA (p. 7).

In 1977, SNAs went over the 100,000 mark in their representation of registered nurses in collective bargaining. ANA initiated the Staff Service Program to

assist SNAs to employ the full-time E&GW staff (ANA, Commission on Economic and General Welfare, 1981, p. 8).

In 1978, ANA President Barbara Nichols issued an "Open Letter to the Nurses of America" declaring the organization's intent to represent nurses more effectively and aggressively; although traditional unions and employers were mounting challenges and greater opposition. She emphatically told nurses, "This professional association is the best union to represent you." That same year the Commission on Economic and General Welfare received an award from the Coalition of Labor Union Women for its promotion of women's rights (ANA, Commission on Economic and General Welfare, 1981, p. 8).

ANA Structural Changes

Once again ANA was involved in examining its structure to see how best to meet its organizational responsibilities to the individual practitioner, the profession and society. The Association over the years had been involved in changing its structure to implement agreed upon functions.

The structure change in the forties was appropriate for then. The decision for two organizations in 1952 focused upon specific needs of individual practitioners. The intent was on strengthening the nurse's position through the organization of sections and the launching of the economic security and counseling and placement programs . . . identifying specific functions of practicing nurses, and establishing necessary standards and qualifications. The

study of "FS and Q" by thousands of nurses throughout the country had opened new vistas for the nurse. ("Editorial," June 1959, p. 813)

One of the major changes in the American Nurses' Association's structural organization in 1952 was to provide for increased responsibility and autonomy in the sections. Nurses were able to join ANA through the sections, secure representation in the House of Delegates, function in their special areas of interest and make decisions which directly affected them. At the state and local levels of the association, functions were aimed at assisting individual nurses in improving their nursing practice and securing optimum working conditions. There was a cooperative nature among all levels --national, state, district--which was further promoted by the section chairmen being voting members on the ANA Board of Directors (ANA, Proceedings of Conference for State Executive Secretaries, 8-10 August 1959, p. 2).

The primary responsibility for the nursing services, education and research rested with the NLN. Major decisions in carrying out the primary functions of the profession were to be made by the organization of professional nurses, the ANA. "The Association moved more naturally to a recognition of the broader horizons of our responsibilities as a profession" ("Editorial," June 1959 p. 813).

At the January, 1955 ANA/NLN Coordinating Council Meeting, there was discussion of the state associations' and state leagues' dissatisfaction with both national organizations. However, the Council decided that it was "inadvisable to experiment now since the present organizational structure has been in existence for only three years." At the January 1956 meeting, the ANA Board favored state experimentation in specific instances but NLN was opposed to any experimentation.

There was general agreement that the two organizations were making good progress nationally and that action toward any further reorganization should be taken only after careful study and planning to ensure no loss of momentum of programs. The Council then voted that a small committee from each board, the Interorganization Functioning Committee, should meet together to make a plan for collecting facts about both the successes and the problems raised regarding the current structure. These facts were then to be brought before the Coordinating Council meeting in January 1957 (House of Delegates Reports 1958-1960, 1960, p. 174).

The Interorganization Functioning Committee met in April 1956 and developed a questionnaire to gather facts from state associations and state leagues. No question was asked regarding the amalgamation of the two

organizations. Questions were asked regarding problems in carrying out the respective programs of the two organizations and problems in relationships between the respective constituent associations.

Several problems encountered by both the state associations and state leagues were identified: the complexity of the structure, the large number of committees and meetings necessary to carry out the programs of both organizations, competition for membership, problems in interpreting functions of the two organizations, duplication of effort, lack of program coordination and financial and leadership needs ("Toward One Organization," April, 1959, pp. 540-43).

The Committee on Facts about Present Organizations reported to the ANA/NLN Coordinating Council in January 1957. The committee recommended a plan for an investigation of the functioning of state and local organizations. The boards accepted the three recommendations of the committee: (1) the project proposal, (2) funds for a five-year study and (3) the Coordinating Council to be used as a clearinghouse for information. In January 1958, the committee was dissolved since the states had lost interest in the project (House of Delegates Reports, 1958-1960, 1960, pp. 172-87).

At the opening of the 1958 ANA convention, the ANA Advisory Council (president and one other representative of state associations, ANA Board, representation from NLN, and others) discussed officially and for the first time since 1952, the desirability of one organization for nurses and nursing (Proceedings of the Forty-First ANA Convention, 1958, p. 20).

The 1958 House of Delegates, later on in the convention, overwhelmingly adopted the following resolution on one organization:

Recognizing that the American Nurses' Association cannot legislate action that affects the National League for Nursing,

Resolved, that the House of Delegates go on record as believing that one national organization can best meet the needs of nurses and nursing, and

Resolved, that the ANA Board of Directors invite the NLN to be cosponsors of a meeting of the state leagues for nursing and the state nurses' associations immediately before the 1959 NLN convention for a progress report on this joint committee (Proceedings of the Forty-First ANA Convention, 1958, p. 20)

ANA Board transmitted the 1958 resolution to the NLN and appointed a committee to recommend methods of implementation. In November, the NLN Board declined ANA's invitation and reaffirmed unanimously, at a meeting of the presidents and executive secretaries of state leagues for nursing, its January 1958 decision. Further, NLN recommended to the ANA, consideration of having the ANA Advisory Council meet with the NLN Council of State Leagues for Nursing, SLN executive

secretaries and the NLN Board for the purpose of clarifying the respective functions of the two organizations and considering ways and means by which each could complement the other on national, state and local levels in the interest of better nursing. The meeting was to be convened just prior to the NLN 1959 convention. ANA was also requested to notify their state and local constituencies so that they could work cooperatively with the state and local leagues to carry out programs for nursing (House of Delegates Reports 1958-1960, 1960, pp. 172-87).

Since the ANA Board was unable to implement the resolution, a meeting in May 1959 was called of the presidents and executive secretaries of all state nurses' associations. In commenting on plans for this meeting, Mathilda Scheuer, president of ANA, stated:

In view of the events of the past months, every effort will be made to stimulate the members of ANA to appraise realistically the problems which they experience under the present structure. Between now and the next meeting of the ANA House of Delegates, attention must be given to issues which are basic to the dissatisfaction expressed through the ANA House of Delegates resolution for one organization. . . . to assure that nursing is organized in the best interests of the profession and the public. ("Toward One Organization," April 1959, p. 542)

These nurses from all fifty states quickly established an atmosphere in which ideas were exchanged freely and opinions expressed frankly. . . . Whether or not the functions of the two organizations are "distinctive and complementary" (as contended by NLN), the fact remains that nurses,

especially in the state and local organizations, are confused and in conflict over their responsibilities. . . . demonstrated to achieve what the words, "one organization" seem to mean to most of them--a simplicity in structure with full authority on professional matters . . . a searching analysis of how well or how poorly the present structure serves the profession and the public . . . and a realistic approach to the structure of the nursing organizations . . . through sorting out those areas where it is essential that ANA maintain control from those areas where it is neither feasible nor necessary for ANA to function alone. ("Editorial", June 1959, p. 813)

In September 1959, the Board of Directors established the Study Committee on the Functions of ANA. This committee was to develop a plan for presentation to the 1960 House of Delegates which would involve the membership in a study directed towards working out any organizational rearrangements. The committee was also to develop criteria to aid in a determination of the functions which ANA, as the professional association, must carry out to discharge its responsibilities (Proceedings of the Forty-Second ANA Convention, 1960, pp. 110-15).

In its report to the 1960 House of Delegates, the Study Committee on the Functions of ANA concluded that ANA needed to assume responsibility for the functions it should carry out and to make whatever arrangements that are necessary to meet the real needs of nurses. Action taken by the ANA House of Delegates required a vote by the delegates on proposals for

changes in the bylaws so that ANA could broaden its scope to encompass a professional association's responsibility in nursing education and nursing service and arrange to meet the demands for emphasis on clinical practice (House of Delegates Reports 1960-1962, 1962, pp. 109-18).

The general characteristics of the suggested arrangements for ANA included considerations for setting standards in the areas of economic welfare, education, practice and service. Functions were to be assigned among levels and units within the organization where each could be performed most effectively with all possible simplicity of structure and economy of resources. The need for communication, coordination, general policy direction and allocation of resources was kept clearly in mind (House of Delegates Reports 1960-1962, 1962, pp. 109-18).

In January 1962, the Board of Directors approved the recommendation of the study committee that the membership of ANA be urged to study questions of rearrangements of the association and the work of the Study Committee on the Functions of ANA, including the forgoing proposal for rearrangements of the association to be presented to the 1962 ANA House of Delegates with the recommendation that the report be taken for study in

the state and district associations (House of Delegates Reports, 1960-1962, 1962, p. 118).

At the 1962 ANA convention the Study Committee on the Functions of ANA in their report encouraged adoption of a resolution:

That the ANA press forward for intensive study by membership at all levels of the association throughout the country so that the basic philosophy expressed in this report can be translated into effective, forward movement of the Association. The committee also submitted criteria for determining priorities developed by the Committee on Current and Long-term Goals: (1) contribution to the development of the profession, (2) whether or not the activities were or could be suitably carried out by others rather than the ANA, (3) strategic considerations of timeliness and public interest, (4) essentiality versus usefulness or desirability, and (5) effected suspension or lessened activities on cost and effort of similar future work. (Proceedings of the Forty-Third ANA Convention, 1962, pp. 31-33).

The Study Committee on Functions of ANA reported at the 1964 convention that it had been five years since the SNA presidents and executive secretaries met to discuss the possibility of one nursing organization. Also that it had been two years since the House of Delegates adopted a new statement of purposes and functions of the ANA (Proceedings of the Forty-Fourth ANA Convention, 1964, pp. 32-33).

The House of Delegates adopted the following resolution:

Resolved, that this House of Delegates commend the work of the Committee by endorsing the

principles and recommendations of their report as a basis for the future development and structure of the ANA, and be it further

Resolved, that the Bylaws Committee be instructed to draft as rapidly as possible the Bylaws, new or revised, needed to embody those principles and recommendations in the ANA structure, and be it finally

Resolved, that in order to take definitive action at the House of Delegates meeting in 1966 the following should occur during the coming biennium (1964-1966):

1. Continued and active study of the present proposals and material at all levels of the organization.
2. Preparation and distribution of tentative proposals for bylaw changes as rapidly as possible so that they can be part of the ongoing study, and
3. Continued work by the committee for further clarification, definition and refinement of proposed structural changes and the inherent functional relationships. (Proceedings of the Forty-Fourth ANA Convention, 1964, pp. 32-33)

Most of the delegates who were opposed to the motion to adopt the resolution were concerned for the future of the Private Duty and General Duty Sections of ANA under the proposed new structure. Those two sections were the largest sections in ANA at that time. The members recommended continued study beyond that suggested in the motion (Proceedings of the Forty-Fourth ANA Convention, 1964, pp. 32-33).

In the 1964-1966 House of Delegates Report, the Study Committee on Functions of ANA referred to the 1965 Supplement Report. The report called for ANA to recognize in its functions and structure, the growing interest and knowledge in areas of clinical nursing

practice and to recognize such concerns as separate and distinct from those of occupational settings in which nurses are employed. Emphasis was placed on the importance of district nurses' association in bringing benefits of membership to most nurses through the support of various groups. ANA would insure authoritative standards for practice, education and services to continually improve the practice and the economic and general welfare of all practitioners (House of Delegates Reports 1964-1966, 1966, pp. 26-29).

The ANA structural unit created to accomplish this was the Divisions on Practice. Since the clinical interests of current practitioners varied, the divisions on practice were established to reflect clinical areas in nursing, those areas of nursing practice where the setting imposes the need for special knowledge and skills and the areas of teaching and administrative practice. The five divisions recommended for the 1966 Bylaws Change were: (1) Medical-Surgical, (2) Maternal Child Health, (3) Geriatrics, (4) Psychiatric, and (5) Community Health Nursing (Proceedings of the Forty-Fifth ANA Convention, 1966, pp. 26-29).

In the 1966-1968 House of Delegates Reports, the Executive Director stated:

The past biennium has marked a period of transition for the ANA. Structural changes adopted by the

House of Delegates in 1966 make it possible to focus on four primary areas of concern--nursing practice, nursing education, nursing services and economic and general welfare. (House of Delegates Reports 1966-1968, 1968, p. 16)

In September of 1966, the ANA Board of Directors made the necessary appointments to the interim executive committee of the five divisions, of officers for the ten occupational forums and of members of the three commissions who took office in January 1967. The elected officials of the sections, branches and conference groups met in the fall of 1966 and made recommendations as to the appropriate disposition or transfer of functions and business to other organizational units (House of Delegates Report 1966-1968, 1968, p. 16).

The Congress for Nursing Practice was established in 1966 to consolidate and coordinate nursing practice without interrupting the autonomy of the Divisions on Practice. Its functions were derived from three areas in the bylaws:

1. Standing committees--Ethical, Legal, Professional Standards, then deleted.
2. Council of Division Chairmen, then deleted.
3. Some of the broad functions and autonomy vested in the structure for the commission were formulated into functions appropriate for the Congress on Nursing Practice.

The chairman of each Division on Practice, once elected by the Division membership would automatically become a member of the Congress. The ANA Board of Directors, with the use of selected criteria, would appoint three additional members for a total of eight on the Congress (House of Delegates Report 1966-1968, 1968, p. 21).*

The House of Delegates to the Forty-Fifth ANA Convention in June 1966 adopted bylaw revisions in order to implement the working relationship statement of ANA/NLN approved by both boards in January 1966. The bylaw revision was done to operationalize the recommended structural rearrangements of the Association (Proceedings of the Forty-Fifth ANA Convention, 1966, pp. 28-29).

At the 1970 biennial convention of the ANA, the Committee on Nursing Research and Studies submitted a proposal for the formation of the Commission on Nursing Research and the dissolution of the current committee. The House approved the proposal and broadened its functions to be comparable to the other commissions. The change indicated ANA's commitment to research--"Scientific validation of nursing knowledge is an absolute essential if nursing practice is to become a profession." At the meetings for bylaws changes the House

approved the fourth commission and described its functions. "A major function of the Commission on Nursing Research is to formulate professional policy in such areas as human subject rights." The distinction was made between the roles of the commission and the American Nurses' Foundation as the research arm of ANA or the "doing arm" (Proceedings of the Forty-Seventh ANA Convention, 1970, p. 40).

Another structural change recommended by the 1970 House of Delegates was the dissolution of the Legislative Committee. The 1966 bylaws revision had transferred the committee's responsibility to formulate policy and recommend action concerning federal and state legislation to the three commissions, the divisions on practice and the other ANA units which subsequently submitted their recommendations and resolutions for legislative action at the 1968 and 1970 convention (Proceedings of the Forty-Seventh ANA Convention, 1970, pp. 41-42).

At the same time the functions of the Government Relations Department of ANA and its "scope of responsibility" were identified:

1. To devise, conduct, coordinate and evaluate a program of assistance to state and district nurses' associations in their government relations endeavor,
2. To receive proposals for legislative action, devise, conduct and evaluate the promotion of

legislation to advance the programs of the organization within the plan for Association priorities. (Proceedings of the Forty-Seventh ANA Convention, 1970, pp. 41-42).

The House also endorsed the Department's proposal for appointment of "a resource panel of consultants to include: tax and labor lawyers, experts on licensure laws, former legislators and government officials, sociologists and political scientists who would advise the department" and "assist in expanding the influence of ANA and its constituents. The proposal was approved by the Board" (Proceedings of the Forty-Seventh ANA Convention, 1970, pp. 41-42). The House voted to accept the 1970 ANA platform as proposed. The platform addressed three main areas:

1. To promote optimum health care for all people.
2. To advance the profession of nursing.
3. To strengthen the efforts of individual practitioners in the pursuit of their concerns as nurses. (Proceedings of the Forty-Seventh ANA Convention, 1970, pp. 41-42)

The Committee on Interrelationships was appointed by the ANA Board of Directors in April 1969 to consider policy in regard to working relationships between and among major structural units of the Association, the Board of Directors, the Commission and the Congress. The Committee examined the new organizational arrangements which were established in 1966.

The extent of the autonomy of each of the major units, the nature of their accountability to the

Board of Directors and to the House of Delegates, the need for organizational cohesiveness and for a unified profession remain continuing concerns as major issues are faced by the organization . . . whose members have many diverse interests. (House of Delegates Reports 1970-1972, 1972, p. 98).

During the 1970s, the various structural units within the organization continued to work together on practice issues. The various units were exploring ways to implement their functions toward this end. There also was concern as to how all the functions of these structural units interrelated at all levels of the organization.

The Committee to Study the Roles and Functions of Various Levels of the Organization reported to the 1978 House of Delegates. Their report included descriptions of functions appropriate to the national, state, district and local unit levels of the organization. The committee identified the following problems inherent in designing models:

- (1) Difficulty in providing effective communication between all members and structural units;
- (2) multiple functions and interest groups of the association, with groups competing for resources; and
- (3) external restraints, e.g. legal, governmental and other professional organizations. (Proceedings of the Fifty-First ANA Convention, 1978, pp. 12-13)

The committee also delineated activities within the trilevel structure appropriate to each tier of the association. They examined such issues as relationships of the various levels, responsibility of each level,

duplication or competitive activities of the levels and funding of programs.

Models selected to depict functions and activities appropriate to each level of the association were:

- 1) Model of proposed functions for national, state, district, regional, and local units within a tri-level structure. In this model, the committee refined the primary location of functions but retained the current trilevel arrangement, including local units.
- 2) Alternate models for substate level
- 3) Model for a federation concept at national level. (Proceedings of the Fifty-First ANA Convention, 1978, pp. 13-14)

The committee believed that the decision-making authority of structural units (commissions, board, House of Delegates), approval bodies, executive committees must be taken into account in developing an ANA model and in defining such groups' presence and authority in any model adopted.

At the end of the discussion of the committee's report, the 1978 House of Delegates adopted the following motion:

That the house request the ANA Board of Directors to continue the Committee to Study the Roles and Functions of Various Levels of the Organization and that it be well supported and authorized to further delineate a federation model for presentation at the 1980 convention and that the Committee on Bylaws begin to be included in their deliberation regarding changes. (Proceedings of the Fifty-First ANA Convention, 1978, pp. 15-16)

The Association had once more examined its structure toward the end of meeting its responsibilities

to the nurse, the profession and society. In the words of the ANA Executive Director:

It is a fundamental of life itself that no association of people ever completely achieves every goal, every objective it sets for itself. This fundamental holds true in education, in government, in the corporate world and in the professions. ANA is moving closer to achievement of its goal of helping every nurse to realize all of her potential. (House of Delegates Reports 1966-1968, 1968, p. 45)

Power Analysis of the American Nurses' Association

ANA continued with organizational rearrangements in order to address the stated functions of the professional nursing organization. The Association, concerned with improving and controlling nursing practice, was undergoing internal changes in an attempt to develop sufficient power to carry out its mission.

Of particular importance to the members was where decisions were being made and who was making the decisions. A reciprocal relationship existed between the House of Delegates and the Board of Directors. Both groups were elected by the membership. The House of Delegates voted to adopt policies and the Board of Directors had the responsibility to implement the policies and report back its accomplishment to the House.

ANA membership was still committed to tri-level participation--local, state and national. Rearrangements of structural units were initiated in order to

carry out the functions of a professional organization at each level. This change was met with some resistance. For example, there was opposition from some sections when there was movement toward the Divisions on Practice. Since section chairmen had voting power on the Board of Directors, the change would mean loss of their power. However, they were willing to trade this power in order to work more effectively toward control of nursing practice through the Divisions on Practice.

The new structural units--the Commission on Nursing Education, the Commission on Nursing Services, the Commission on Economic and General Welfare, the Commission on Nursing Research; the Congress for Nursing Practice; the Divisions on Practice; and the various councils and committees--were established and coordinated for the overall goal of meeting the responsibilities of a professional organization. Various exchanges occurred among the units, that is they deferred their own wants in specific instances in order to move the association forward on a united front.

When members were in disagreement over issues such as: entry level for professional nursing, economic security programs, and membership dues; there was a noted decrease in membership. Some nurses chose to leave the organization and join specialty nursing

organizations; others chose to work through committee, etc. to accomplish their goals from within the organization.

ANA was able to effect power within its own structure. However, when membership wanted to move toward one professional nursing organization, ANA was unable to do so. As long as NLN members chose not to merge with ANA, one national nursing organization was an impossibility. As an alternative, there was a restructure of the organization to carry out the functions of a professional nursing organization. ANA continued to work cooperatively with NLN in order to fulfill nursing's responsibility for improved nursing education, nursing services and nursing practice.

ANA as the professional nursing organization remained committed to serving nurses, the nursing profession and society.

CHAPTER VII

FORECASTING: POWER BASES FOR NURSING (1980s ONWARD)

Introduction

The American Nurses's Association entered the 1980s with a number of accomplishments. These accomplishments were related to both the improvement and control of nursing practice by the profession. Through the reorganization of the association, the various structural units successfully worked on the development and the initial implementation of standards of nursing practice, education and service.

The Association had addressed nursing education issues related to basic, graduate and continuing education programs for the professional nurses. ANA attempted to respond to the needs and the trends of the times. There was also an expansion of the Economic and General Welfare program with ANA working through the state nurses' associations giving support and providing educational programs. Additionally, ANA intensified its legislative efforts on behalf of the nursing profession and society.

ANA Social Policy Statement

In 1980, ANA published, Nursing: A Social Policy Statement. This publication discussed the nature and scope of nursing practice and a description of the characteristics of specialization in nursing. ANA, as the professional society for nursing in the United States, assumes responsibility for defining and establishing the scope of nursing practice (ANA, Congress for Nursing Practice, 1980, p. 1).

This statement by ANA serves as a basis for both the direction for nursing and for the association for the eighties and beyond. The Social Policy statement affirms nursing's social responsibility and discusses how that responsibility is exercised in nursing practice. Additionally, the statement is intended

to provide a foundation that promotes unity in nursing in a basic and common approach to practice, to clarify the direction in which nursing has evolved and to provide a means for distinguishing between desirable and undesirable directions for future development. (ANA, Congress for Nursing Practice, 1980, p. 1)

An examination of nursing in relationship to society and an identification of the mutually beneficial relationship between society and the profession is described in the document. Five major areas in which nursing has leadership responsibilities are identified:

- (1) Organization, delivery, and financing of health

care, (2) continuing development of health resources, (3) provision for public health, (4) development of new knowledge and technology through research, and (5) health care planning as a matter of national policy (ANA, Congress for Nursing Practice, 1980, pp. 3-4).

Other areas identified in the pamphlet included: the evolution of the health care system in the United States from disease-oriented to health-oriented system, the increasing costs of this system with increasing regulations and the need for nursing to become involved in the political process (ANA, Congress for Nursing Practice, 1980, pp. 4-5).

The pamphlet also discussed nursing's role in the health-oriented system.

The complexity and size of the health care system and its transitional state, increasing public involvement in health policy and a national focus on health, and the professionalization of nursing--all of the factors combine to intensify the importance of the direct human interactions inherent in nursing's response to human needs and society's expectations. (ANA, Congress for Nursing Practice, 1980, pp. 6-7)

Concern for the nature of nursing's working relationship with other disciplines was also expressed.

Descriptions of the nursing process, definition of nursing, and delineation of the scope of nursing practice are discussed in the statement. This discussion occurs within the social context, identifying the

relationship between nursing and society and their responsibility to each other. Also included is a discussion of specialization in nursing and how it contributes to nursing's responsibility to society.

The ANA in presenting this statement for nursing articulated the direction that nursing took and must continue to take to meet societal needs. By clarifying what nursing and nursing process are, how practitioners are prepared, the difference in practice between a generalist and a specialist indicates the profession's and the association's awareness of its responsibility to society. As stated in the document:

Requirement of the baccalaureate for entry into professional practice, of advanced learning for specialty practice, administration, and teaching, and of doctoral education that includes focus on research capabilities emerges as necessary to fulfillment of nursing's responsibility. (ANA, Congress for Nursing Practice, 1980, p. 22)

The ANA statement further articulates that:

As the professional society for nursing, ANA must provide structural arrangements that recognize the wide diversity of clinical expertise that exists among nurses-generalists, generalists who concentrate their practice in specialized areas, and qualified specialists in nursing practice--and thereby give recognition of and show tolerance for the difference and complexity that characterize contemporary nursing. This diversity must be seen as a constructive response of nurses to social needs in a time of rapid, complex, and sophisticated changes in present-day health care systems. (ANA, Congress for Nursing Practice, 1980, p. 29)

ANA's responsibility to the profession and the public is clearly enunciated. The Association has responded by means of statements such as this one and through the work accomplished through its structural units and programs. Not only has ANA recognized the need for adequate preparation of nursing practitioners, but it has recognized advanced preparation and excellence of practice through its certification program and the American Academy of Nursing. It is through pronouncement and implementation of statements such as the Social Policy Statement that ANA will enhance its power base.

Standards of Nursing Practice

In the 1980s, ANA continued its work on the implementation of standards for nursing practice, nursing education and nursing services. The Congress for Nursing Practice of ANA published its formulation of Standards of Nursing Practice in 1973.

As Kathleen Sward, M.A., R.N., in an editorial in the June 1974 issue of The American Nurse stated:

The standards are an impressive first step--but it is only the beginning. The standards are means to an end, to qualify, not ends in themselves. They are the down-payment on the eventual fulfillment of society's trust. They enable the profession to assure the consumer that quality nursing care can be identified, measured and delivered--and that individual nurses and, ultimately, the profession, stand accountable. The distance covered by the next steps depends upon all in nursing. (p. 3)

ANA has gone beyond that first step in assisting the profession in the implementation of these standards, since their publication in 1973 and the endorsement by the House of Delegates in 1974. Throughout the 1970s, the Association through its structural units continued to work on the maintenance, improvement and implementation of standards. ANA has functioned and continues to function as the "gatekeeper" of the standards for the profession.

These standards have served as guidelines for nursing practice. They go beyond the minimum standard required for licensure and build upon this basic requirement. ANA must continue to oversee the implementation of these standards in order to insure the public of quality nursing care from its practitioners. Standards of nursing practice are related to standards for nursing education.

Standards for Nursing Education

In order to maintain control of nursing practice, ANA must continue to articulate its position on basic educational preparation as enunciated in the 1965 Position Paper and other ANA statements on education throughout the 1980s and onward. ANA's ability to continue to press on the implementation of the 1978 resolutions on titling, competency and career mobility

is under scrutiny from many sectors. Although there is a philosophical acceptance of the baccalaureate degree as the entry level into professional nursing, the 1985 goal of implementation was not met and is now only at an initial stage.

The Commission on Nursing Education and subsequently the Cabinet on Nursing Education has sought input and disseminated information on titling and competency. At the recent 1985 House of Delegates meeting a resolution on titling for "professional" nurse and "associate" nurse was adopted.

The 1985 House of Delegates took historic action on the related matter of titling for licensure of two levels of nursing practice, urging state nurses' associations ". . . to establish the baccalaureate with a major in nursing as the minimum educational requirement for licensure to practice professional nursing and to retain the legal title, Registered Nurse, for that licensure"; and "to establish the associate degree with a major in nursing as the educational requirement for licensure to practice technical nursing." The house also voted that ANA "go on record as supporting the legal title of Associate Nurse for the technical level of nursing" (ANA, "Report of the ANA Board of Directors," 1986, p. 1)

Also at the 1985 convention, five states were selected to receive financial support through funds allocated by the ANA Board of Directors and disbursed and monitored through the Cabinet on Nursing Education. "These funds were to assist them in establishing congruence between the baccalaureate preparation for

professional nursing practice, and rules, regulations and statutes governing nursing licensure" (Proceedings of the ANA 1985 House of Delegates, 1985, p. 72).

The 1985 House also directed the ANA Board of Directors to develop a national plan for the systematic implementation of house action on titling and licensure for two levels of nursing practice and to report back to the 1986 House of Delegates. The Board of Directors presented its report on the role of the national level of the organization in the implementation of house action on titling and licensure as follows:

- 1) Support to state nurses' associations, the level of the organization directly involved in implementing professional standards for nursing education in the state legislative and regulatory arena;
- 2) Development of public relations strategies;
- 3) Interpretation of the ANA position to other national nursing and health related organizations;
- 4) Definition of relevant policy issues still to be debated and acted upon by the House of Delegates; and
- 5) Data gathering. (ANA, "Report of the ANA Board of Directors," 1986, p. 2)

In making plans for the implementation of the resolution on titling and licensure, both the House of Delegates and the Board of Directors considered the anticipated impact on the educational system as identified by the Cabinet on Nursing Education. This impact included one on the system itself, faculty, financing of nursing education, manpower, regulation of professional practice,

system itself, faculty, financing of nursing education, manpower, regulation of professional practice, membership in the professional organization, the economic welfare of the individual nurse and the profession, access to nursing service. (Ibid., p. 2)

The association was working actively to anticipate and minimize as many problems as possible. Each of the cabinets of the association was investigating the impact of grandfathering of licensed nursing personnel into the Associate Nurse title and waiver of related educational requirements, and on the scope of practice for professional and technical nursing. Additionally in 1985, the National Public Relations Campaign was initiated by the ANA Board of Directors to help both the lay public and the profession itself to understand the proposed change in the nursing education system. ANA believed that this campaign established a sound framework for public relations and communication activities (ibid., p. 3).

Another area of focus of the association has been on meetings of ANA officials and staff with the officials and staff of the National Federation of Licensed Practical Nurses (NFLPN), the Organization for Advancement of Associate Degree Nursing, the National Leagues for Nursing, the American Association of Colleges of Nursing (AACN), and the American Organization of Nurse Executives (AONE),

to clarify organizational positions on titling and licensure for nursing practice, identify questions of policy still to be resolved, and to discuss program activities in which each organization will engage in order to move forward toward resolution of these issues. (Ibid., pp. 3-4)

The results of this work by the ANA was evidenced at the recent forum on Entry into Practice at the 1986 ANA Convention. Representatives of AACN, ANA, NFLPN, NLN and AONE presented the positions of their respective organizations. Three areas of concern identified by the chairman of the ANA Cabinet on Nursing Education were: (1) clear differentiation of scope of practice for the two categories, (2) grandfathering and waivering of LPN to associate, and (3) educational mobility. The American Association of Colleges of Nursing and the National Federation of Licensed Practical Nurses were in essential agreement with ANA (ANA, "Forum on Entry into Practice," 1986).

The NLN president reported that the NLN Board of Directors in October 1985 had approved a motion on two categories of nursing:

NLN supports two levels of nursing practice, professional and associate. Further, NLN supports the NLN councils working closely with ANA cabinets to help define the scope and practice of nurses within these levels (ANA, "Forum on Entry into Practice," 1986).

The group presenting the most opposition and concern was the Organization for Advancement of Associate Degree Nursing. A major concern that they

expressed was over the grandfathering of the LPN to associate status. This concern was related to the difference in educational preparation between the two groups (ANA, "Forum on Entry into Practice," 1986).

The discussion and exchange of feelings and concerns at the forum demonstrated a willingness, on the part of some, to work toward a solution to problems surrounding the acceptance of titling and licensure for two categories for nursing practice. It was evident that there was much work to be done, but there was the sense of a forward movement.

ANA continues to share information with the National Council of State Boards of Nursing. The association, also, is discussing ANA's position with the American Medical Association and the American Hospital Association through its executive liaison (ANA, "Report of the ANA Board of Directors," 1986, p. 4).

ANA plans to continue heightening public awareness and understanding about the nursing profession and the association and to educate the nursing community about the policies and programs of the association. There will be a particular focus on the proposed changes in educational requirements for nursing practice (ibid., p. 3).

North Dakota was the first state to begin to implement the entry level position. In January 1986, the North Dakota Board of Nursing

promulgated revised administrative rules for nursing education programs. North Dakota law N.D.C.C. 43-22.1, passed in 1977, requires licensure by the Board of RNs and LPNs and the promulgation of administrative rules for nursing education programs. By January 1, 1987 (the date of implementation of the revised administrative rules) graduates who enter nursing education programs must have completed an approved nursing program that awards the appropriate academic degree in order to be eligible for licensure. (Macdonald, 1986, pp. 169-70)

Maine is the second state initiating titling and licensure changes. However, it is

the first state to adopt legislation to standardize educational requirements for two levels of nursing practice. On April 10, 1986 the state legislature of Maine approved legislation indicating its intent that by 1995, or as soon as possible thereafter, there be two levels of nursing: one requiring an associate degree, the other a baccalaureate degree. ("Maine Adopts Legislation to Standardize Nursing Education," August 1986, p. 4)

Entry into Practice remains a very controversial issue within the profession and in the health care system. How ANA moves to assist in the initiation and the coordination of legislation enacted in the fifty states and territories who are consistuent members of ANA will demonstrate how strong a power base ANA has. Additionally, ANA's ability to continue to influence the control of the practice of nursing will be an indication of its power.

ANA continues in its responsibility of setting standards for undergraduate, graduate, and continuing education. In its publication, Standards for Professional Nursing Education, is stated:

. . . standards for professional nursing education and standards for continuing education in nursing are linked directly to standards for nursing practice, standards for organized nursing services, and standards for specialized nursing practice. They form the fabric of guidelines for the profession as described in the ANA document Nursing: A Social Policy Statement. (ANA, Cabinet on Nursing Education, 1984, p. 1)

Standards for Nursing Services

One of the priorities for the ANA for the 1985-1986 biennium was to:

Establish the profession's standards for nursing by: 1) promoting the understanding and use of ANA's Standards for Organized Nursing Services, 2) achieving recognition of ANA's Standards for Organized Nursing Services within the standards of the Joint Commission for Accreditation of Hospitals and through federal legislation. (Proceedings of the ANA 1985 House of Delegates, 1985, p. 57)

The ANA Cabinet on Nursing Services in addition to continued implementation of standards for organized nursing services is addressing issues relevant to changing societal needs. At the 1985 House of Delegates meeting such issues as: nursing's role in cost containment, refinement of Diagnostic Related Groups (DRG's), studies on cost identification and patient classification systems were discussed. A decrease and shift in

hospital occupancies has led to the reduction in staffing patterns. The cabinet will be working with the Cabinet on Economic and General Welfare in order to develop guidelines for decreased staffing involving RNs (Proceedings of the ANA 1985 House of Delegates, 1985, p. 79).

The Cabinet on Nursing Services is aware of "the rapidly changing practice environment demands upon progressive nursing leadership" and "recognizes a need for development of strong nursing middle management." The cabinet also works collaboratively over related issues with the American Organization for Nurse Executives. Of especial interest will be the development of guidelines for nursing clinical privileges (Proceedings of the ANA 1985 House of Delegates, 1985, p. 81).

As one of its activities, the cabinet maintains representation on the advisory committees to the Joint Commission on Accreditation of Hospitals. The cabinet, as the ANA representative on the commission, in response to proposed standards has consistently targeted maintaining and/or improving the quality of health care services. A particular emphasis has been placed on standards for long-term care (Proceedings of the ANA 1985 House of Delegates, 1985, pp. 79-82).

ANA through the Cabinet on Nursing Services will need to continue to assume an active role in the formulation of systems for cost containment and delivery of quality health care. The association needs to strengthen its articulation with other nursing organizations, health care agencies and governmental agencies in order to further develop its power base to maintain control of nursing practice in the health care system.

Economic and General Welfare

The 1986 ANA Convention participants celebrated the fortieth anniversary of the Economic and General Welfare Program and "reviewed with pride the accomplishments of the program in advancing nurses' welfare and ensuring quality of nursing care." The Cabinet on Economic and General Welfare has been active in developing strategies for "promoting every nurse's future." "The strategies developed by the cabinet will, out of necessity, interrelate with the responsibilities of other structural units and require close collaboration among ANA officials" (ANA, "Informational Report of Cabinet on Economic and General Welfare," 1986, pp. 1-4).

The cabinet's proposed long-range plan was expected to:

appropriately interface with ANA's long-range plan; provide a unified, organized approach in providing collective bargaining to nurses; address alternatives for registered nurses not involved in collective bargaining regardless of their setting; and, address the provision of economic and general welfare services to all state nurses' associations. (Proceedings of the ANA 1985 House of Delegates, 1985, p. 86)

Of particular interest to the cabinet is actively working on issues such as pay equity for nurses and preservation of RN bargaining units. The cabinet is also concerned with changes in the health care and the nursing profession that influence the economic and general welfare program. Related to these changes the cabinet is working with other ANA cabinets on

educational requirements for entry into nursing practice and credentialing; nurse managed centers and nurse entrepreneurship; demand for nurses and salaries, fringe benefits and working conditions; multi-hospital corporations, prospective payment systems, and corporate restructuring. (Proceedings of the ANA 1985 House of Delegates, 1985, p. 89)

The 1986 House of Delegates adopted resolutions in support of economic and general welfare activities. If ANA is to have a strong Economic and General Welfare Program, the cabinet will have to continue to work effectively with other ANA cabinets and with ANA constituent members (SNAs) to represent all nurses in the association.

The decade of the '80s and beyond hold new and different challenges for nurses that must be addressed effectively and efficiently if the nursing profession is to secure its rightful place in the

emerging health care system. As in the past, ANA's economic and general welfare program will play a key role in this process and, through the program, the American Nurses' Association will continue braving new frontiers. (Flanagan, 1986, p. 29)

ANA-PAC

The political action arm of ANA was established in 1974 and has been known as N-CAP--Nurses Coalition for Action in Politics. Headquartered in Washington, D.C., it has been active in obtaining legislative action on behalf of nursing and nursing's interests. N-CAP has worked to fulfill ANA's legislative objectives, raises funds and contributes to candidates for elective office who have demonstrated their interest in and/or support for ANA's legislative position (Proceedings of the ANA 1985 House of Delegates, 1985, p. 51).

Additionally, N-CAP has been active in providing political education for nurses and encouraging nurses to become involved in politics. N-CAP was instrumental in getting Congressional support for the establishment of the Nursing Research Center at the National Institutes of Health.

At the 1985 House of Delegates meeting, delegates moved to adopt the resolution: "That the 1985 House of Delegates recommends that the N-CAP Board of Trustees change the name of N-CAP to The American Nurses Association-Political Action Committee (ANA-PAC)" and

"That the name change be fully implemented by the end of 1986" (Proceedings of the ANA 1985 House of Delegates, 1985, p. 51). This was accomplished by the 1986 convention.

ANA's political action committee is one of its most accepted programs within the profession. ANA-PAC has worked actively with the ANA structural units to obtain needed legislation. ANA's ability to obtain needed legislation is a demonstration of its power base.

Credentialing Center

Since the Credentialing Study Report of 1979, ANA has continued to explore the establishment of a Credentialing Center. There has been debate as to whether it should be incorporated as part of ANA or a separate unit outside of ANA. The Board of Directors' concerns were related to: (1) appropriate control of credentialing activities on the part of the association; (2) appropriate allocation of fiscal resources to credentialing; and (3) ability to provide contract services to outside organizations.

In goals adopted by the 1984 House of Delegates for the 1984-1985 Association, priorities were:

1. Develop a coherent system for credentialing in nursing

2. Strengthen ANA's role as a credentialing agency
3. Continue to work effectively with other credentialing agencies

The 1985 House of Delegates adopted the ANA Board of Director's recommendation:

That the House of Delegates endorse the action of the ANA Board of Directors to retain the Center for Credentialing Services as an administrative unit within the American Nurses' Association (Proceedings of the ANA 1985 House of Delegates, 1985, pp. 52-53)

Thus the 1985 House retained the association priority on credentialing. According to the ANA annual report a Committee on Credentialing was established to advise the Board of Directors. ANA has maintained contact with other national nursing certifying organizations (ANA, Annual Report, 1985, pp. 4-5).

ANA needs to continue to implement the actions taken by the House of Delegates. Through the development of its Credentialing Center and its contacts with other credentialing agencies, ANA will strengthen its power base. The control of the credentialing mechanism will assist ANA in setting and controlling standards for nursing practice.

ANA Structural Changes

In December 1975, in response to the concern over continuing financial and related structural

problems within the association, the Board of Directors of ANA established the special Committee to Study the Role and Functions of Various Levels of the Organization. In addition to studying, the functions of the committee was charged

to examine the functions of the various levels of the organization, the arrangements for direct membership in each level, the economic and general welfare program, and rights and privileges of membership. (Proceedings of the Fifty-Second ANA Convention, 1980, p. 198)

The committee represented a wide geographic balance and collectively they represented years of experience as professional nurses, as members of the association, or as staff to various levels of the association. The members adopted Robert Merton's philosophical basis for an association:

The professional association is an organization of practitioners who judge one another as professionally competent and who have banded together to perform social functions which they cannot perform in their separate capacity as individuals. (Merton, 1958; Proceedings of the Fifty-Second ANA Convention, 1980, pp. 199-200)

Two organizational models were presented to the 1980 House of Delegates for their consideration. They were both presented as alternate ways to achieve the purposes of the association. The two models were the federation model with state nurses' associations as the constituent members; and, a second model that provides

an option of direct membership at one or more levels of the association.

The models raised questions related to membership mechanisms, linkages between the levels, competition among the units and between the levels, cost efficiency and organizational cohesion. The federation model was seen as having the possibility for increased consensus and more rapid action at the national level. Under the direct membership model, the possibility for increased response to the interest of individual members was identified (Proceedings of the Fifty-Second ANA Convention, 1980, pp. 198-201).

At the 1982 House of Delegates meeting, which took place over a two-day period, the delegates adopted a modified federation proposal and accompanying provisos. This action by the House culminated nearly a decade of association debate on organizational and membership issues.

Adoption of the 1982 modified federation model brought changes to some of the ANA structural units. The Congress on Nursing Practice and divisions were deleted. The commissions were replaced by cabinets. According to Article VII, a cabinet is defined as an organized deliberative body to which the House of Delegates assigns specific responsibilities related to

fulfilling the functions of ANA. Cabinets are accountable to the Board of Directors and report to the House of Delegates (ANA Bylaws, as amended 1 July 1982).

ANA had undergone structural changes over the years to carry out its functions and purposes. The organizational schemes were appropriate for the needs of the association at the specific times that they were adopted. See appendices A through G for the organizational charts, both proposed and adopted, that illustrate the ANA structural changes as they occurred.

Other organizational and bylaw changes were related to composition of the House of Delegates, restricted to a voting body of not more than 615 delegates. The House of Delegates was to meet annually. The Advisory Council was deleted and the Constituent Forum was established in its place. The Nursing Organization Liaison Forum was also established. The membership of this forum was comprised of duly authorized representatives of ANA and of nursing organizations that meet the specification of the ANA bylaws (ANA Bylaws, as amended 1 July 1982).

ANA through its new structural organization set out to accomplish the functions of the professional association. The first annual meeting of the House of Delegates was held in 1984. The House of Delegates at

that convention called for the Board of Directors to develop a long-range plan for ANA.

ANA has developed its power bases through programs such as the Economic and General Welfare and ANA-PAC. The welfare of nurses both economically and politically is of concern to the association. ANA is also concerned about the control of nursing education and nursing practice. Through articulation of statements on these areas and initiation of programs to implement these positions, the association has developed power even though controversial issues have arisen. Both ANA leadership and membership have utilized the structure of the organization to achieve desired goals related to the identified functions of the organization.

The establishment of the ANA Cabinets on Nursing Education, Practice, Services and Research is also being used to develop power through the enunciation of standards on nursing education, nursing practice and organized nursing services. The implementation of these standards is establishing the credibility and power of both the profession and the association.

At the recent Fifty-Fifth ANA Convention, 13-19 June 1986, the House of Delegates adopted a document that included a mission and strategic plan for ANA,

eight long-range goals for the nursing profession, and an ANA business plan for 1987-1991.

The Board proposed that the statement of organizational mission for the American Nurses' Association in achieving fifteen-year goals for the nursing profession be:

To improve access to quality health and nursing services by providing:

1. Leadership and representation for the profession in both national and international affairs
2. Information and research relevant to the development and advancement of nursing practice, nursing education, nursing services and the economic and general welfare of nurses
3. For a coordinated system of credentialing for the nursing profession

The long-range goals as proposed by the Board and adopted by the House are:

1. Maintain and strengthen nursing's role in client advocacy
2. Expand the scientific and research base for nursing practice
3. Clarify and strengthen the educational system for nursing

4. Develop a coordinated system of credentialing for nursing
5. Restructure the organizational arrangements for delivery of nursing services
6. Achieve effective control of the environment in which nursing is practiced and the services offered
7. Enhance the organizational strength of the American Nurses' Association
8. Develop comprehensive payment systems for nursing services ("Report of the ANA Board of Directors --Statement on Mission and Strategic Plans," Proceedings of the Fifty-Fifth ANA Convention, 1986, pp. 1-4)

Future Directions

ANA has chartered its mission for the next fifteen years. With the fast changing society, advances in technology and science and societal financial constrictions both nursing and the health care system needs to prepare for the future.

There are a variety of issues that ANA will need to address. ANA has collaborated with other organizations to maintain and improve nursing's control of nursing practice. The Association has and continues to actively work through its structural units and to rearrange them as necessary to carry out its purposes. Toward this end the association is consistently

examining its structure in order to determine how adequately it allows fulfillment of ANA's functions. Leadership in the organization has pushed for change as indicated.

Carrying out the functions of the professional association will require both the commitment and expertise of nursing leadership and the strengthening of ANA programs. Additionally, nurses will need to continue to move from a reactive to proactive stance and into more futuristic action.

ANA must continue to develop nursing leadership, minimize fragmentation within nursing and the association, and strengthen its liaison with other nursing groups to present a more united front on various nursing issues and interests.

Historically, ANA has been able to collaborate with other groups as has been evidenced in the past studies done on nursing and nursing education. Although painfully slow at times, changes for the advancement of nurses and nursing have resulted.

The National Commission on Nursing Implementation is currently conducting a project known as NCNIP. The initiation of this study is a result of the work of the National Commission on Nursing in 1983. The American Nurses' Association, American Association of

Colleges of Nursing, American Organization of Nurse Executives, and the National League for Nursing accepted the challenge to move from analysis of nursing issues and recommendations to coordinated national implementation. With a grant awarded by the Kellogg Foundation, NCNIP officially began in May 1985.

The stated objectives for NCNIP's three-year study are:

- 1) Outline the common body of knowledge and skills essential for basic nursing practice, the curriculum content that supports it, and a credentialing process that reinforces it.
- 2) Identify and disseminate models of nursing management in hospitals, various health agencies, and communities which lead to cost-effective quality care.
- 3) Through research, test, refine and advance the knowledge on which improved education and cost-effective quality nursing care rest. (National Commission on Nursing Implementation, 1986)

Once again nursing is willing to examine itself, be accountable for its actions and make the necessary changes to provide quality nursing practice in the health care system. If indeed the '80s are the decade of decisions for ANA, then the association will have to decide where it best places its time, money and energy to fulfill its functions. Decisions will have to be made regarding what programs to strengthen and what priorities to set to actualize its mission. This will be difficult, since each of the programs is important to

the various interest groups within the association and the profession.

Major area of concern is the controversy over the implementation of the entry level into nursing. To achieve this goal will once more require the leadership of ANA. The communication of facts and the coordination of all enabling activities will be time consuming and costly and a test of ANA's power base. Some of ANA's power has been demonstrated in that two levels of nursing is gaining acceptance and implementation has been initiated in a few areas. The implementation will enhance the scope of nursing practice to provide quality care and make nursing competitive with other professions.

Another area of concern is the economic and general welfare of all nurses. This again will be time consuming and costly. Coordination of ANA structural units and the levels of the association is needed to carry out programs. There will need to be collaborative work between the structural units and ANA-PAC to obtain the necessary legislation to move the association's goals forward.

Nurses are increasingly accepting the need for collective action to accomplish goals and achieve power.

At the 1972 ANA Convention, as stated in the presidential address:

It is irresponsible for nurses to negate, or fail to develop and use fully, the power and authority which they now have. If nurses believe that nursing service is good for society--good for people--then they will embrace their capabilities and address them fully to the destiny of our profession and enlargement of the benefits that it provides for all of the people. (Peplau, 1972, p. 8)

ANA will continue to develop its power bases through the strength of its legislative and political programs, its public relations programs, and its collaboration with other professional groups to enact desired programs. In the words of the ANA president to the 1985 House of Delegates:

Let us reap the benefits of the wisdom, the vision, and the determination of those who preceded us in this organization. And let us plant the seeds which guarantee the future generations a vital profession and strong, thriving professional association. (Cole, quoted in ANA, Annual Report, 1985, p. 19)

ANA, through its leadership and membership, must continue in its mission to strengthen both the association and the profession in its response to society.

CHAPTER VIII

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

One cannot discuss the start of professional nursing without discussing the role of women during that era of United States history. The effect of the Industrial Revolution upon changing societal roles and values was felt in nursing, as one segment of society. The differences that existed in roles of the affluent and the working-class women were noted in nursing as well as society in general. With the gradual acceptance of affluent women being able to leave the home and seek work, a new class of women was joining the ranks of "nurses." Nursing was seen as a viable and respectable means of employment for women.

The formation of organized training schools in 1873, greatly impacted nursing as it was then known. Nursing moved gradually from "untrained" to trained through the end of the nineteenth century and well into the twentieth century. As part of this transition, the disciplinary and militaristic heritage was being replaced by a recognized need for scientific and

professional training. It was no longer sufficient to be of "good moral character." The applicant to the school of nursing had to meet entrance criteria and there was a planned theoretical program. All of these changes were occurring slowly, and through the efforts of nursing leadership.

There was a growing awareness, by a number of nurse leaders, of the need to organize nurses. The first organization to be formed was the American Society for Superintendents of Training Schools for Nurses in 1893. This organization emanated from a recognized need by a group of nursing school superintendents. It became more apparent to them that standardization of curricula and instructional programs for schools of nursing was necessary in order to improve nurse education. They believed that they could better achieve this through group action.

At the same time, there was recognition of a need for a "grass roots" effort to go beyond the concept of the individual nurse and individual school to address the needs of all nurses and the profession. The American Nurses' Association had from its inception, in 1896, been considered the professional association for all nurses and the spokesman for nursing. This collective

action used to form these two groups was the start of organized nursing in the United States.

Instrumental in the formation of the associations was a small band of daring and visionary women. These women belonged to both associations and often held positions in both organizations. Over the years, they also held influential work positions such as: Board of Managers (Robb), Board of Nurse Examiners (Palmer), Nurse Inspector (Goodrich) and Director of the Hospital Economics Course at Teacher's College (Nutting). As a result, the leaders were well informed and could communicate more easily with each other and reinforce each other's ideas. Those leaders were also instrumental in the formation of the International Council of Nurses and in the ANA becoming a member of that organization.

Collectively those women had a vision of the direction that should be taken to move nursing toward becoming a profession. Part of this movement was the improvement of nursing education, nursing practice and the welfare of nurses. These goals have remained constant throughout the Association's history.

Another facet of this early development of the association was the initiation of a journal in 1900. The American Journal of Nursing had as a very important aspect of its birth that it be owned and operated by

nurses for nurses. The Journal was used as a means of communication among nurses, identifying needs and exchanging ideas. In addition to news items and clinical papers, there was a regular column, "The Progress of State Registration." The Journal had the same editor, Palmer, for the first twenty years.

The first decade of the Association, the 1890s, was devoted to coordinating the efforts of both organizations, the NLNE and the ANA, to standardize and regulate nursing education programs. NLNE focused upon the curriculum of schools and ANA focused on the state registration of the graduates of these programs. ANA became more active in coordinating and assisting states in obtaining the legislation needed for registration of nurses. A major achievement was noted with the four Nurse Practice Acts of 1903. This marked the beginning of the profession's self-regulation.

As society and nursing moved into the twentieth century, ANA was undergoing the first of many structural changes to be made to meet the functions of the association. In order to assist in the proliferation of nurse practice acts, the basic entry unit was gradually shifting from the alumnae association to county associations and finally to state associations. The state associations were needed to obtain legislation in order to

regulate nursing education and nursing practice in each state. By 1912, there were twenty-nine states that had some type of state legislation for registration of nurses. Most of the Nurse Practice Acts were permissive. The increase and movement for mandatory licensure of nurses occurred after 1938.

Other structural changes included the amalgamation of the three national nursing organizations, ANA, NLNE and NOPHN in 1913. These organizations met annually until 1920 and then biennially until the restructure of all the nursing organizations in 1952. ANA was incorporated in 1917 under the District of Columbia laws. This incorporation allowed the state associations to be part of the national as long as their bylaws were in compliance. The Committee on Bylaws Revision worked on restructuring the association from 1916 to 1922 in order to strengthen the state nurses associations. In 1916, the Advisory Council was initiated. This council was composed of the state presidents, ANA officers, the chairs of the sections and the editor of the Journal. Through this mechanism the council was able to directly communicate with the ANA board and they met in conjunction with the annual convention. The first two sections of the association to be formed were the Private Duty and the Mental Hygiene sections.

Also, in 1916, the House of Delegates became the official voting body of the ANA.

As the United States entered World War I, nursing was undergoing a number of changes. Demands were being placed upon nursing resources. The majority of nurses working in the hospitals were still student nurses. Graduate nurses were encouraged to join the American Red Cross Nursing Service. The Committee on the Nursing of the General Medical Board on the Council of the National Defense was formed with Adelaide Nutting as its chair. In order to plan for wartime and postwar needs, the committee with the help of the Red Cross and the ANA, surveyed national nursing resources and nursing in military hospitals. This survey pointed out the need for record keeping since there was no record of the total number of nurses available.

During this period some innovations in nursing education were noted. The Army School of Nursing was opened with Annie Goodrich as its first dean. The school offered a three-year program. Also, in 1918, the Vassar Training Camp experiment was initiated. This program took college graduates into an accelerated nursing education program. The experiment was sponsored by the Red Cross and the Council of National Defense and

was believed to have a higher standard for nursing education.

The National League of Nursing Education published their Standard Curriculum for Schools of Nursing in 1917. This curriculum was intended to be used as a model for schools of nursing. With the burgeoning of schools, from 549 in 1900 to 1,885 in 1929, nursing was intent upon improving schools. In 1915, the first list of schools approved by the Boards of Nurse Examiners was published.

From 1924 to 1934, the Depression greatly affected the American way of life. In nursing the hardest hit group was the private duty nurses. They were a victim of seasonal employment contingent upon the public's ability to pay. ANA along with the National Organization of Public Health Nursing was concerned for both the welfare of nurses and the administrative problems of public health programs. In 1932, the Committee on Distribution of Nursing Services encouraged hospitals to employ graduate nurses and decrease the number of schools. Programs supported by ANA for the welfare of nurses were the National Recovery Act of 1933, the Federal Emergency Relief Administration in 1934 and the Works Progress Administration Programs of 1935.

During this time ANA and NLNE continued to be concerned about nursing education programs. A revision of the 1917 curriculum was published in 1927, A Curriculum for Schools of Nursing. In 1937, NLNE published a new curriculum guide.

In addition to standardized curricula, a number of studies of nursing and nursing education were conducted. In 1923, Nursing and Nursing Education in the United States was a study which pointed out the shortcomings of nursing education and public health nursing. Another study conducted during that time was The Grading Report. This study was conducted from 1926 until 1934 and the report was published in three parts. The first was concerned with the supply and demand for nursing services, the second was a job analysis of nursing and nurse teaching and the third part of this report was a grading of schools and was concerned with closing weak schools and raising the educational standards of the better schools. The studies were widely discussed but the effect of the studies seemed negligible.

The focus on the educational preparation of nurses continued as nursing roles were expanding. University education for basic preparation of nurses had begun with the opening of the Yale University program in 1923. Although the movement was slow, there were other

university programs being initiated. Studies during this time indicated the need for educational programs in institutions of higher learning. Advanced preparation for faculties of these programs was also noted. This was also true for advanced preparation for public health nurses. Programs such as the one at Teachers College provided this advanced educational preparation.

The United States entry into World War II meant the need for military as well as civilian nurses. In 1943, the Cadet Nurse Corps was initiated through the Bolton Bill. The Corps provided training of more nurses. In 1945, there was a proposal to draft nurses. ANA opposed the draft proposal, but the war ended so it never came to fruition. After the war was over, there were a great number of military nurses who needed to be absorbed into mainstream America.

ANA was engaged in providing certain services and programs for the membership. The association had long been involved in Registries for the employment of private duty nurses. ANA believed in the formation and standardization of central registries by the association.

Another program of ANA was the Professional Counseling and Placement Services (PC&PS). Initiated in 1936, the program was designed in response to high

unemployment and job insecurity of nurses. State Nurses' Associations were encouraged and supported in opening local offices.

ANA also formed various bureaus to provide services and information for its members. The Central Bureau disseminated lists of approved schools. The establishment of the National Nursing Headquarters was another attempt to coordinate and disseminate information.

The year 1946 was the fiftieth anniversary of ANA. The 1946 Convention of the American Nurses' Association was one of many firsts. Delegates voted to establish the first platform of the association for the improvement of nursing services and the welfare of nurses. Delegates also voted to establish a committee to study the structure of ANA. For the remainder of the 1940s and the 1950s ANA worked to implement this platform while the committee studied ANA structure for possible changes.

ANA as a member of the National Nursing Council, formerly the National Nursing Council for War Service, collaborated with other national nursing organizations and some allied health groups to identify problems of nursing education and nursing service. One of the problems identified was the need to study the existing

national nursing organizations. This finding reinforced the need for a structure study.

The work of the council in identifying problem areas led to: the inception of the school accreditation program under the direction of the NLNE, the initiation of a socioeconomic study conducted by the Department of Labor, and the initiation of Brown's "school study." At the conclusion of the Brown study of 1948, the National Nursing Council went out of existence. This council was seen as very powerful and demonstrated the ability of the six national nursing organizations to work together on issues.

The continued problems of nurses related to their working conditions and pointed out the need for ANA to represent nurses. Other work groups in the United States were involved in union activities and improvement of employee conditions. Nursing was moving toward collective bargaining following the lead of these groups. Questions raised within the profession were in regard to the professional ethics of collective bargaining and whether it should be controlled by professional societies or by unions. The Economic Security Program, although controversial, had gained the increasing support of nurses by 1946. Based on the successful work of the California State Nurses' Association, ANA initiated

a more extensive national program. ANA worked with state associations to initiate or strengthen their programs. The Economic Security Program was becoming a major professional activity of the association. The strengthening of this program was reinforced by both the needs of the times and the original purposes of the association.

The 1950 House of Delegates voted to adopt a no-strike policy believing that employers had a special obligation to bargain with them. However, the American Hospital Association was opposed to collective bargaining by nurses. Their state associations were able to successfully obtain an amendment to the Taft-Hartley Labor Act. This amendment excluded hospitals from having to bargain and ANA's program was seriously impacted.

As further development of its program, ANA conducted workshops for state representatives and distributed manuals to assist the states. In 1954, ANA financed a demonstration project to test certain techniques. By 1958, ANA's Economic Security Program was labeled a success and had achieved a new status in employer-employee relations. However, there remained controversy over this program and how it impacted on other ANA programs.

ANA continued work on its other programs. These included the Professional Counseling and Placement Services, concerned with finding "the right nurse for the right job" and better distribution of qualified nursing services; the Intergroup Relations Program concerned with racial issues confronting association members related to both membership and employment; and, the Government Relations Program concerned with obtaining needed legislation to support nursing interests.

Major studies conducted in the late 1950s included the 1948 Ginzberg Report, The Program for the Nursing Profession, which reviewed a group of selected problems related to the current and projected shortages of nursing personnel: student nurse applicants, specialization of nursing functions, education of nursing personnel, nurse's role on the health team and career incentives for nurses. The second study was the 1948 Brown Report, Nursing for the Future, which was concerned with who should organize, administer and finance professional schools of nursing. This study pointed out that the problems of nursing were related to the problems of nursing education. Both studies indicated that nursing education should take place in institutions of higher learning with the public assuming more responsibility for financing educational programs.

ANA continued to undergo major structural revisions. The duplication among the national nursing organizations had been recognized earlier but had to be delayed due to nursing's involvement in the war effort. ANA commissioned the Raymond Rich Associates to conduct a study of its structure. The report presented at the 1946 convention contained two alternative plans for organizing the association. Plan I called for one organization for lay members and professional nurses. Plan II called for two groups, one for professional nurses only and the second for nurses and non-nurses who would work together on an equal basis. The ANA House of Delegates voted for a complete analysis of the Rich Report, the establishment of a joint committee of the six national nursing organizations to study organizational problems and called for a special session of the House to be held in 1947.

The 1947 special convention was the first ever in the history of ANA. The delegates voted to reject both Plan I and Plan II of the Rich Report and to refer the report to the newly appointed Joint Structure Committee for further study. They also delayed action on the proposals until the 1948 biennial convention. At that convention the proposal for one national nursing organization was presented. The main area of difficulty

with the proposal centered on the problem of non-nurse members which affected ANA's membership in the ICN. The proposal was referred to the Joint Structure Committee for further study.

The next proposal for membership study was the 1949 Alternate Plan. This plan was similar to Plan II of the Rich Report and called for two organizations, one for nurses only and the second for nurses and non-nurses. There would be a joint board between the two organizations for coordinating activities of mutual interest. The 1950 delegates voted to adopt the two organization plan with the retention of the ANA corporation and the functions and sections as approved by all six national nursing organizations. The joint board was to become a subsidiary corporation, jointly owned by ANA and NLN.

This plan was also accepted by the other five national nursing organizations, provided that ANA retain its corporation and that any changes in ANA functions would be accomplished through revision or amendments to the ANA Bylaws. The second association was to be built upon an existing charter. Since the NLNE charter already had provision for nurse and non-nurse members, it became the second association integrating the NOPHN,

the ACSN and the AAIN. ANA had already assimilated the NACGN.

A joint coordinating committee was established to effect a smooth transition of all the organizations. This committee was composed of the chairman of each organization's structure committee, together with the president and executive secretary of each organization. At the 1952 convention, ANA delegates approved the general plans for the ANA and NLN and adopted the necessary revisions to the bylaws of the association. The structure study of the six national nursing organizations had received widespread interest and participation by nurses. The profession had engaged in a long period of self-examination and study.

Between 1948 and 1958, the association had worked toward improving the general welfare of nurses, improving nursing education programs and improving nursing services to provide better health care for the public. At the same time ANA made the needed changes in its structure to fulfill its functions.

Upon entering the 1960s and 1970s, ANA continued to be concerned about the improvement and control of nursing practice. The association was once again involved in examining its structure. At the 1958 convention, the House of Delegates called for a study to

investigate how ANA was meeting the responsibilities of a professional organization. The Board appointed the Committee on the Study of the Functions of the American Nurses' Association.

To fulfill its responsibilities for nursing education and practice the association was involved in developing standards for nursing education, nursing practice and nursing services. Two main issues during this time were the entry level for professional nursing and the economic and general welfare of nurses.

At the 1960 convention, the Committee on Current and Long-Term Goals presented a proposal to have the baccalaureate program become the basic educational foundation for professional nursing practice. Delegates adopted the goal as a basis for further discussion and study. In 1965, ANA's Committee on Education published its first definitive statement on nursing education, Educational Preparation for Nurse Practitioners and Assistants to Nurses: A Position Paper. This paper, also published in the December 1965 issue of the American Journal of Nursing under a different title, created much concern and controversy within the profession.

Since its publication, ANA was engaged in continued interpretation and clarification of the association's position and collaborative planning with all

groups involved in health care. Throughout the 1960s and 1970s entry level remained a topic of concern and study by nursing groups as well as others. The Commission of Nursing Education proposed three resolutions adopted by the 1978 House of Delegates: (1) Identifying and titling the two categories of nurses entering nursing practice, (2) establishing a mechanism for deriving competency statements for the two categories, and (3) increasing accessibility of career mobility programs in nursing.

The ANA Commission on Nursing Education appointed a task force on Entry Into Practice to develop mechanisms for implementation of these resolutions. The commission continued to work through the work groups of its task force so that by 1985 the minimum preparation for entry into professional nursing practice would be the baccalaureate degree in nursing.

ANA, in addition to its statements on basic education issued statements on graduate and continuing education. There was a recognition of the ongoing need for nurses to build upon their basic education. With the continued expanding role for nurses through advanced specialized practice, graduate education was gaining increased importance. Graduate education was important as well for the advancement of nursing theory and

science. There were more nurses getting their master's and doctoral degrees.

Also concerned with nursing services, in 1965 ANA published Standards for Organized Nursing Services. These standards were to serve as guidelines for the development of a nursing care system relevant to contemporary health care needs. In April 1973, ANA Congress for Nursing Practice published the standards for nursing practice as a working document. There was a set of eight generic standards. Based on these standards, specialized sets of standards were formulated for each of the divisions on practice within the association.

ANA in addition to setting standards for nursing practice wanted to reward excellent practice of nurses who functioned beyond the minimal standards set for licensure. The 1958 House of Delegates had adopted as Goal II of the association: that ANA establish ways to formally recognize members who demonstrated exceptional accomplishments in the practice of nursing, contributed to the development of the profession, advanced nursing knowledge, and served both society and the profession by their contributions. The implementation of this goal led to the development of a certification process. In May 1973, ANA formally announced the initiation of its

nationwide certification program to recognize excellence in practice.

The next step in recognizing excellence of practice was the establishment of the American Academy of Nursing. ANA Bylaws revision at the 1966 convention allowed for the establishment of an academy for the advancement of knowledge, education and nursing practice. Through adoption of a resolution by the ANA Board, the American Academy of Nursing was initiated in 1973 with thirty-six charter fellows.

ANA also initiated a credentialing study in 1977. The 1974 House of Delegates had charged the Board to "move with all deliberate speed to establish a system of accreditation of basic, graduate, and continuing education programs in nursing." At the end of the study in 1979, ANA Board of Directors adopted a motion that a task force be established. They requested that a distinctive fund to carry out the functions of the task force be established through the American Nurses' Foundation.

The Economic and General Welfare Program continued to grow during the 1960s and 1970s. The program sought to have nurses achieve employment status commensurate with their preparation and qualifications and with the intellectual and technical nature of their

services. A second objective was to involve nurses actively in determining the conditions of employment under which they practice, through collective action.

In 1966, the Commission on Economic and General Welfare was established. The commission studied the association's approach to the economic security of nurses. They identified the need for an expanded program to represent more nurses in a short period of time and to assist state associations with qualified staff. Additional staff were assigned to specific projects throughout the country.

At the 1968 convention delegates voted to rescind the eighteen-year-old no-strike policy. In 1970, the House of Delegates voted to rescind the 1950 neutrality policy of the Association. Delegates were making major philosophical changes in ANA's approach to economic security.

Between 1970 and 1972, there were reductions in ANA staff services to the state associations. ANA was undergoing a financial crisis. In January 1972, the Board approved and funded a modified program of specialized field service. The commission was asked to develop long-range, five-year projections for the field service program based on significant trends.

In 1974, the association launched an aggressive campaign to assist the nation's 800,000 active registered nurses for the purpose of professional collective action. In 1976, the House of Delegates reaffirmed the multipurpose nature of ANA and the right of participation of directors of nursing in ANA. In 1978, the ANA president announced ANA's intention to represent all nurses more effectively and aggressively. That same year the Commission on Economic and General Welfare received an award from the Coalition of Labor Union Women for its promotion of women's rights.

In the late 1950s, ANA once more looked at its structure. One of the major changes in the American Nurses' Association's structural organization in 1952 was to provide for increased responsibility and autonomy in the sections. At the state and local levels of the association, functions were aimed at assisting individual nurses in improving their nursing practice and securing optimum working conditions. The section chairmen were voting members of the Board of Directors.

Despite all the good feelings about the cooperative spirit that existed among the three levels, the state associations and state leagues were experiencing some dissatisfaction. They identified the following problems: the complexity of the structure, the large

number of committees and meetings necessary to carry out the programs of both organizations, duplication of effort, lack of program coordination and financial and leadership needs.

At the 1958 convention, delegates adopted a resolution in support of one national nursing organization and directed the ANA Board to work with the NLN board toward this end. Since ANA and NLN could not agree on how to proceed, ANA established in 1959 the Study Committee on the Functions of ANA. The committee was to develop a plan to present to the 1960 House of Delegates. This plan was to involve membership in a study directed towards working out any organizational rearrangements. The committee was also to develop criteria to aid in a determination of the functions which ANA, as the professional organization, must carry out to discharge its responsibilities.

At the 1960 House, the committee reported that ANA needed to assume responsibility for the functions it should carry out as a professional association and to make whatever arrangements that were necessary to do so. The proposed plan included considerations for setting standards in the areas of economic welfare, education, practice and service. Functions were to be assigned to the appropriate structure or level of the association.

The 1962 House of Delegates recommended that the report be taken for study to the state and district associations. At the 1964 convention, the delegates adopted the proposal of the Structure Committee for further study and requested that the Bylaws committee be instructed to draft the necessary bylaw revisions for the 1966 House. The 1965 Supplement Report was distributed to assist the state and district associations in studying the effects of the proposal. The major structural units included in the plan were the three Commissions for Nursing Education, Nursing Service and Economic and General Welfare; the Congress for Nursing Practice; the Divisions on Practice (which replaced the sections) and the Occupational Forums. The 1966 House adopted the recommended bylaws revisions.

At the 1970 convention, the Committee on Nursing Research and Studies submitted a proposal for the formation of the Commission on Nursing Research and the dissolution of the current committee. The House approved the proposal and charged the commission with formulating professional policy in such areas as human subject rights. The distinction was made between the functions of the commission and the American Nurses' Foundation.

The 1970 House also recommended dissolution of the Legislative Committee. A number of its previous functions had already been transferred to other ANA structural units through the 1966 bylaws revisions. The Government Relations Department of the association continued to be supportive to the units. During the 1970s, the various structural units within the organization continued to work together on practice issues. These units were implementing the designated functions of the professional association.

However, in the late 1970s, once again there was a call to look at the structure of the association. The Committee to Study the Roles and Functions of Various Levels of the Organization, initiated in 1975, presented two models for study to the 1978 House of Delegates. One was a tri-level model and the second was a model for a federation concept at the national level. The House recommended financial support for further study by the committee and that the committee present plans for a federation model to the 1980 House.

In the 1980s, ANA continued to study the models recommended by the Committee to Study the Roles and Functions of Various Levels of the Organization with attention to direct membership in each level, the economic and general welfare program and the rights and

privileges of the membership. The direct membership model addressed the needs of the individual nurse while the federation model provided increased consensus and more rapid action at the national level. Since the advantages of both were important for the association, the 1982 House of Delegates voted to adopt a modified federation model with accompanying provisos.

The new structure was composed of cabinets which replaced the Congress for Nursing Practice, the Divisions on Practice and the commissions. The Advisory Council was replaced by the Constituents Forum. There was now a Nursing Organization Liaison designed to collaborate with nursing organizations who met the ANA bylaws requirements. The size of the House of Delegates was reduced to 615 and they were to meet annually beginning in 1984.

ANA continued to articulate standards for nursing practice, nursing services and nursing education as well as for the economic and general welfare of nurses. During the first half of the 1980s, the association continued to provide for the maintenance, improvement and implementation of standards.

The entry level issue continued within the profession and the association. ANA, at the 1985 House of Delegates meeting, adopted a resolution on the titling

for licensure of two levels--"professional" and "associate." ANA also initiated a National Public Relation's Campaign to educate nurses and the public regarding the issues. The association met with other national nursing organizations and health related groups to interpret their position on the entry level.

ANA was also aware of the impending impact of entry level upon the states and funded money to assist five states with implementation. In 1986, ANA assisted the first two states in their movement toward implementation. North Dakota, was through its Board of Nursing, initiating changes in its regulations for the two levels, and Maine was initiating changes in legislation for the two levels of nursing.

Although the issue remains controversial, the profession is moving forward. The effects of the implementation will require work and cooperation in identifying and dealing with problems, but the 1985 entry level for professional nursing is closer to reality.

The other controversial and major program of ANA is the Economic and General Welfare Program. There is more acceptance of this program and in 1986 at its fortieth anniversary is a viable program within the association. The Cabinet of Economic and General Welfare is working toward representing all nurses whether

they are in collective bargaining units or not and representing all RN bargaining units. This cabinet works in concert with the other seven cabinets of ANA.

ANA-PAC, the American Nurses' Association-Political Action Committee, is the political arm of ANA and has as an activity the political education of nurses and their political involvement. They also contribute to campaigns and endorse candidates who support nursing interests. ANA-PAC also assists other ANA structural units in obtaining needed legislation.

Two significant events of the '80s for ANA were the establishment of the Nursing Research Center at the National Institutes of Health. ANA-PAC was instrumental in obtaining the Center. The other event was the 1985 House of Delegates' endorsement of the Board's action to retain the Center for Credentialing Services as an administrative unit within ANA. The initiation of this unit will assist ANA in setting and controlling standards for nursing practice.

ANA's Nursing: A Social Policy Statement, published in 1980, is a pivotal work which sets the direction of nursing for the '80s and onward. The statement delineates the nature and scope of nursing practice and describes the characteristics of specialization in nursing. Current trends in health care are

reflected in the statement and it provides a foundation that should promote unity in nursing. The policy statement also identifies leadership responsibilities for nursing in health care delivery.

At the 1986 ANA convention the Board of Directors presented a statement for the organizational mission of the American Nurses' Association to achieve the fifteen-year goals for the nursing profession. The House of Delegates adopted the mission statement and the Board's eight goals to move the association forward. ANA had accomplished much; much was left to be done.

Conclusions

The American Nurses' Association has through the years consistently changed its structure to fulfill the purposes and functions of the professional association. ANA has maintained its commitment to work for the welfare of all nurses and the control of nursing education and nursing practice to provide quality nursing care for all peoples. In so doing, ANA has through either its leadership or membership moved to develop power bases to effect desired programs.

At the inception of the professional association, the control of the organization was in the hands of a few dedicated women who had a vision of what direction nursing and the association should take to develop

nursing as a profession. Their commonality of thinking and goals attracted them to each other and there was a solidarity among them. They shared their thinking with other nurses and together they were able to achieve goals such as state licensure of nurses, standardized curricula and accreditation of nursing schools. Because of their expertise and leadership ability the other members of the association legitimized their authority. When the members wants differed, as in desiring to maintain alumnae associations, they complied for the greater goal of state registration. This solidarity of purpose bound them together. As long as there was meaningful benefits for the members they were willing to subject themselves to the leadership.

The solidarity of leadership provided a strong foundation for the young association. The growing power of ANA was demonstrated through the increasing number of states who were enacting legislation for licensure of nurses.

As the evolution of the association continued, there was a power relationship developing between the state associations and the national association. The national association provided information, strategies and sometimes funding and staff, and the state associations were needed to implement programs. The trade-offs

that occurred between the states and the national provided a balance between the two levels and moved them toward mutual goals. State associations were in a similar relationship with the local associations, with the local associations subjecting themselves to the states' authority. The national association's power was further evidenced by the need for district and state associations' bylaws to be in compliance with ANA's.

The ANA in exchange for the power given it by the district and state associations provided services through the structural units, programs and services. Membership in turn supported the national association's policies and implemented them.

ANA during the period 1913 to 1946, in addition to developing its power through the work of its structural units and programs, was also collaborating with other nursing organizations. The NLNE was affiliated with ANA and acted as its educational department. Through this affiliation ANA was able to use the expertise of this group and influence the curricula used in schools of nursing. ANA's ability to work collaboratively with other groups demonstrated its power in that area.

Another demonstration of ANA's power was the invitation consistently extended to ANA to sit on

committees such as the National Nursing Council. These invitations illustrated the fact that ANA was seen as a spokesperson for nurses and nursing. This was especially true since ANA represented the largest group of nurses. Additionally, this gave ANA leadership an opportunity to influence national policy and provide some continuity between civilian and military nursing practice and nursing education. ANA participated in the formation of such programs as the Army School of Nursing, the Vassar Training Camp and the Cadet Nurse Corps. ANA in turn was able to implement programs recommended by these groups.

When the ANA Structure Committee was initiated in 1946, there were a number of members who were in support of one national nursing organization, the American Nurses' Association. This support for one organization by the constituent members was an indication of the power that ANA had at that time. ANA, however, did not control other nurses or nursing organizations and there was not unanimous support for one organization. The issue of non-nurse membership was one of the obstacles to the adoption of the one organization plan. ANA's being retained as the professional nursing organization to speak for nurses and nursing reinforced its power.

ANA, further developed its power by widely disseminating information on the organizational plans in the Journal and in reports. The Structure Committee also sought input from nurses and other organizations. ANA's participation on a Joint Structure Committee was seen as a desire to work together with other organizations for the advancement of nursing.

As an alternative to having one organization to perform all the functions for nursing, in 1952, ANA leadership strengthened the association by establishing and rearranging various structural units. Through this new structure ANA was able to establish the functions, standards and qualifications necessary to control nursing practice. This control was viewed as a necessary part of self-regulation of nursing. Minimal standards had been set through legislation for registration. Now ANA was identifying the functions of various nursing groups, establishing the necessary standards and specifying concomitant qualifications. In its ability to implement these functions, standards and qualifications ANA demonstrated one more instance of its power through membership compliance.

The two national nursing organizations, ANA and NLN, were able to continue to collaborate through their Coordinating Council. Together the leadership of both

organizations were able to establish policies and provide services in support of nurses and nursing.

However, as time passed membership again believing that the functions of a professional association were not being met through the two national organizations pushed for one national nursing organization. This was not possible to accomplish without the cooperation of both organizations. Therefore, the ANA board initiated a study of how the Association could be rearranged to meet the identified functions of a professional association.

Another committee was formed to examine the current functions and structure of ANA. The committee did this in reference to what the functions of a professional association should be. Other organizations were examined. Merton's view of a professional society as having responsibilities to the individual practitioner, the profession and society was used as a basis for their work. In the '60s ANA decided upon a new structural arrangement for the association. The participation of the membership in making decisions regarding the structure is a demonstration of the sharing of power between the leadership and the membership in their reciprocal relationship.

In this structure a reciprocal relationship also existed between the House of Delegates and the Board of Directors. Both groups were elected by the membership at large. The House was the voting body and as such voted to adopt policies. Membership charged the Board with implementing these policies and reporting back to the House.

With this new structure, ANA moved to the important work of developing standards for nursing education, nursing practice and nursing services. The establishment and implementation of these standards would further the profession's attainment of self-regulation. ANA's ability to put these standards in place and get nurses to articulate them was another indication of their developing power. Other evidences were the increase of advanced practice by nurses and their educational preparation at the master's and doctoral levels.

ANA's most recent structural change once again depicted its willingness to examine its own structure and make the necessary adaptations to keep it a viable association for nurses and nursing. The modified federation model adopted in 1982 was intended to have the organization be responsive in a more cohesive manner. Although still concerned about individual membership, the association needed to be able to move more swiftly

and in a more decisive manner in a rapidly changing society. ANA had also made some important advances through the establishment of its Credentialing Center, the Research Center and the important work of ANA-PAC.

ANA's power has also been noted in its ability to initiate and implement programs related to controversial issues such as the entry level into professional nursing and collective bargaining. Members who were in support worked to achieve these goals. Other members who were opposed were willing to comply to get other needs met by the association. Still other members who were opposed chose to leave the organization for another nursing group or to completely leave nursing.

Since ANA presented its Position Paper on the baccalaureate degree as the entry level into professional nursing, ANA's power has been tested. The many divergent opinions and feelings surrounding the issue have been divisive. This has been one of the most emotional and controversial issues facing the association to date. Educational preparation has long been a concern and topic within the association and the profession. Since the first training programs for nurses, the need for standardization and accreditation of programs has been noted. The focus of this debate has changed with the times and nursing always seems to be attempting

"to fit in" rather than say what direction nursing should take. Collegiate education has been advocated since the early 1920s. The controversy between hospital schools of nursing and programs in institutions of higher learning was further fueled with the advent of junior college programs in the early 1950s. That brought to three the kinds of educational programs to become a registered nurse and only one kind of license.

All of these registered nurses with different educational preparation are eligible to be members of ANA. The association has the responsibility to represent all of them, at the same time represent the interests of the profession and the interests of society. ANA's dilemma becomes more apparent. Yet, ANA had taken a stand on this issue and had worked not to disenfranchise its members while upholding the goals of the profession in a future-oriented society. ANA leadership has initiated the structural changes to move the association and the profession closer to its goals. At the same time it has made a number of trade-offs to encourage acceptance of this position. Some of its power has been eroded by nurses who are in opposition leaving the association. Conversely, ANA has been able to get the support of a number of nurses and nursing organizations.

Another ANA program which has also been controversial is the Economic and General Welfare program. It was initiated as a formal program because of the poor working conditions of nurses. However, the welfare of its members has always been a concern of the association. The program was launched in 1946 but the poor conditions had been in existence for quite some time. Opposition of nurses stemmed from a concern of "unionism" versus "professionalism." There was also opposition to collective bargaining by a number of the members. After the success of the program in California, there was gradual acceptance of the program by the membership.

ANA was following the lead of other working groups within society. The public was more accepting of collective activity. Nurses were also becoming more accepting of and recognizing the need for nurses to band together to improve conditions and have their rights met. There was also more acceptance of women working especially after World War II. Women were in more management positions as were nurses. The socialization of roles for women was gradually changing. Nurses were becoming more assertive and independent.

In the '70s and '80s, the Commission on Economic and General Welfare was becoming a stronger structural

unit within the association. There was growing support among the members of its function within a professional organization. Nurses who remained opposed to collective bargaining were willing to stay within the association to obtain other benefits.

The evolution of the American Nurses' Association as an organization has not been dissimilar to the growth of other professional organizations. During the association's infancy, nursing leaders had looked at the evolutionary development of other groups and organizations. These leaders had noted the distribution of labor among the various levels within the other organizations. ANA profited from the experience of these organizations. There was an examination of the steps taken by these organizations to move them forward toward their professional goals. For example, the association had patterned its change from alumnae associations to county and state associations, as basic entry units into the association, after the structure of the American Medical Association (AMA). This structure was noted to be the most expedient to move toward state registration. Toward the end of the nineteenth century, the AMA was involved in standardizing educational programs and licensing physicians. Additionally, AMA, over the years, was developing its economic power by creating a

monopoly in medical practice through the exclusion of alternative practitioners and limitation of the supply of physicians.

Other professional organizations such as the American Medical Association, the American Psychological Association, the National Teachers Association, to name a few, have had the same struggle of low memberships and limited membership involvement as ANA. In addition, ANA has addressed similar issues of other organizations. For example, collective bargaining is also a concern of the Teachers Association; health care delivery is of concern to the AMA and the AHA; and, professional and technical practice has also been a concern of the Engineer's Association. These organizations have also experienced difficulties with mutual acceptance of professional goals, by the membership and leadership. However, these professions have not had the same diversity of educational preparation and interests of its members as ANA has.

Structural changes of other organizations have not been examined with the same internal and external intensity and scrutiny that ANA has. Organizations such as AMA and AHA have been willing to examine both the nursing profession and its organizational structure relative to the problems of nursing and make

recommendations. However, these same organizations have not invited nursing to examine their structures and make recommendations.

The American Nurses' Association has patterned its structural changes after the successes of these other organizations and in response to the needs of both the members and the profession. Additionally, ANA has worked collaboratively with organizations such as the AMA and the AHA to further the interests of nursing and health care.

Still in its first century of growth, ANA has made changes as indicated. ANA represents the largest number of nurses of any nursing organization. Yet, it does not represent the majority of nurses. Some nurses have become disenchanted with the association and dropped their membership. They represent a loss of power for ANA. When the association was smaller, nurses were more homogeneous. Initially there were the superintendents, the private duty nurses and the public health nurses. Although each group had special interests, they were able to unite their efforts and work toward registration of all nurses. These nurses had one overriding common interest. Now, there is greater diversity in the association and among nurses and they have more difficulty in putting vested interests aside

and in working toward common goals. ANA, although living in a complex society, has achieved a fairly solid foundation and now must move forward to further develop its power and truly speak for all nurses and the profession as it carries out its responsibility to society.

The American Nurses' Association, in order to strengthen its power base, must work toward making the association strong at all levels. The Federation model, which has the state nurses' association as the unit of membership, has served to strengthen the ties between the national and state levels. However, ties with the local level by both the national and state levels needs to be further developed. This can be done in a number of ways. For example, a periodic one page newsletter identifying both the accomplishments and concerns of ANA could be sent from the national headquarters to individual nurses who belong to ANA. Such a newsletter would serve to point out to members just what the association had been able to accomplish for nursing and how their dues and participation have contributed to this. The fact that ANA has developed power bases needs to be more strongly communicated to the members and to the profession as a whole.

Secondly, a tighter coordination of practice interests at the local, state and national levels could

be enhanced through joint meetings or conference groups related to specific clinical issues. This joint effort would provide an opportunity for communication and collaboration among the three levels.

Perhaps the time is right for ANA to take more forceful action implementing the entry level issue. ANA's financial support to five states to begin implementation of the entry level is certainly moving the association in the direction toward representation of professional nurses.

Recommendations

The study of the American Nurses's Association has been an interesting and rewarding one. As can be imagined there was a great amount of historical material published regarding the association. The amount of material related to such an extensive time frame and the confidentiality of some of the material, presented problems for this researcher.

ANA has had a long history in the development of the nursing profession in the United States as well as with international nursing. Its influence, whether positive or negative, has been felt within the health care system and in society. Some of the information that might have proved helpful in the analysis of these events were contained in restricted or closed files.

The examination of some of this inaccessible historical material might have generated a different perspective or reinforced the analysis of other material that was available. In the examination of structural changes of ANA, it is important to explore the relationship of structure to the roles of leadership and membership. Similarly, the association's positions on issues are influenced also by leadership and membership.

Exploration of the early issues of the American Journal of Nursing provided papers which illustrated various leaders' points of view. Additionally, review of the reports contained in the House of Delegates Reports and the Proceedings of the ANA Conventions were helpful in gaining insight as to who the leaders were and how they were able to work together. However, it would be helpful to have more of the ANA files open to support the observations from these other areas.

Another area that presented a problem was in how statistics on ANA membership were kept. Facts About Nursing contained some of the statistics but not for all the years. Additionally, when trying to look at the number of nurses in the United States, different criteria were used for different years. The use of one standard set of criteria would be helpful (see Appendix H).

The issue of proportionally low membership of ANA needs to be examined. The tremendous amount of work that the association has done with nurses both within and outside the organization supports the need for further examination. Several controversial issues have arisen throughout the association's history. Any one of these issues or a combination of them could be contributory factors to the membership question. Other organizations also have the problem of low membership unless membership is mandatory.

The review of documents that were available from the start of the association until the present was very time-consuming but stimulating. The amount and depth of the work accomplished by the association was impressive. ANA material available provides opportunity for a number of studies and therefore recommendations.

One such study that would be useful would be a more definitive study of the various structural changes that have occurred throughout ANA's history. A closer look at how decisions were made and how and what people were appointed to these committees would be informative. The choice of a particular structure moves the association in a specific direction for a number of years.

Another area that bears investigation is how ANA deals with controversial issues. How structural units

are used to move ANA's positions forward needs to be examined and analyzed. The association's collaboration with other groups to gain their support on issues must contribute to this. In the early days of ANA, a number of the leaders held positions in more than one organization. Because of this they had access to information and it made communication with each other easier and more timely.

Throughout the years ANA has been invited to participate on a number of committees. ANA's influence as a result has been felt outside the association. The role that ANA has assumed on these committees and how ANA's participation has influenced policies needs to be examined. ANA was a constituent member of the National Nursing Council, a group believed to be very influential. How influential was ANA in all the decisions that this group made? This is one question that might be answered by a more careful investigation of ANA's involvement with this council.

A number of nursing leaders have emerged in the past and in recent years. Yet most students and for that matter a number of "rank and file" nurses would not recognize their names let alone be aware of their contributions to the association and the profession. Articles published about these leaders would contribute

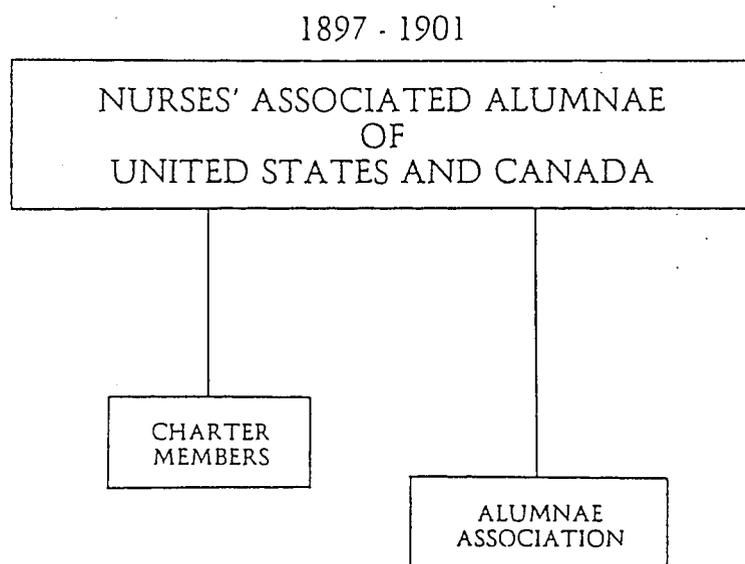
to nursing's heritage and at the same time be a morale booster for nurses. Additionally, it could give the public a more realistic picture of nurses and nursing's capability. The Biographical Dictionary of American Nurses being compiled by Vern Bullough and Olga Church will address this need.

Finally, there needs to be a stronger emphasis on the vital role of nursing in society, not just as nurses, but as participating citizens concerned with social issues. Nurses, in addition to and as part of their role as nurses have made valuable contributions to society. A written history of these contributions would be valuable.

The American Nurses' Association has contributed to the growth of the nursing profession. It has been "gatekeeper" for the profession and the nurses. Still a young association, not even one hundred years old, it has many achievements that it and nurses can be proud of. Much remains to be done, but the path is set.

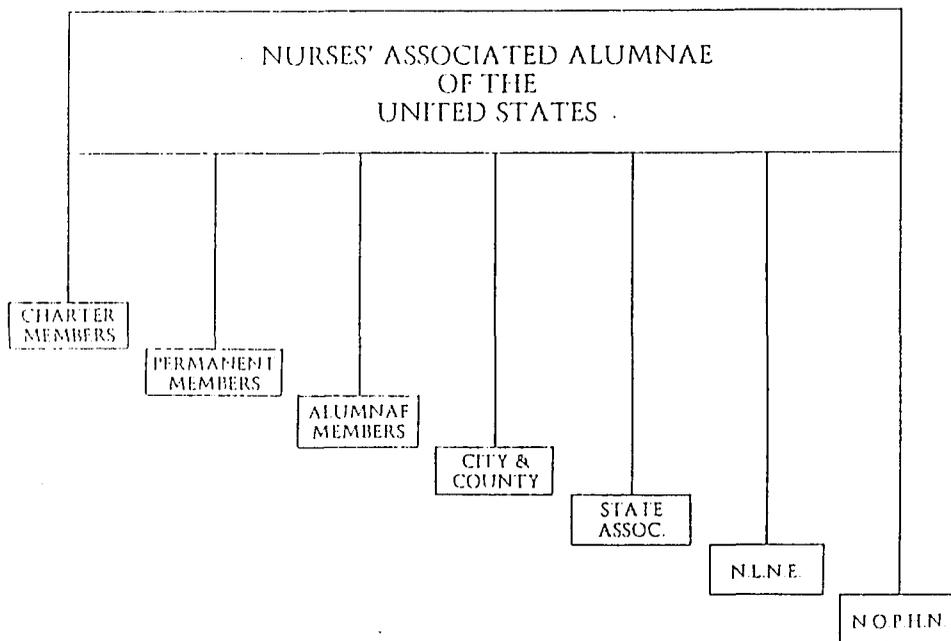
APPENDICES

APPENDIX A
MEMBERSHIP CHARTS FROM 1897-1916



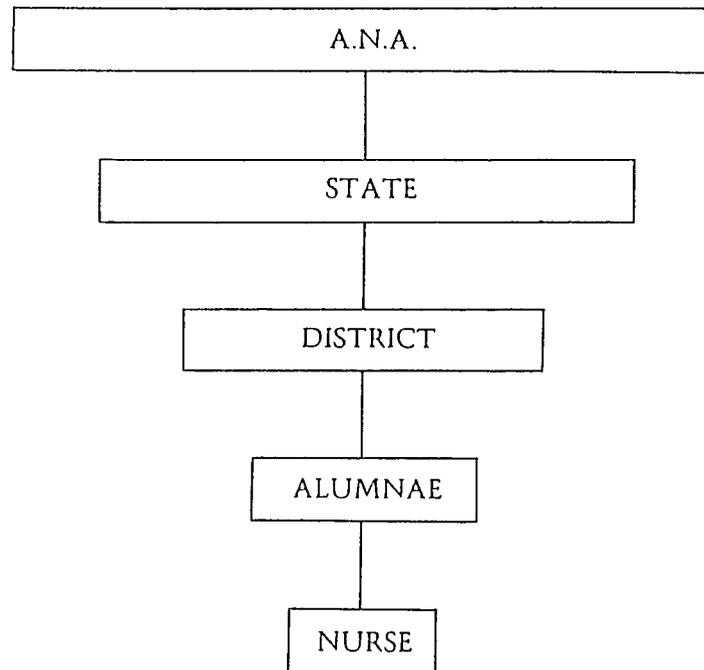
SOURCE: Lyndia Flanagan, One Strong Voice
(Kansas City, Mo.: The Lowell Press, 1976), p. 60.
Printed with permission.

1901 - 1916



SOURCE: Lyndia Flanagan, One Strong Voice
(Kansas City, Mo.: The Lowell Press, 1976), p. 61.
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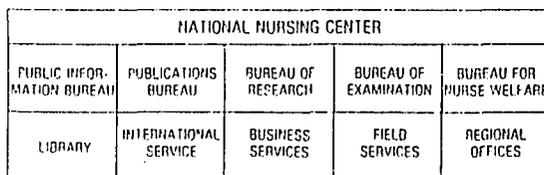
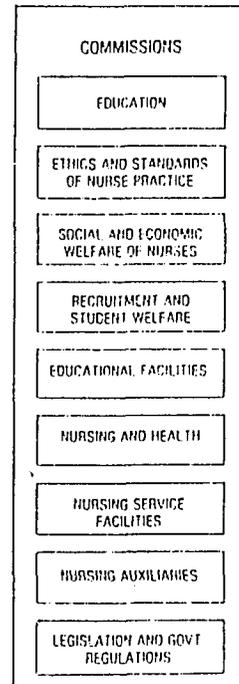
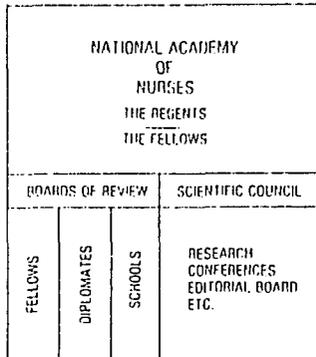
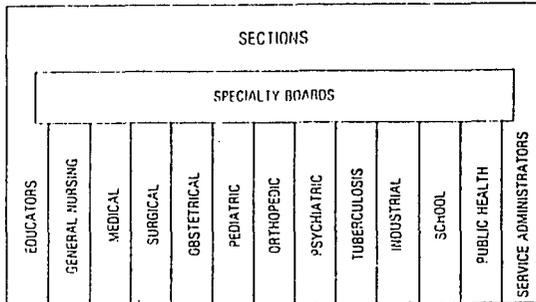
DISTRICT PLAN OF MEMBERSHIP
1915 PROPOSAL



SOURCE: Lyndia Flanagan, One Strong Voice
(Kansas City, Mo.: The Lowell Press, 1976), p. 62.
Printed with permission.

APPENDIX B
RAYMOND RICH ASSOCIATES PROPOSALS
FOR STRUCTURAL UNITS

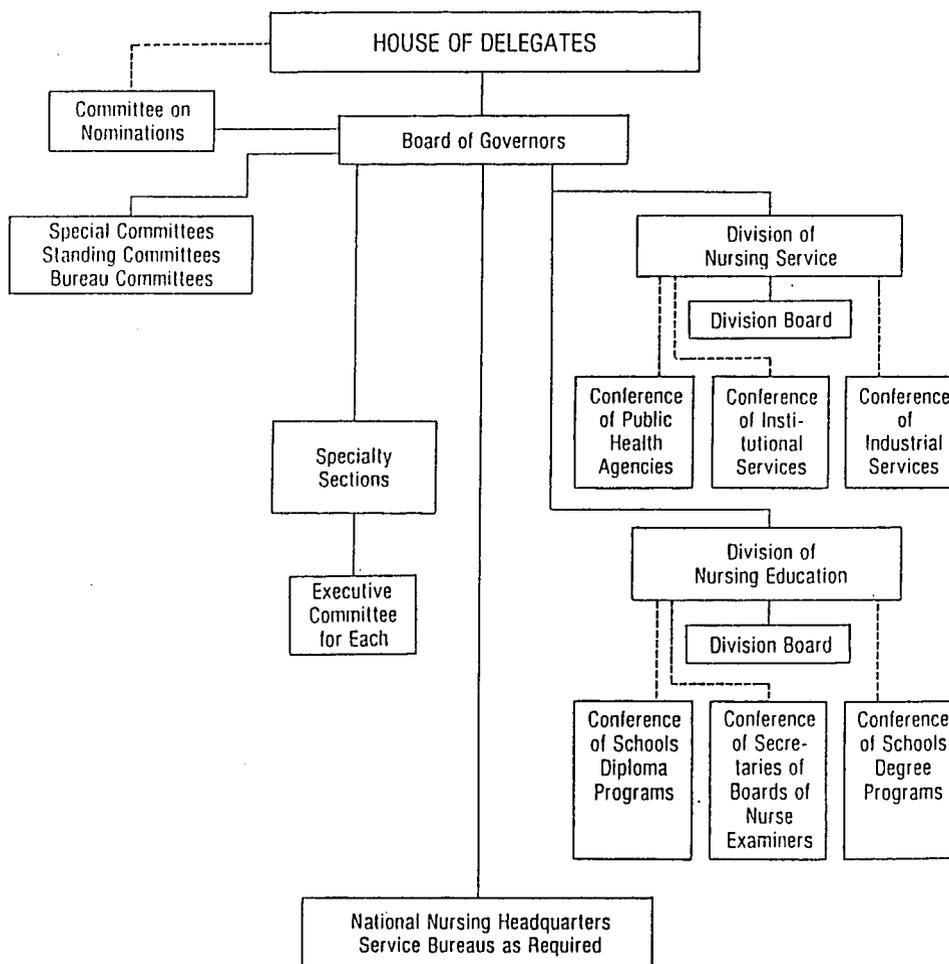
RAYMOND RICH ASSOCIATES' PROPOSALS FOR STRUCTURAL UNITS



SOURCE: Lyndia Flanagan, One Strong Voice
(Kansas City, Mo.: The Lowell Press, 1976), p. 137.
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APPENDIX C
JOINT STRUCTURAL COMMITTEE PROPOSALS--
1948 AND 1949

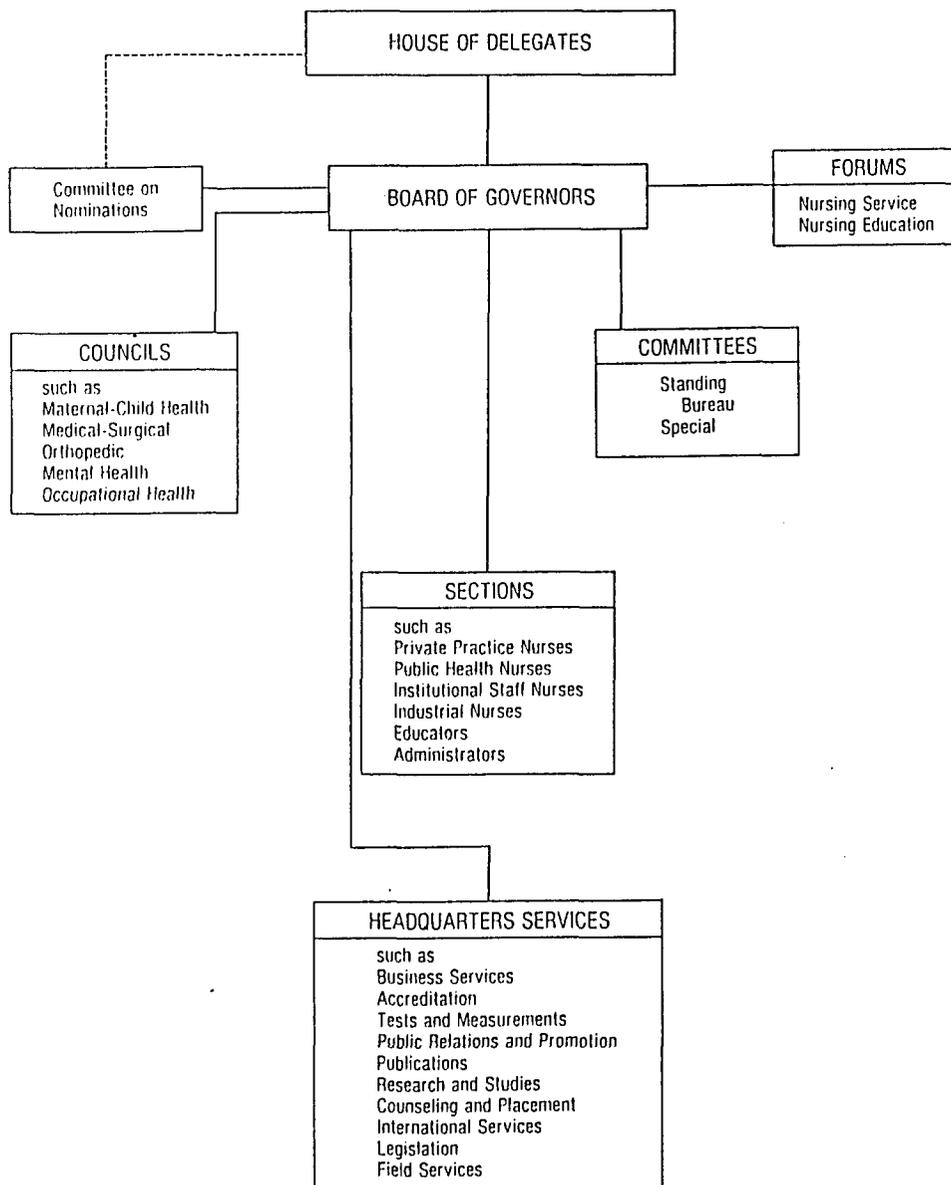
**1948 TENTATIVE PLAN FOR
ONE NATIONAL NURSING ORGANIZATION
AMERICAN NURSING ASSOCIATION**



SOURCE: Lyndia Flanagan, One Strong Voice
(Kansas City, Mo.: The Lowell Press, 1976), p. 146.
Printed with permission.

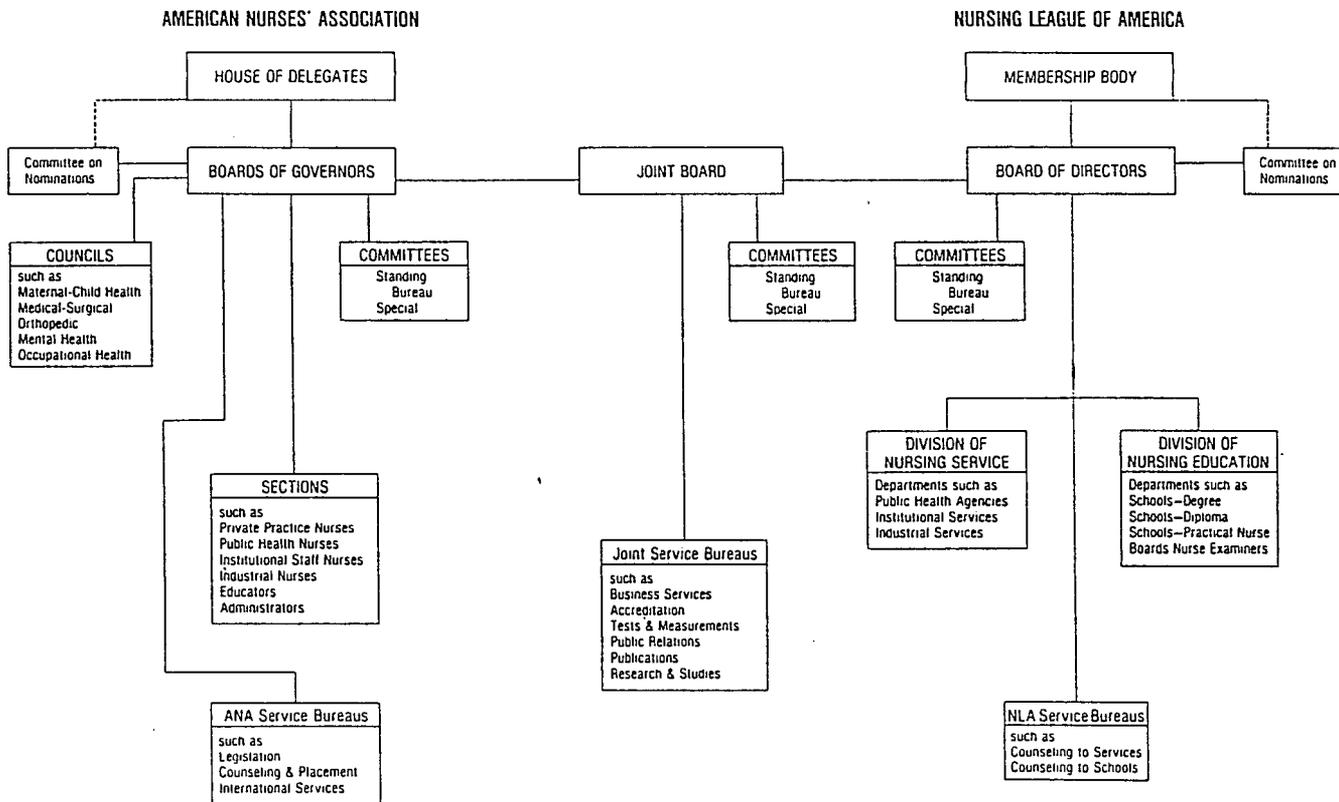
1949 PLAN FOR ONE ORGANIZATION

AMERICAN NURSING ASSOCIATION



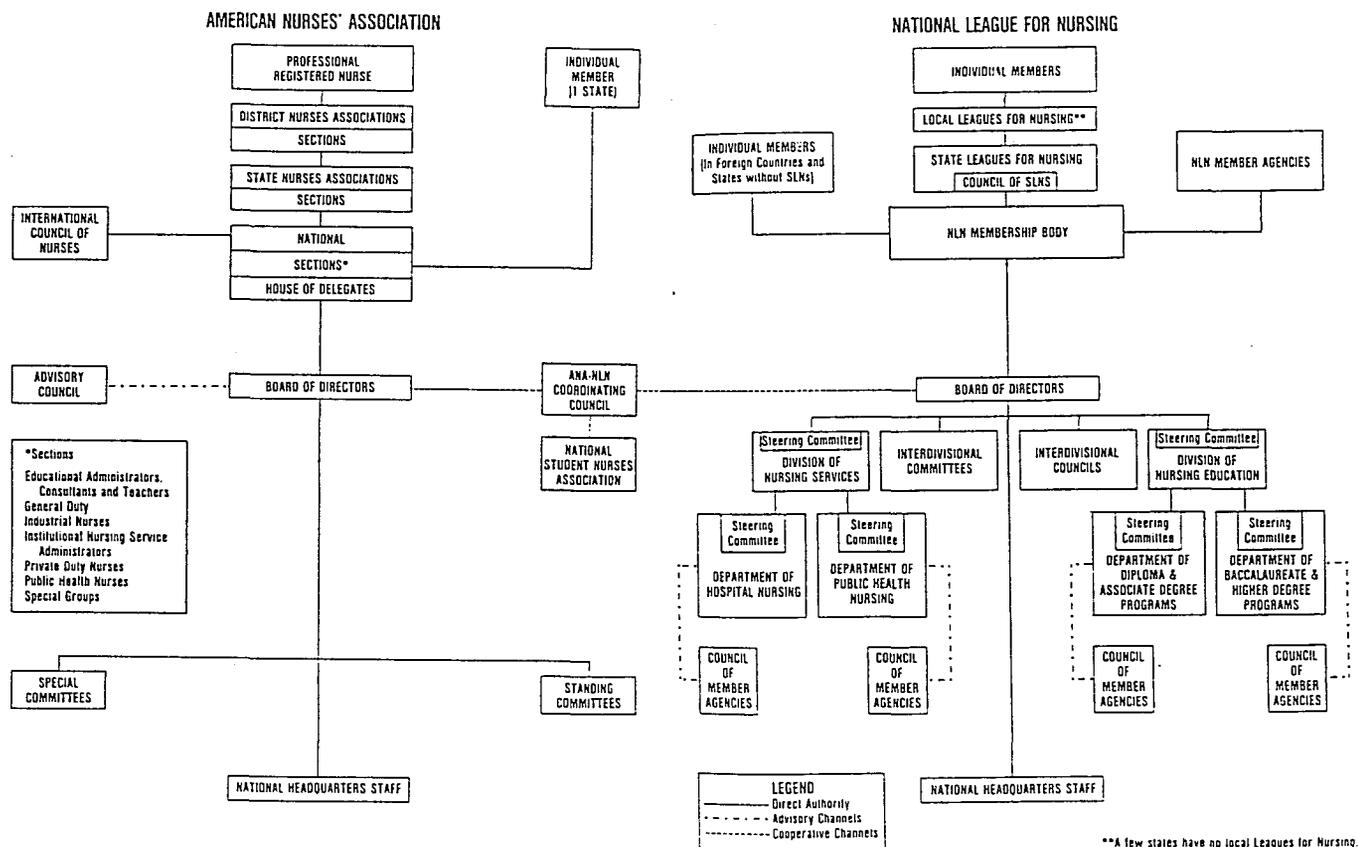
SOURCE: Lyndia Flanagan, One Strong Voice
 (Kansas City, Mo.: The Lowell Press, 1976), p. 154.
 Printed with permission.

1949 PLAN FOR TWO ORGANIZATIONS



SOURCE: Lyndia Flanagan, One Strong Voice (Kansas City, Mo.: The Lowell Press, 1976), p. 151. Printed with permission.

APPENDIX D
MEMBERSHIP ORGANIZATION CHARTS--1952

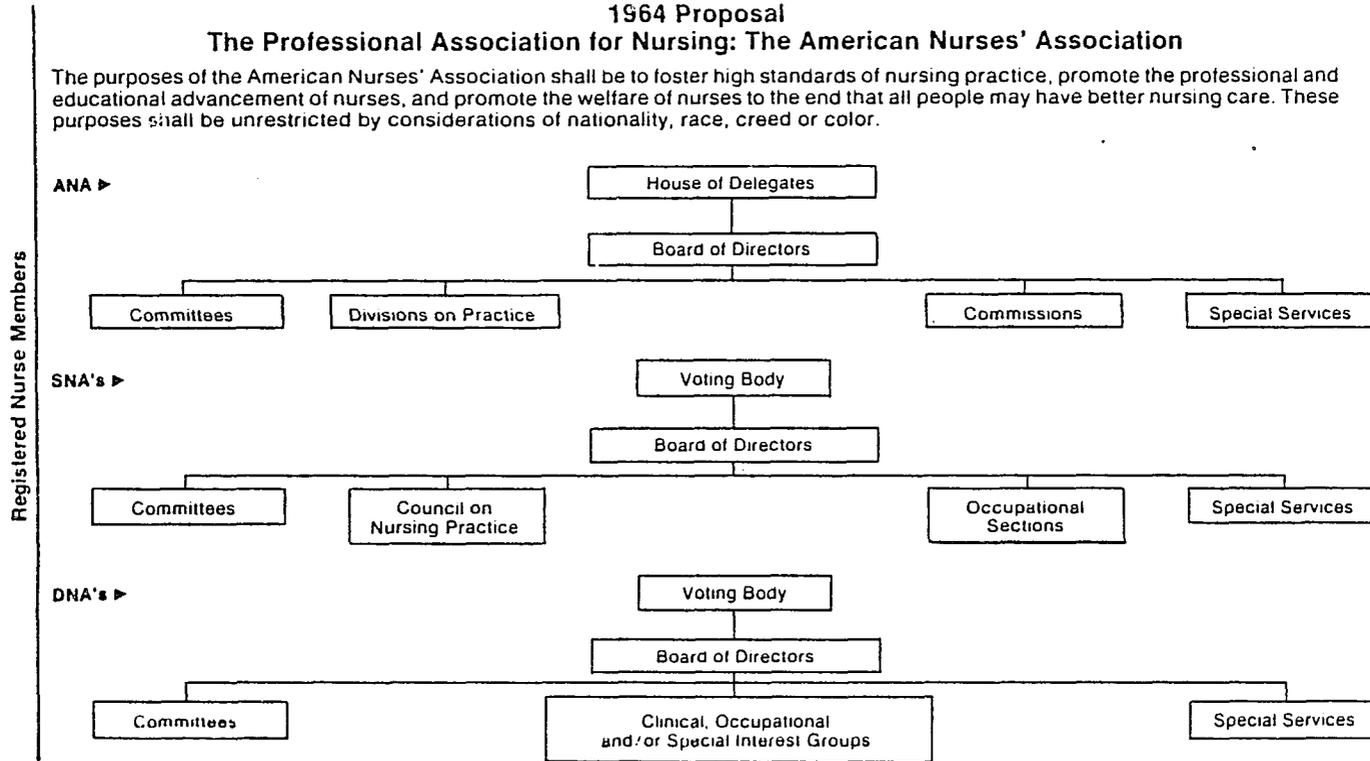


SOURCE: Lyndia Flanagan, *One Strong Voice* (Kansas City, Mo.: The Lowell Press, 1976), pp. 160-61. Printed with permission.

APPENDIX E
ANA STRUCTURAL ARRANGEMENTS--
1964 AND 1966

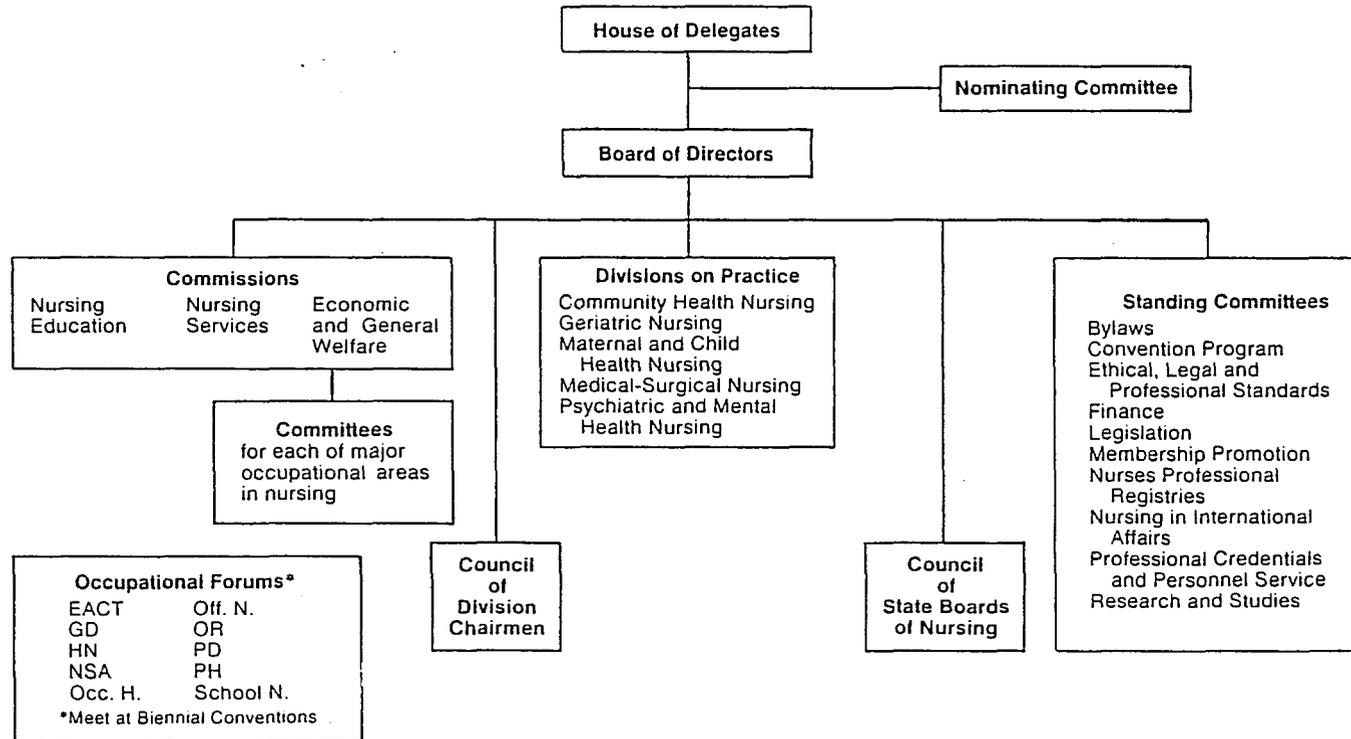
**1964 Proposal
The Professional Association for Nursing: The American Nurses' Association**

The purposes of the American Nurses' Association shall be to foster high standards of nursing practice, promote the professional and educational advancement of nurses, and promote the welfare of nurses to the end that all people may have better nursing care. These purposes shall be unrestricted by considerations of nationality, race, creed or color.



SOURCE: Lyndia Flanagan, *One Strong Voice* (Kansas City, Mo.: The Lowell Press, 1976), p. 198. Printed with permission.

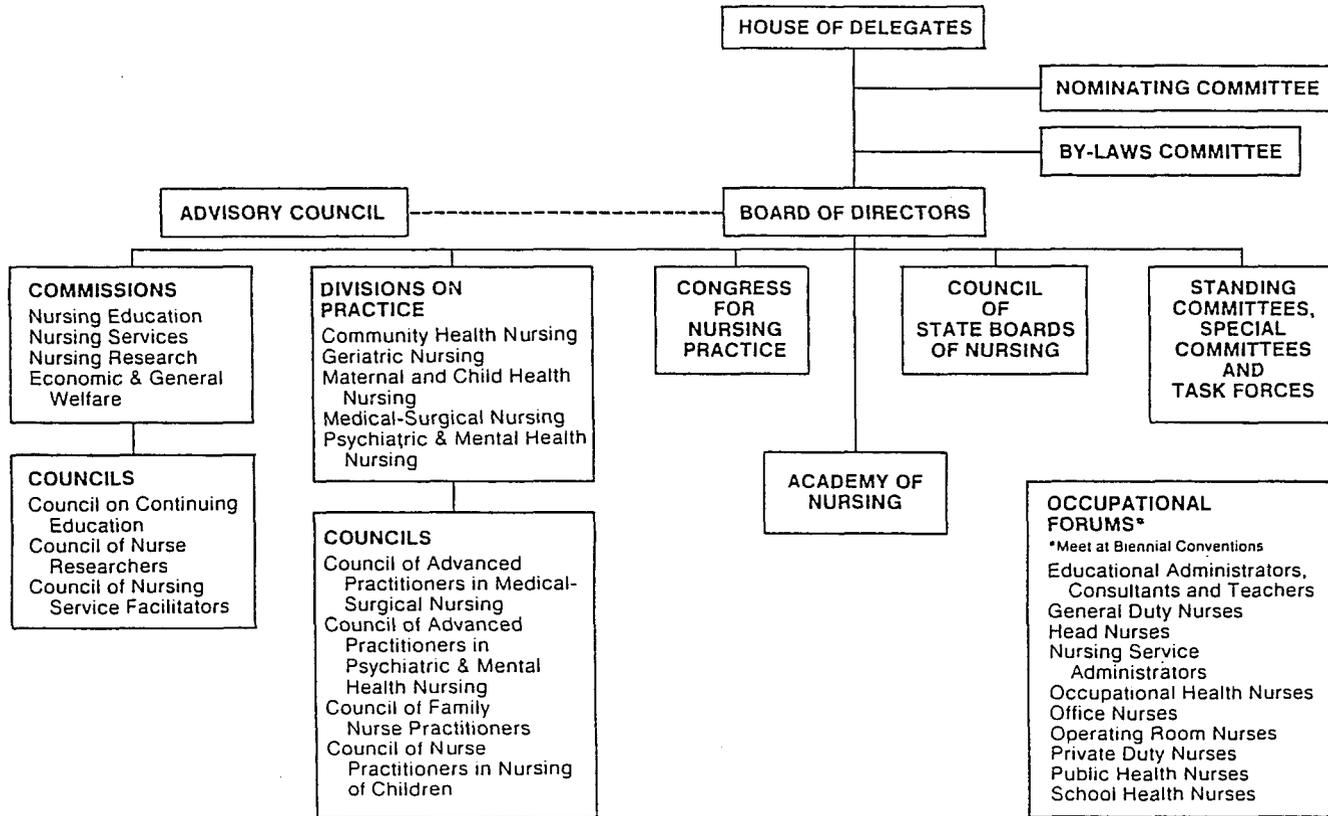
Structural Arrangement as Adopted in June, 1966
American Nurses' Association
NATIONAL LEVEL



SOURCE: Lyndia Flanagan, One Strong Voice (Kansas City, Mo.: The Lowell Press, 1976), p. 202. Printed with permission.

APPENDIX F
AMERICAN NURSES' ASSOCIATION: STRUCTURAL
UNITS, NATIONAL LEVEL--1975

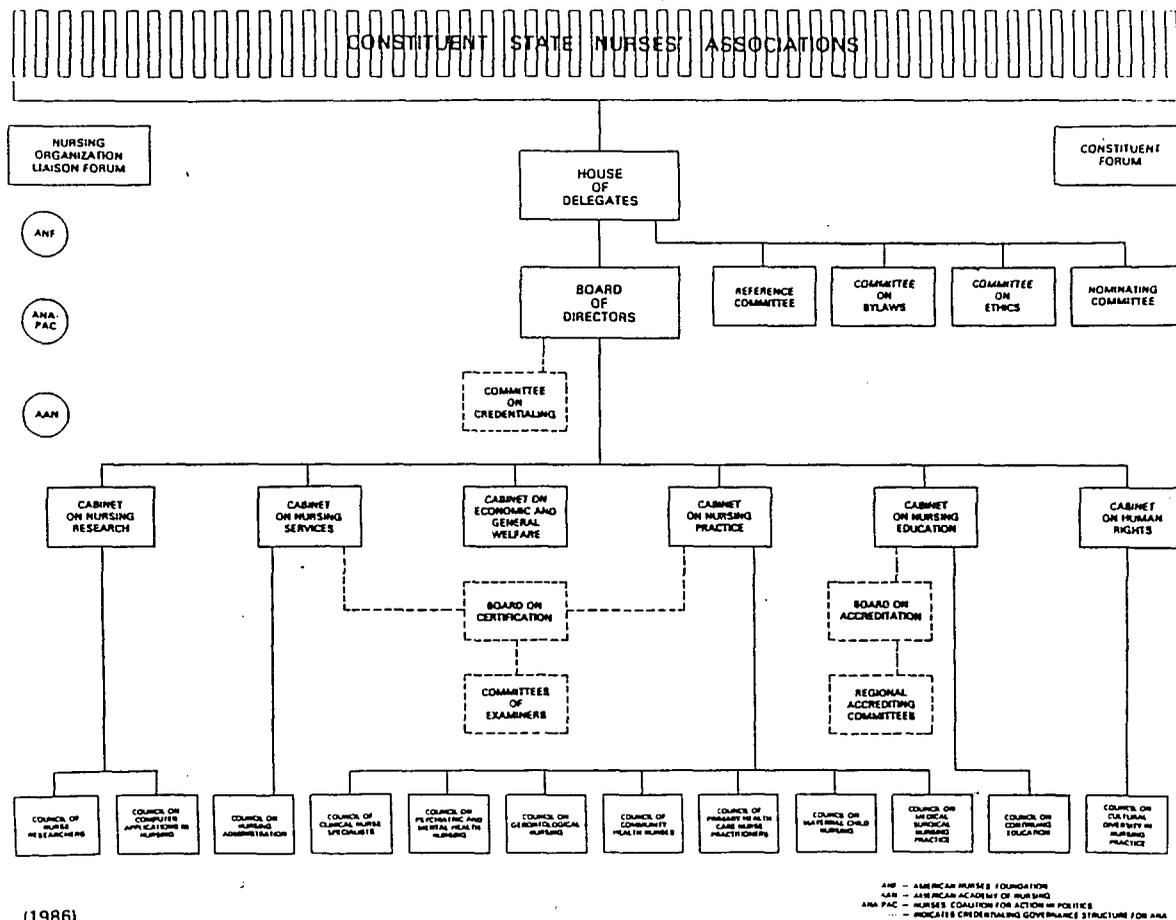
AMERICAN NURSES' ASSOCIATION: STRUCTURAL UNITS, NATIONAL LEVEL—1975
 2420 Pershing Road, Kansas City, Mo. 64108



SOURCE: Lyndia Flanagan, One Strong Voice (Kansas City, Mo.: The Lowell Press, 1976), p. 216. Printed with permission.

APPENDIX G
AMERICAN NURSES' ASSOCIATION: MODIFIED
FEDERATION MODEL--1982

American Nurses' Association
Organizational Structure



(1986)

SOURCE: American Nurses' Association, 1986, n.p.

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APPENDIX H
COMPARISON OF ANA MEMBERSHIP AND
ESTIMATED NUMBER OF GRADUATE
NURSES/REGISTERED NURSES

Table 1

Comparison of Membership in the American Nurses'
 Association and Estimated Number of Graduate
 Nurses in the United States, 1919-1948

Year	Number of ANA Members	Estimated Number of Graduate Nurses
1919	28,676	--*
1920	35,559	109,879**
1921	39,966	--
1922	42,609	--
1923	46,274	--
1924	47,970	--
1925	49,394	--
1926	54,933	--
1927	62,833	--
1928	71,787	--
1929	78,560	--
1930	87,036	214,292**
1931	109,013	--
1932	103,371	--
1933	98,557	--
1934	110,578	--
1935	120,522	--
1936	130,482	--
1937	138,092	--
1938	148,555	--

Table 1 (continued)

Year	Number of ANA Members	Estimated Number of Graduate Nurses
1939	157,461	--
1940	167,701	284,159***
1941	178,017	--
1942	183,344	--
1943	178,738	--
1944	178,415	--
1945	181,428	--
1946	176,307	--
1947	161,509	--
1948	164,160	--

*Data not available.

**Includes nurses who are gainfully employed.

***Includes nurses who are seeking work.

SOURCES: U.S. Department of Health and Human Services, Division of Nursing, "1984--A National Sample: Survey of Registered Nurses," unpublished data; American Nurses' Association, Center for Research, Statistics and Data Analysis, Facts About Nursing 84-85; American Nurses' Association, 1972 Inventory of Registered Nurses.

Table 2

Comparison of Membership in the American Nurses'
 Association and Estimated Number of Registered
 Nurses in the United States, 1948-1985

Year	Number of ANA Members	Estimated Number of Registered Nurses
1949	171,341	506,050
1950	175,785	--*
1951	173,201	556,617
1952	177,081	--
1953	173,340	--
1954	175,840	--
1955	177,490	--
1956	181,093	--
1957	181,366	734,402
1958	190,463	--
1959	173,242	--
1960	170,911	--
1961	169,998	--
1962	168,912	847,531
1963	151,943	--
1964	153,272	--
1965	159,101	--
1966	172,591	909,131
1967	204,704	--
1968	203,909	--

Table 2 (continued)

Year	Number of ANA Members	Estimated Number of Registered Nurses
1969	--	--
1970	181,115	--
1971	--	--
1972	166,676	1,127,657
1973	176,575	--
1974	196,024	--
1975	201,817	--
1976	198,884	--
1977	193,429	1,401,633**
1978	186,573	--
1979	181,212	--
1980	161,188	1,662,382**
1981	160,232	--
1982	160,922	--
1983	162,280	--
1984	180,716	--
1985	185,369	1,887,697**

*Data not available.

**Weighted population estimated derived from a sample of RNs.

SOURCE: American Nurses' Association, Center for Research, Statistics and Data Analysis, Facts About Nursing 84-85.

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