Historical Perspectives (Expanded Version)

Learning Objectives:

After completing this chapter, the reader will be able to:

1. Explain why studying the history of health care and nursing is important to the profession of nursing.
2. Name three “historical threads” found in the study of nursing history. Discuss why these are important.
3. List the key elements found in the healthcare practices of prehistoric societies and discuss how these are similar to and different from modern practices.
4. Discuss the Christian influences on health care and nursing.
5. Explain the importance of religious nursing orders in the development of the profession of nursing.
6. Discuss the influences of the Renaissance and Reformation on health care and nursing.
7. Name three early leaders in nursing and describe their contributions to the profession of nursing.
8. Describe the major changes in health care and nursing that occurred during and immediately after World War II.

## INTRODUCTION

Modern society is future oriented. Sharing in this futuristic orientation, the healthcare establishment, including nursing, continually looks toward developing technology and changes in the structure of society for guideposts to the future of the profession.

Many of the problems and difficulties found in the healthcare system today in general, and in the profession of nursing in particular, have their roots in the historical developmental process that has occurred over the centuries. A knowledge of these historical roots can help in understanding why the profession of nursing is the way it is and can even suggest solutions to problems that may seem unsolvable.

For example, nursing today appears to be a profession with a high level of responsibility but with a low level of self-determination power. How did this situation develop? What can be done about it? There is also a great deal of confusion about the educational preparation for professional nurses. Other healthcare professions do not seem to have this problem with education—why does nursing? How can this confusion be corrected?

A key characteristic of a profession is that it is essentially an intellectual and learned activity. An important element of being a learned activity is that those who belong to the profession have a lifelong commitment to learning and to the long-term development of the profession. Leaning about the profession’s past, understanding its development, and relating that information to its future growth is an important part of the process.

**Question for thought: What have you learned in past history courses that was important to you? What do you remember from your high school and college history courses?**

One of the difficulties in attempting to study history is that much of the information

seems to be unrelated. History is often presented as a series of isolated facts, such as people's names, major events, and dates that have to be memorized. The study of history begins to make sense only when these various and seemingly isolated facts are somehow interrelated to form a coherent picture that points the way to the future. One effective way to connect information that may at first seem unrelated is to find common themes or historical threads that weave their way through the fabric of history and are present to some degree at all times and in all places.

The history of health care and nursing has several of these common themes or historical threads. In attempting to understand why certain groups of people did what they did in relationship to health care, three elements seem to be always present:

- the group or society's beliefs regarding the cause of illness,
- the value placed upon individual life, and
- the role of women in that society.

In addition, the effects of wars, which often produce large numbers of wounded and injured, has had a major effect on the development of technology and the direction of health care.

The following presentation is not meant to be a thorough historical treatise on the history of healthcare and nursing. Rather, it presents some of the key historical milestones that form the general foundations of health care and nursing as it is practiced today. It is divided into three parts: Part I, Early Nursing; Part II, Nursing in the United States; and Part III, Nursing Leaders.

## Part I

## Early Nursing

### Health Care Without Nurses

From the viewpoint of modern health care, it is difficult to envision a healthcare system without nurses. Yet, nursing as it is practiced today is a recent historic development. The major concern of most early civilizations was the survival of the group. The most fundamental needs of survival were nourishment, shelter, and procreation. Because illness and injury threatened survival at the most basic level, it was also one of the major concerns of early civilizations. Early human history is marked by a trial-and-error process for meeting the basic needs for survival at all levels. Many primitive healthcare practices grew from this process.

## Prehistoric Civilizations

The study of prehistoric civilizations is limited by the lack of written records of their existence. Only through archeological findings and through observation of some "primitive" societies that exist today do scientists have a basic knowledge of the composition and function of these societies. It is generally accepted that these societies were tribal in nature, and while some remained rooted in one area, most of the tribes were nomadic. The constant search for new food supplies, as well as seasonal climatic changes, made the frequent movement of large groups a necessity.

In primitive societies, the women of the tribe often assumed responsibility for the survival of the society. These women were responsible for bearing children, feeding them, protecting them, and providing their basic education and socialization into the tribal culture. By extension of these roles, the women of the tribe also provided care for those who were ill or injured. Because the women were the only real stable element in the society, (men went off to hunt and to war, they were gone for long periods of time and often didn't come back) tribes were often matriarchal in structure.[1] Although it is difficult to determine the exact sociological

standing of women in prehistoric times, it would seem that in practice they were very important to the tribe.

Health, illness, and death were interwoven into the total life experience of prehistoric societies and often more related to religion and religious practices than to science and learning. Without even a rudimentary understanding of pathogens such as bacteria and viruses, the causes of illness and disease were often attributed to other world forces. Generally, three elements were thought to cause illness and disease in prehistoric societies.

- illness could be caused by an evil spirit entering a person's body;
- illness might be caused when a good spirit left the person's body, and
- certain types of witchcraft could be performed on the person's body that would cause illness or disease.

From this religious viewpoint of the cause of disease, modern medical practices such as giving the person antibiotics or placing them in isolation would make little sense.

Primitive societies had individuals who, over a period of time, had demonstrated a special skill in caring for those who were sick. These individuals were called by a variety of names, including witch doctors, shamans, root doctors, medicine men and women, or simply healers. They could be either male or female, and their treatments were a combination of religious practices and basic home remedies discovered through trial and error.

Treatment regimens of prehistoric healers were steeped in magic, and the functions of healthcare providers included influencing the spirit world through the use of charms, magic incantations, dance rituals, potions made from herbs and plants, body massage, and even hypnosis. Some evidence indicates that primitive surgery techniques such as drilling holes in the

skull (trephining) and blood letting were practiced to help release evil spirits from the client's body.[2] Such healthcare practices quickly developed into ritualistic religious ceremonies and rites, so the healer also became the tribe's key religious figure.

**Question for thought: Name several home remedies or ritualistic health practices used in your family. How did these develop? Is there any proven success in their use?**

In some tribes, healers became a separate social class, and the knowledge of their rituals and practices were passed on to new healers through an apprenticeship system. No hospitals existed, and all of the care of the sick or injured was given in the home setting.

Although the lives of each tribe's own members were of high value due to the need to continue the existence of the tribe, individual human existence as a philosophical concept probably was not as important to these groups. Life expectancy was very short, so individuals who reached their 30s were a rarity. Death was an ever-present companion to these tribes, and the intimate nature of war in prehistoric society made death a very personal matter.

Ancient Civilizations

*Ancient* is a relative term but generally refers to civilizations that existed from the earliest recorded history to the early part of the Christian era. The dates range from about 4000 B.C. to A.D. 476. In some of these ancient civilizations, health care and the practice of healing was very important and showed advanced development. In other civilizations, healthcare practices took a back seat to the concerns of government and territorial acquisition.

Asian Civilizations (3500 B.C.–A.D. 500 )

While the Asian civilizations have some of the oldest recorded history known, it was only in

relatively modern times that knowledge of their healthcare practices came to the attention and understanding of the Western world. Several groups can be identified in this culture, but they share many common elements. Similar to prehistoric civilizations, health care for the Asian civilizations was intertwined with religious practices.

The earliest religion of this culture was based on the teachings of Tao (Taoism), which held a fundamental belief in a balance in all things. The terms *yin* and *yang* have their origins in Taoism and represent the intermingling of heaven and earth. The yin was viewed as a feminine force, which was primarily passive and negative in nature. The yang was seen as a masculine force and was aggressive, positive, and active in nature. Although these two forces are in constant competition with each other, they also act to complement each other and produce a state of balance.

Health, in Taoism, is the state of balance. Illness occurs when the balance no longer exists. The "out-of-balance" state of illness was often attributed to the actions of "disease demons" from the other world. As a result, much of early Chinese medicine and health care revolved around driving demons from the client's body by such methods as noisy firecrackers; potions made from paper with magic symbols written on them; and teas made from special herbs, roots, and ashes.

As their civilization evolved, a more modern approach was incorporated into the ritualistic treatments of the earlier periods. These practices included the use of assessment techniques such as observing the client, asking questions, and feeling the pulse. Acupuncture also developed during this time and was used as a mode of treatment to bring the opposing forces of the yin and yang back into balance in the client's body. An interest in preventive health care

also was evident in the use of medicinal herbs, some of which are found in medications and food supplements used today. Surgery was performed on a limited basis but included such practices as blood letting, suturing of wounds, and castration of the male slaves who worked on the palace grounds. Massage and hydrotherapy were also used in the treatment of disease.

**Question for thought: Is acupuncture a valid mode of medical treatment? Do you think it really works? Why?**

Because of the interrelationship of healthcare practice and religion, when the religion changed, healthcare practices also changed. A major change occurred in China around 500 B.C. when Confucius became the primary religious and political leader. Although he continued many of the earlier practices, he emphasized the importance of ancestor worship, family unity, and the use of knowledge in all things, but he further degraded the role of women in society.

Historically, the role of women in China had always been one of inferiority. The main value that women had, besides managing the home, was their ability to bear sons to continue the family name. Confucianism stressed the inferiority of women to men and lowered their status even more. The mere thought of women working outside of the home would be sacrilegious to the follower of Confucianism.

During the pre-Confucius period, there was some evidence that certain small areas of the temples had been set aside for healing prayers and practices. These areas could not be called hospitals or clinics in the modern sense. They were more like chapels and were staffed exclusively by male priests. After Confucianism was accepted as the state religion, these prayer areas or healing halls were closed, and families were expected to care for their own ill or injured at home. There is no evidence of any group that might be considered nurses, although in the

home setting, the care was provided almost exclusively by women.

Around 200 B.C., Buddhism had spread from India and began to replace Confucianism as the major religious belief in China. Present-day Chinese medicine is a complex mixture of ancient religious practices, traditional healing methods, and modern Western technology.

Southern Asian Civilizations (3000 B.C.–A.D. 1000)

The modern-day countries of Pakistan, Bangladesh, Nepal, Bhutan, and India were all settled by an Aryan people who migrated from the West around 3000 B.C. During the early years of this civilization, these settlers intermingled with the native residents of the region, and by 2500 B.C., a highly developed culture existed. They had a well-developed written language, which showed evidence of the use of geometry, trigonometry and the decimal system.

By 1600 B.C., the predominant religion was Hinduism (Brahmanism). Hinduism has as its main creeds a belief that everything in nature is a part of god (pantheism), that the state of nothingness is to be sought through prayer and meditation (nihilism), that the soul never dies but is reborn after death (reincarnation), and that the form of the soul's rebirth is always different and may be in the form of an animal (transmigration). After a long series of reincarnations by which the person demonstrates that he or she can live a "good life," the soul is united with the supreme being and no longer is reincarnated. Although not clearly delineated, illness and disease were thought to be caused by violation of the religious laws and by outside forces that entered the body.

These religious beliefs and practices (codes of conduct) were written down in four books (Vedas) that also serve as a historical record of this civilization. Intermingled with the religious creeds in these books were rules that affected the health and well being of the culture. There was

a strong emphasis on good hygiene, as well as descriptions for the use of magic charms and rituals for the cure of disease, treatment of trauma, and promotion of fertility.

By 700 B.C., the main Vedas were supplemented with writings that indicated a well-developed practice of surgical procedures performed under sedation and included the removal of tumors, hernia repair, tonsillectomies, blood letting, and Cesarean deliveries. Strict rules of cleanliness had to be followed when performing surgeries. There is also evidence of the medical treatment of such diseases as hepatitis, tuberculosis, leprosy, and diabetes mellitus. Hindu physicians had a large group of drugs and pharmacological preparations at their disposal made from a number of plants and herbs.

The first evidence of the existence of places outside the home for the care of the sick and injured (hospitals) is also found in this culture. These first hospitals were for the upper class and were staffed by groups of men who both cared for the sick and attended to the demands of the physicians. Although not named as such, based upon their job descriptions, these men could probably be called nurses. The physicians, as both healers and religious leaders, had a dual task of curing the sick and enforcing the codes of conduct. Both the codes of conduct and general Indian law forbade women from working outside the home. Indian law established a strict, four-level caste system that forbade movement between the levels. Women were generally classified on the lowest levels of this system.

Major changes in the social, religious, and healthcare structures occurred in this culture around 530 B.C. In Buddhism, the chief goal of all people was to achieve a total inner peace of nirvana (nothingness) through prayer, meditation, and penance. Because it was possible for all people to attain this inner peace equally, the caste system gradually became meaningless in

Buddhism. The codes of conduct lost its influence, and by 200 B.C. were replaced by the Laws of Manu. Very similar to the Ancient Hebrews' Mosaic Laws, these new rules took a more democratic approach to society. Public hospitals were established, and both physicians and nurses where held to high standards of conduct. There was even a primitive form of licensure for physicians whereby they had to demonstrate that they were competent in medical practice and were of high moral character. The majority of the hospital workers were still men, but the breakdown in the caste system allowed some older women to care for the sick in these early hospitals. Later on, however, as Buddhism lost its influence, many of the hospitals were disbanded, and society drifted back toward the caste system of Hinduism. India today is a mixture of these two religions in which women, for the most part, are considered second class.

## North African Civilizations (4000 B.C.–A.D. 1900)

The lives and very existence of the ancient nomadic desert tribes of North Africa centered around water, much as they do today. The Nile River became the focal point for many of these tribes, who eventually united to form the great ancient Egyptian civilization. As one of the best organized of the ancient civilizations, the settlers of the Nile River were among the healthiest people in the region and had a very progressive healthcare system for their time in history.

As with other ancient civilizations, religion was the cement that held together many elements of Egyptian society. Although some diseases and illnesses were attributed to the work of evil spirits and punishing gods, Egyptian healthcare providers were able to transcend these beliefs and showed a well-developed understanding of basic disease processes.

Egyptian writings dating to 1500 B.C. list 250 known diseases and more than 700

medicinal preparations that could be used to treat these diseases. Purgatives were especially popular. These writings also describe the use of a large number of surgical procedures, the practice of dentistry, and the use of the midwife, trained in schools of midwifery, for deliveries. Bandaging became a well-developed art used not only on those who had traumatic injuries but also in the preparation for burial of the dead.

**Question for thought: Why were purgatives and the practice of blood letting popular in ancient cultures? Are these practices still used today?**

Egyptian society also demonstrated an understanding of preventative healthcare practices. It had strict laws concerning personal hygiene, the preparation of food and drinks, and the need for exercise, and it forbade promiscuous sexual relations. Community planning was an important element in Egyptian society and was demonstrated in a water delivery system that protected the supply from pollution and in an advanced sewage system. Birth control was also practiced.

Overall, the Egyptians seemed to have a rather high respect for life, particularly for their own citizens. The lives of the slaves they acquired as their empire expanded were of a much lesser value. Although the majority of the care of the sick still took place in the home setting, there is evidence of the establishment of rudimentary hospitals. These were often called "houses of death" and were used to isolate dying persons from the healthy. A trip to an ancient Egyptian hospital was usually the last trip the person ever took.

Because women in Egypt enjoyed a higher status, more freedom, and greater dignity than women in the surrounding regions, the hospitals were staffed by both men and women.[1] Although they really had no word equivalent to the modern term *nurse*, Egyptian hospital workers could easily be identified as nurses from the description of their duties. These duties

included feeding tetanus victims, bandaging wounds, bathing clients, and providing emotional support for the dying. However, the physicians were exclusively men and often functioned in multiple roles such as surgeon, priest, architect, politician, and magician.

**Question for thought: Multiple roles for physicians in ancient cultures was the norm. Would that practice work in today's healthcare system? Why or why not? Do you know of any physicians who have multiple roles?**

Southwest Asian Civilizations (2500 B.C.–A.D. 1000)

The nomadic tribes of Southwest Asia lived and developed as a great empire in what is often called the Cradle of Civilization. Initially existing as separate and independent city states, they united in 2100 BC and formed the powerful Babylonian Empire.

A key element in both the religious and healthcare practices of the Babylonians was the study of astrology and mathematics. It was believed that illness was caused by actions that displeased the gods and allowed evil spirits to enter the person's body. Therefore, the primary focus of Babylonian health care was dedicated to driving these evil spirits from the person's body. Major healthcare practices to achieve this goal included special diets, massage therapy, and extended rest periods. Babylonian physicians also used strong purgatives made of plants, crushed stones, and animal feces to rid clients' bodies of evil spirits.

A unique practice found among this culture was the use of the marketplace as a source of medical information. It was not uncommon for individuals who were ill to go to the marketplace and ask people who were passing by to look at them and tell them what disease they had. The passerby, if he or she knew or surmised what the illness was, would make suggestions for treatment that the ill individual could try at home.

Later, as the Babylonian culture developed, laws were written governing medical practice. The sixth king of Babylon, Hammurabi, put into force what is now known as the Code of Hammurabi. In addition to laws that covered criminal and civil conduct, it included strict laws governing the fees physicians could charge and punishment for physicians who were incompetent and injured clients. Babylonian justice was swift and decisive. A surgeon whose client died after surgery might have his hand amputated as a punishment. Babylonian writings show evidence of a system of child care and treatments for such diseases as fever, jaundice, cardiac abnormalities, and tuberculosis.

The status of women in this part of the world was, and still remains, one of subjection and dependence.[1] As the empire succumbed to the oppressive rule of Islam, the status of women fell even lower. Care of the ill and injured was carried out at home, and there is no evidence of institutions such as hospitals or any groups that could be identified as nurses. As this civilization began to decline, the Code of Hammurabi lost much of its influence, and medical practice reverted back to a more primitive, magical stage.

### Southeast Mediterranean Civilizations (2000 B.C.–A.D. 500)

At the same time nomadic tribes were settling in the area between the rivers called Babylon, others of these same tribes migrated to the West and took up residence along the Mediterranean Sea. Referred to by the Babylonians as the “people from beyond” (Hebrews), these tribes built towns in the Jordan River Valley and eventually became a nation by 1900 B.C. Through the process of assimilation, the Hebrews adopted many of the religious and healthcare practices of their neighbors.

A major chapter in the history of this nation was its conquest by the Egyptians and eventual escape under the leadership of Moses. Much like the other cultures of the region, the early Hebrews believed in many gods but came to realize early on that one of these gods was supreme over all the others. During the time they spent in slavery in Egypt under the influence of an Egyptian emperor who advocated monotheism, the Hebrews began to believe that there was only one God. Although the Egyptians later reverted back to polytheism, the Hebrews remained monotheistic, a factor that set them apart from their neighbors.

Under the guidance of Moses, the Hebrew nation combined its strong monotheistic belief with Egyptian sanitary laws to form the Mosaic Code that eventually regulated all elements of their lives. Similar to other ancient cultures, religion and medicine overlapped in many areas of practice.

The Hebrews struggled to understand the concepts of good and evil, and particularly to understand why disease and misfortune befell good people. Illness and misfortune were generally attributed to the will of God and often viewed as punishments for violating the Mosaic Law. A major element of the Hebrews' healthcare practices was aimed at appeasing God through animal sacrifices and purification rituals. The Mosaic Law also included very specific rules that governed hygiene, food preparation, isolation of individuals with diseases, menstruating and pregnant women, and childbirth. Even today, these laws from the Mosaic Code include many sound healthcare practices that can prevent or limit the spread of disease. In ancient times, these laws were necessary for the survival of the nation.

Women were held in higher esteem in the Hebrew culture than they were by their Islamic neighbors to the east. Human life had a high value, and human sacrifice of any type was strictly

forbidden. The Mosaic Law encouraged the care of widows, orphans, the poor, and even strangers, as a part of their daily lives. They established roadside houses where strangers could stay and where sick travelers could be given care. These roadside houses were not hospitals, and no particular groups of people were identified as caregivers or nurses.

Primary care of the sick was given at home by a family member. Hebrew writings reveal rather advanced medical practices for their time. Operations, such as Caesarian sections, amputations, and circumcisions were routinely performed. They had a good knowledge of anatomy and physiology, particularly of the circulatory system. As in other ancient cultures, the priest and the physician were often one in the same individual. Besides performing surgeries and ministering to the ill, the physician/priest was also responsible for enforcing the rules of purification, performing sacrifices, and conducting the rituals associated the preparation of food.

Aegean Peninsula Cultures (1500 B.C.–A.D. 500)

The first indications of life on the Aegean Peninsula can be traced back to as early as 4000 B.C. By the time the Greek civilization flourished on this rocky strip of land that juts into the northern Mediterranean Sea, several cultures had already come and gone. Modern-day Greeks are descendants of the bellicose Aryan tribes from the North who invaded and conquered the peninsula as they migrated south.

Early Greek religion (1000–450 B.C.) and its associated healthcare practices were marked by a belief in a multitude of powerful gods who had very humanlike faults, including jealousy, anger, revenge, and lust. Illness and disease was thought to be the work of demons, evil spirits, or disgruntled deities. Early Greek medical practitioners therefore spent a great deal of time

attempting to appease displeased gods and exorcising evil spirits from the ill individuals' bodies. Apollo was the god of medicine and good health. One of Apollo's sons by a human mother, Asklepios, was considered to be the chief physician and was pictured holding a staff wrapped with the sacred snakes of wisdom and immortality. This staff with its encircling snakes most likely forms the model for the modern-day caduceus, the symbol of medicine.

In an attempt to please Apollo, Asklepios, and other gods who could cause illness and disease, the Greeks built magnificent temples where animal, and sometimes human, sacrifices could be offered. At certain times, in certain locations throughout Greece, a rather low value was placed on human life. Abortion and infanticide were practiced as methods of birth and population control.

In addition to areas for sacrifice and prayer, the temple or sanatorium often included separate areas where hot baths could be taken in special mineral water to improve health. These temples served as health spas with both men and women attendants. Unlike hospitals, the temple spas forbade people with diseases, terminal illnesses, or pregnant women from entering. The attendants at these spas did not function as nurses. The priests at the temples combined their priestly duties with the duties of the physician.

Over time, a type of ambulatory clinic (*iatrion*) developed away from the temples for the care of sick or injured travelers. These clinics were often combined with shelters for strangers (*xenodochium*) and formed a primitive type of hospital where some basic sick care could be provided. Later Greek writings discuss methods for caregiving, such as bathing clients, special diets for clients with heart and kidney diseases, use of poultices, and changing and smoothing bed linens.

Although women where held in relatively high esteem in the Greek culture, they were not permitted to practice any of the arts. It is most likely that nursing care given outside the home was provided by men.

The major change in Greek medical and, to some degree, religious practice came around 400 B.C. with the writings of Hippocrates. He originally belonged to a group of priest/physicians who traveled the countryside providing services to small villages and towns. This band of roving physician/priests placed more emphasis on their physician duties than on their priest duties. Often called the father of medicine, Hippocrates came to believe, and eventually taught, that disease was the result of failure to follow the natural law rather than the result of the actions of disgruntled gods and spirits. The work of the physician, according to Hippocrates, was to help the client regain harmony with nature and the natural law, not to appease gods or exorcise demons.

**Question for thought: How is the medicine practiced by Hippocrates similar to the medical practices found in ancient China? How are the two different?**

Some important methods to achieve this harmony with nature included good personal hygiene, eating a balanced diet, and avoiding excess in all things. Hippocrates believed in treating the whole client—mind, body, spirit, and environment—as well as making diagnoses based on observation of client symptoms rather than on the disease itself.

Other contributions made to healthcare practice by Hippocrates and later Greek physicians included a method for thorough and systematic client assessment, use of case studies as learning tools, and the establishment of high ethical standards. Hippocrates was particularly concerned with ethics and ethical standards because of his experiences with unethical physicians

who injured clients and overcharged for their services. While the Hippocratic Oath may seem archaic by today's standards, it does contain many sound ethical principles upon which good nursing and medical practice can be based.

**Questions for thought: Read the Hippocratic Oath. List the ethical principles found in this document in today's terminology. What parts of the oath do modern physicians commonly violate? How could this document be modified to fit modern healthcare practices?**

Hippocrates also authored many books that covered a range of subjects, such as bathing, bandaging, and the treatment of fractures. He liked to use the case study approach in his writings and teaching and even wrote of treatments that were ineffective so that others would not make the same mistakes.

Culture of the Roman Peninsula (750 B.C.–A.D. 476)

The most modern of the ancient cultures, ancient Italy, because of its central geographical location, was an eclectic culture from is very earliest origins. The Roman passions for organization, building, and knowledge soon became evident as the small towns and cities became organized into a powerful empire. By 290 B.C., Rome was the capital city of central Italy. Over the next 150 years, a series of farsighted and aggressive dictators formed the country into a powerful and feared empire.

Despite their sophistication in construction techniques, government, and conducting war, the Romans clung stubbornly to superstitions and polytheism as the foundations of their religious and healthcare practices. Because of the eclectic nature of this people, when the Romans conquered a new civilization or country, rather than completely destroying it, they tended to

absorb and incorporate the useful elements of its culture into their own practices.

The Romans attributed disease, injury, poverty, and death to actions that displeased the gods. Health, prosperity, and long life were, the Romans believed, the result of performing actions that pleased the gods. Because there was a god for almost every illness, injury, or physiological state, a large portion of Roman healthcare and religious practice centered on appeasing these various deities. But basic Roman practicality also allowed them to keep as slaves healthcare providers captured during their conquests of other lands. It was not unusual for rich, upper-class Romans to have Greek physicians as their personal slaves who both provided healthcare services when they were sick and acted as tutors for their children.

Despite their deeply rooted beliefs in the supernatural cause of diseases, the Romans managed to develop a relatively advanced system of medicine. Again, borrowing heavily from the knowledge of the Greeks, Hebrews, and other conquered nations, the Romans developed a pharmacology of over 600 herbal and plant medications. They also adapted and improved upon the Hippocratic method of observation and diagnosis, eventually being able to diagnose as separate diseases such condition as epilepsy, diabetes, tetanus, pneumonia, malaria, and diphtheria. A large number of surgeries were also performed by Roman physicians, including Cesarean births (where the term originated), tracheostomies, amputations, and appendectomies. Other healthcare practices of the Romans included physical therapy for athletes; diagnosing the symptoms of infections; identifying mercury, lead, and asbestos as the causes of job-related illnesses; and the publication of several medical texts.

Perhaps the Romans' greatest contributions to health care were more related to their ingenuity in construction than to their passion for health. They understood early on that a clean,

unlimited water supply was necessary to maintain their large cities. Construction of the great aqueducts that brought water from the mountains hundreds of miles across the country to Rome and other cities is considered, even today, an astounding accomplishment. The Romans also drained and filled marshes and swamps, which helped eliminate diseases found in these areas. They built baths and spas in their houses that helped maintain good hygiene, had central heating for their houses, and moved cemeteries out of the cities to surrounding hills and countryside. Although they still used open sewage systems in their cities, these were routed around heavily populated areas and were a major improvement over previous systems of sewage disposal.

The value of human life in the Roman Empire was relative to the individual's standing in the social system. Official citizens of Rome enjoyed many benefits and a high standard of living. For noncitizens, including slaves, travelers, and transients, it was a different matter. Human sacrifice of slaves was not uncommon in the great temples of Rome. Slaves were considered mere pieces of property to be used and disposed of as necessary. For noncitizens, crucifixion was a standard form of punishment for a variety of relatively insignificant crimes. Citizens of Rome could not be crucified, no matter what the crime. Gladiator contests to the death were a common form of Roman entertainment.

Because maintenance of the great Roman armies was an absolute necessity for the protection of the empire, early hospitals were established to take care of sick or injured soldiers. Much like Mobile Army Surgical Hospitals (MASH units) used during the Korean war or the more modern Combat Support Hospitals, the Roman hospitals were located close to the battlefield and could be relocated as the battle front moved. The Romans also practiced a type of first aid for soldiers who were injured in battle, and they invented a transport system to get these

fallen men quickly to field hospitals. The field hospitals were staffed by both male and female attendants, and many of the services they provided could be included under the umbrella definition of nursing care. They cleaned wounds, bandaged injuries, fed and cleaned clients, and provided comfort and solace to the wounded and dying.

**Questions for thought: Why were abortion, infanticide, and human sacrifice so widely accepted in ancient societies? What differences in modern society make these practices less acceptable?**

Roman women, particularly women who were official citizens of Rome, enjoyed a much higher social status than any of their predecessors or contemporaries in other parts of the world. Women pursued activities and employment outside the home and could own property in their own names. They participated as equals with men in business and politics and could dine at table with the men as equals. Midwives were common and assisted with births in the home setting. Because hospitals were restricted to the military, most of the everyday, nonmilitary sick care was provided in the home by women.

Early Efforts at Nursing

Christian Influences on Nursing (A.D. 30—)

Born at the pinnacle of power of the Roman Empire, Jesus of Nazareth grew and developed in the conquered but politically stable and well-protected region of Palestine. Because of the Roman "hands-off" policy that allowed conquered regions to maintain their own religions, social practices, and even governments, as long as they paid taxes to Rome and were not too disruptive, Jesus was able to travel throughout this region and preach his message of the fatherhood of a loving God who offered salvation and redemption for everyone. Expanding upon

concepts found in the Hebrew scriptures, he taught his followers to help and care for all people, including enemies, even to the point of personal sacrifice and death, because of the equality of all humans as brothers in the sight of God.

Converts to Jesus' teachings came from all religions, all races, and all nations protected under the umbrella of the Roman Empire. During this early period, Christian communities were established throughout the Roman Empire, but they were small and very loosely organized with no central hierarchy. As time went on and the first followers of Jesus began to die, the Christian community realized that perhaps the second coming was not going to happen right away, and more organization was needed.

As Christianity spread and became more organized, it became a threat to the Roman Empire. Being a Christian became more and more dangerous. Although Roman citizens who were also Christian still could not be crucified, other unpleasant forms of punishment and execution could be carried out. Noncitizen Christians were crucified in large numbers when caught practicing their beliefs.

In general, Christianity brought a strong belief in the sanctity of all human life to an otherwise brutal society. Early Christians viewed common Roman practices such as human sacrifice, infanticide, and abortion as forms of murder. Slavery was also condemned by the Christians, and rich Roman citizens who became Christians were encouraged to free their slaves and treat them as equals.

Although still struggling to understand the cause of disease and illness, the early Christians saw value in personal suffering as means of purification useful in gaining eternal salvation. Care of the sick, poor, and disadvantaged was of primary importance in Christianity,

and groups of believers soon became organized to provide services to those in need.

Due to its development in and throughout the Roman Empire, early Christianity viewed women in much the same way as the Roman civilization did. The early writings of the Christian period record that women played an important role in the development of the faith and in providing services to the sick and poor. Specific groups of women had specific tasks. Virgins ministered to the sick; widows provided care and food for the poor and homeless. A group of Christian women known as deaconesses were responsible for conducting religious ceremonies when the male ministers were absent from the community.

As the wealthy women of the Roman Empire were converted to Christianity, both the quantity and quality of the care of the sick and poor increased. These women established convent-like residences in their homes for groups of women who dedicated their lives to care of the sick and poor. Some converted their rich and spacious palaces into hospital-like institutions where the sick could be given care and also hear the teachings of Jesus. The origins of the term *nurse* is often attributed to this early Christian period during the height of the Roman Empire. Derived from the Latin word *nutrire*, meaning to nourish, nurture, or suckle a child, the key element in understanding the term is the practice of providing care for someone who cannot care for himself or herself.

**Questions for thought: Is the word nurse the best title for what the modern profession does? What other titles might be more appropriate?**

The majority of the early Christian hospitals existed in the form of roadside houses for the sick or injured, called *diakonia*. In these sick houses, care was provided to the poor, the destitute, or the traveler who could not get home. Both male and female attendants rendered this

care. Again, although not officially called nurses, much of the care they provided certainly would fall into the category of nursing care. There were no formal schools or training programs for these care providers, and their skills were learned through a trial-and-error process as well as through observation of others who were giving care. If not particularly sophisticated, the care in these roadside hospitals was at least sincere and given in a loving and helpful manner. The majority of the care given for the sick or injured was still provided in the home setting by a family member.

## Nursing in the Medieval Period (476–1453)

The 1,000 years that comprise the medieval period also form the transition time between ancient and modern eras. Also known as the Middle Ages, the medieval period itself is roughly divided in half.

The first 500 years of the medieval period, up to A.D. 1000, is known as the Dark Ages. The Dark Ages were marked by a general disintegration of organized government, little interest in learning and scientific development, and widespread poverty, illness, and death. What political control existed was in the form of feudalism in which a rich lord owned large tracts of property; the common people (vassals or serfs) worked the land and paid the lord a portion of their crops as taxes.

Health care during the Dark Ages was, in general, dismal. Widespread plagues, particularly the bubonic plague, or black death, ravaged the known world and killed a large percentage of the population. Other diseases, such as smallpox, leprosy, and diphtheria, also took a large toll in human life, sometimes killing up to half of the entire population of a country. What

little health care there was under the feudal system was provided by the lady of the manor, who was untrained and could do little except make the serfs comfortable before they died.

The one element that did act as a unifying factor during the Dark Ages was the Church of Rome, or Catholic Church. While many of Jesus' important teachings had either been forgotten or changed into an unrecognizable form during the Dark Ages, the institution itself, with its well-structured hierarchy and classical Roman passion for organization, acted as a pillar of stability that gave a meaning and direction to an otherwise drifting society. Both the lords and their serfs clung tenaciously to their beliefs in the Church, making it the single most powerful religious and political entity during this time period.

Health Care Through Religious Orders

One outgrowth of this strong if unsophisticated faith, when combined with the abject poverty of the majority of the population, was the establishment and growth of monasteries and convents. Those men who joined monasteries and women who entered convents believed that salvation required withdrawal from the materialism of the world, individual self-denial, and a life dedicated to prayer. Based upon the "rules" as established by St. Basil, St. Augustine, St. Benedict, or St. Francis, those who entered the monastic way of life were required to take vows of poverty, chastity, and obedience. These religious communities were originally designed to be small, self-sustaining, independent communities, but under the organizational skills of their leaders, they quickly developed into large institutions that housed hundreds of individuals and encompassed hundreds of acres of land within their boundaries. The size, wealth, and power of some of the largest monasteries were sometimes viewed as a threat to the security of the local feudal lords.

As the monasteries grew and attracted individuals with a variety of talents, skills, and interests, they became the centers for learning and culture in a society otherwise devoid of these activities. Although little new learning or scientific development took place in the monasteries, at least they preserved the literature, scientific, and religious teachings from earlier ages. Because of a dedication to the teachings of Jesus concerning the care of the disadvantaged, some of the monasteries and convents became centers for the care of the poor and the sick. A split soon developed between those orders that were strictly contemplative, dedicating their lives to prayer and sacrifice, and those orders that were more socially active and combined lives of prayer and sacrifice with providing care for the poor and the sick.

By A.D. 500, several religious nursing orders had been established throughout modern England, France, and Italy. These orders were both male and female. They provided care to the sick in established hospitals and also traveled to rural areas to provide services. Initially located inside the monastery walls, independent freestanding hospitals were eventually built off the monastery grounds.

An offshoot of the monastic way of life was the development of secular or lay orders such as the Alexian Brothers. Organized and operated much like religious orders, the lay orders had fewer religious restrictions and obligations and could provide a wider range of services to the sick. The individuals who joined these secular orders did not profess life-long vows as the religious orders did and could leave the order after a designated period of time.

Although the health care provided by these religious orders seems primitive by today’s standards, it was the best that was available during a bleak period in the history of the world. Human life was valued in and of itself, and anyone entering a monastic hospital for care could

anticipate being treated with the most compassionate and best care available. However, concern for the salvation of the sick person's soul often superseded concern for his or her physical healing. The care that was rendered in the monastic hospitals was often based more on a blend of religious rituals and home remedies than on principles developed through scientific methods.

Nevertheless, there is evidence that these early religious nurses, both men and women, carried out such treatments as bandaging, cautery, blood letting, enemas, and leeching. Special emphasis was given to diets and bathing, and perhaps one of the biggest contributions to health care during this time period was the devotion to cleanliness and hygiene that lessened the spread of infections. Monastic hospitals were well known for their obsessively sanitary conditions.

There is little evidence of any formal schools that taught the skills required to care for the sick. Rather, medieval nurses training consisted of an apprenticeship system whereby a new monk or nun was assigned to an older member of the community to learn whatever skills were required to provide nursing care.

## Health Care Provided by Military Orders

The end of the Dark Ages was marked by a series of invasions and wars against the Moslems to recapture the Holy Lands. Under Pope Urban II, a Holy War was proclaimed against the religion of Islam, resulting in the Crusades.

Because the Crusades involved the movement of large numbers of troops, all their support services, and even their households across several thousand miles of difficult terrain, over many months, Christian churches and even towns were built along the route. Like most wars, the Crusades also produced large numbers of sick and injured who were far away from

home. The need for care of these crusaders was met by the development of military nursing orders composed exclusively of male religious devotees who provided both first aid on the battlefield and long-term care in crude hospitals set up in Jerusalem. The best known of these military nursing orders was the Knights Hospitallers of St. John.

Because they often had to defend themselves, their clients, and the hospital itself against attacks, these military nurses wore suits of armor. Their emblem was the red cross, which came to signify care for the sick, injured, and needy. The military nursing orders established during the Crusades were well organized, very dedicated, and particularly difficult to disband. They became powerful entities in themselves and existed in one form or anther well into the Renaissance period.

## Development of the Modern Nurse (1350–1600)

### Influences of the Renaissance

Although the seeds of modern nursing had been planted during the Dark Ages with the development of religious nursing orders, it took the sunlight and rain of the Renaissance for nursing to sprout into a recognizable form. But nursing was not to grow at a steady pace during this time period. Not unlike occurrences in contemporary nursing, its development was marked by rapid growth spurts offset by episodes of growth retardation. Major political changes initiated by the Reformation was the one element that had the most effect on the health care of the period.

The Renaissance was a time of intellectual reawakening for much of Europe. Starting in Italy around 1350, the curtains of ignorance and superstitions of the Dark Ages were slowly rolled back across all of Western Europe as new discoveries, inventions, and philosophies were

developed. Names associated with the Renaissance include Galileo, Copernicus, Descartes, and Newton. Crude forms of such inventions as the microscope, thermometer, pendulum clock, and telescope can be traced to this time period, and these inventions eventually led to discovery of other new knowledge. Within this renewed interest in learning lay the philosophical, political, and religious seeds of discontent, which were to come to full bloom some 100 years later.

Initially, the healthcare establishment that had developed during the Dark Ages had a great deal of difficulty in applying the new learning to the actual care of clients. Most health care of the early Renaissance was still being provided in hospitals run by religious organizations. With over 500 years of tradition and development, the monastic hospitals viewed the primary goal of care as the salvation of the sick individual's soul, with the restoration of health and cure of illness only a secondary goal. Use of more modern methods of diagnosis and treatment of disease were often viewed as disrespectful, improper, or even the work of the devil.

**Question for thought: Name several common modern healthcare practices that would have been viewed as disrespectful, improper, or works of the devil by medieval monastic healthcare providers.**

Influences of the Reformation (1517)

The origins of the Reformation are usually attributed to Martin Luther (1483–1546) of Germany. Although widespread discontent with certain religious and political structures of the Roman Catholic Church had been stewing for many years, Martin Luther, a Catholic monk, brought the issue to a head.

Health care in the Catholic nation-states, including Italy, France, and Spain, generally remained unchanged from that of care established during the Middle Ages. The religious

hospitals run by monks and nuns still provided a consistent, if somewhat primitive, form of health care. During this period, the number of male nursing orders gradually decreased, so by 1500, almost all the healthcare providers were nuns. New technologies were generally shunned, and nursing education continued under an apprenticeship form. There was little education for physicians beyond the knowledge gathered in the libraries and hospitals of monasteries.

Major changes in health care occurred, however, in the nation-states that broke away from the Catholic Church, such as England, Germany, and the Netherlands. The large monastery and convent hospitals had been rich and powerful centers of the Catholic faith. They were now seen as a security threat to the new Protestant leadership. The property the monasteries rested on was confiscated, and the monks and nuns of the nursing orders were expelled from these countries.

With no other healthcare structures in place to assume their functions, health care in these countries soon degenerated to a point worse than that of the early Middle Ages. Under Protestant political and religious leadership, the status of women was gradually reduced from one of importance in the care of the sick and homeless to a level of subordination and dependence. Women were forbidden to work outside the home, and it was believed that their primary role was the care of the home, the bearing of children, and fulfillment of their husbands' needs.

Eventually, crude hospitals were established in larger metropolitan areas to provide care for those who could not be attended at home. Because women of the upper classes were forbidden to work outside the home, these hospitals were often staffed by those members of society who belonged to the lower socioeconomic groups, including prostitutes, alcoholics, opium addicts, and convicted prisoners. Working in these rudimentary hospitals was hard, with

long hours and poor pay. Some nurses supplemented their meager earnings with property and money taken from the patients. The hospitals were often filthy, filled with fouled linens and human excrement. The care provided was substandard, and nursing in these countries was viewed as the lowest and most menial form of work that a woman could undertake. Male caregivers were not to be found in these hospitals, and the male nurse all but disappeared during this period.

Out of the healthcare chaos of this period developed secular nursing orders of nuns who gradually took over the care duties in these hospitals. The most famous of these orders, the Sisters of Charity, was established in 1600. Although the care and services provided by these orders was minimal, the general sanitation and ethical standards of the hospitals improved greatly. Also seen in hospitals run by nursing orders was the development of a nursing hierarchy. The primary nurses were called sisters, and those designated to help the sisters provide care were called helpers and watchers. Although often no clear distinction in duties among these groups was made, the overall benefit of competent, skilled nursing care was beginning to be recognized.

Other positive developments in health care that occurred during this period included the writing of the first nursing textbooks and the organization and widespread use of midwives in the delivery of babies. William Harvey (1578–1657), called the father of modern medicine, was born in England, where he made major contributions to medical practice. A more modern understanding of the microbial origin of many diseases developed. Joseph Lister began to understand how disease was spread, and he developed aseptic practices that are still used today. In France, Louis Pasteur discovered that bacterial organisms could be killed by heat, and the process of pasteurization was born. Although medical education was developing, it was still

under an apprenticeship system and involved the use of many home remedies. There were no standards of care for care for either nurses or physicians, and many abuses existed. Although hospitals were gaining importance, the majority of health care was still given in the home.

## Influences of the Industrial Revolution (1850–1950)

One side effect of the intellectual reawakening of the Renaissance period was the rapid development of new manufacturing technologies. Up to this time, Western Europe had been a rural society, with most of its population living on small farms where they grew, raised, and made what they needed to survive. The majority of the clothing, furniture, tools, utensils, and equipment they required for day-to-day living was either made on the farm or manufactured by hand locally. The Industrial Revolution introduced technologies that could centrally produce large amounts of material goods, quickly and at a reduced price.

During the Industrial Revolution, the role of cities changed from centers of trade and social interaction to locations for the new factories and cramped dwellings. Starting as a slow trickle, the initial migration of people from the countryside farms to the cities quickly grew to a flood when Western Europe was struck with a series of famines and plagues. The rural migrants found horrid conditions in the urban centers. Because people were forced to live in crowded apartments and under impoverished conditions, disease quickly spread. Wages were low, and child labor was a way of life—children as young as 7 and 8 years old often worked 18-hour days in hot, unventilated sweatshops. Alcoholism, drug addiction, and crime were rampant among the factory workers.

The rich factory owners were concerned that the degenerating health conditions of their

workers might reduce production and affect their profits. Although generally opposed to most reforms that dealt with their labor practices, many factory owners supported and even implemented forms of health care that would keep their workers on the job.

An early form of community health nursing, in which nurses with various levels of knowledge and skill would visit the sick at home, grew from the desire to keep workers healthy. It soon became evident that disease among this population was caused by their living and working conditions, and unless these conditions were improved, health care would not improve. As interest in reform grew, several nursing groups were organized to help the poor, the sick, and the abandoned.

The Sisters of Charity, originally organized to provide nursing care in the city hospitals, expanded their services to include home care and orphanages for abandoned children. The Sisters also started an education program for unmarried and abandoned women that would prepare them to work as care providers in hospitals. The Brothers of St. John of God provided similar services and were one of the few male nursing orders to survive the Reformation and Industrial Revolution. Several non-Catholic nursing orders were founded, including the famous Quaker Society of Protestant Sisters of Charity who provided care primarily for prisoners and children.

**Question for thought: Socioeconomic forces often drive the direction of health care. What current socioeconomic conditions are driving current healthcare practices? Where do you think they are heading?**

The Industrial Revolution had little effect on the provision of health care in the religious hospitals of the Catholic countries. These institutions were strongly resistant to the developing scientific knowledge and technology and tended to stay with traditional methods of medical and

nursing care. While the non-Catholic countries were more open to new medical techniques, discoveries, and modes of treatment, the conditions in most of the secular hospitals was so poor that the quality of the health care remained low.[3] Although often called the "dark ages of nursing," many important contributions, including those of Florence Nightingale, occurred during the Industrial Revolution.

## Nursing in the United States

An important element of the search for new knowledge that occurred during the Renaissance was the desire to explore the unknown world and settle new lands. The discovery and subsequent colonization of the New World was a direct result of this impetus to explore. The Reformation, with its desire for religious and political freedom, helped to expand the search for new lands where persecuted groups could settle. Health care in the New World tended to mimic the care found in European countries from which the settlers had come, but it usually lacked the resources to match even the minimal standards of the mother countries.[4] Also, the care given varied somewhat among regions depending on which nation or group was settling that particular part of the country.

# Part II

## Nursing in the United States

### Health Care in Pre–Revolutionary War America

Settled initially by groups from the English Isles, the Atlantic coast of the embryonic United States also attracted groups of attracted Dutch, French, and other groups of settlers to

areas in Massachusetts and New York. Mortality rates among early settlers was extremely high. Quickly spreading diseases, infections, simple complications from pregnancy and delivery, starvation, as well as Indian massacres, frequently devastated whole villages. The five hospitals that existed in the foundling America before the Revolutionary War were really houses for the homeless and poor that had rudimentary infirmaries attached to them. There were no identifiable groups of nurses for these infirmaries, and care of the sick was provided by other slightly healthier homeless individuals who usually had no healthcare training at all.[4] The primary modes of care consisted of prayer and home remedies.

The European trading companies soon recognized that the lack of health care in the New World was detrimental to their ability to man their many sailing ships that carried slaves and goods to, and raw materials from, the New World. In 1658, the Dutch East India Company, one of the major traders at that time, founded Bellevue Hospital in Manhattan. It provided care for the newly arrived African slaves and for sailors who had become sick at sea. With mortality rates ranging between 50% and 75%, Bellevue, the best of the early hospitals, soon became known as the “house of horrors.”

Formal medical or nursing education was nonexistent, and there was no system of registration or licensure to guarantee even minimal levels of competency, so anyone with a strong back and a willingness to work long hours could be hired as a nurse. Any male with even a high school–level education would be pressed into service as a physician, and quacks provided a large amount of the medical care. As in England and the other non-Catholic countries, women were considered subordinate to men and usually were prevented from working outside the home.

The western coast of the United States had been settled primarily by explorers from

Spain. These early colonies soon expanded under the strong central Spanish leadership to include areas ranging from California to Mexico, Peru, and Florida. France also sent explorers to the New World and settled New Orleans, the central portion of the United States along the Mississippi Valley, and parts of eastern and central Canada.

After the initial period of exploration, conquest of the natives inhabiting the lands, and establishment of settlements, these countries imported the same type of health care found in the mother countries. Health care in the regions settled by France and Spain was primarily provided by the religious nursing orders. An early French hospital, the Hotel Dieu, was established and staffed by the Sisters of St. Augustine. One of the first schools of nursing in the New World was established in 1640 by the Sisters of St. Ursula in Quebec. Because of their religious orientation and the belief that care of the sick was an important element in living a Christian life, more Spanish and French religious orders established hospitals in the New World over the next 100 years. This care continued unchanged for many years, and religious hospitals can still be found in these areas today.

## Health Care in Post–Revolutionary War Colonial America

It was perhaps inevitable that the American colonies, established on the principle of freedom of religion, would eventually attempt to break away from the mother country of England. Life as a colonial soldier was wrought with danger and death, not only from English musket balls but also from starvation, hypothermia, and disease. During the winters especially, dysentery, scarlet fever, and smallpox devastated whole camps. There was no organized medical or nursing corps for this rag-tag army, but small groups of untrained volunteers cared for the

wounded and sick in their own homes or in large buildings such as churches or barns. Despite these great difficulties, the will and determination of the Colonists prevailed, and the United States became an independent nation.

The Revolutionary War period in American history did bring together a group of talented, dedicated, and visionary individuals who formed the fledgling American government. Benjamin Franklin stands out among this group. At his urging, several important healthcare advances were made. He managed to found the Pennsylvania Hospital in 1751, which was the first U.S. hospital dedicated to treatment of the sick. This hospital had separate areas for the sick, the insane, and those who were afflicted with moral defects. The Philadelphia Dispensary was founded by the Quakers in 1786 to provide free outpatient care for the poor, as well as surgical, obstetrical, and medical services for those who could not pay.

**Question for thought: Are "moral defects" illnesses? Should they be treated in the healthcare setting?**

Other health and nursing care developments during the post–Revolutionary War period included the establishment of the New York Hospital in 1791, which also offered classes in basic health, the biological sciences, and even child delivery and child care. With the newfound religious freedom after the Revolutionary War, religious nursing orders such as the Dominicans, Sisters of Mercy, Lutheran deaconesses from Germany, and the Sisters of Charity, began to establish hospitals based on their European models. Through the influx of these religious nursing orders, the standards of health care in the United States increased markedly between the Revolutionary and Civil wars.

Early schools of nursing, usually under the control of the religious nursing orders, were

beginning to be established during this time. Despite the rapid increase in the number and quality of hospitals, the majority of the nursing care was still being given at home by family members. Hospitals were places of last resort, when home care failed or was insufficient to effect a cure. Up into the early 1900s, only people who were on death's doorstep went to a hospital. Expectedly, mortality rates were very high in these institutions.

## Health Care During and After the Civil War

Social and economic forces that had been building from the earliest times of Colonial America reached their peaks and collided in 1861, producing the conflict known as the American Civil War. The idea of individual freedom and independence had its focal point in the upper New England and Middle Atlantic states, and eventually this area came to view slavery as a violation of these fundamental rights.

The Southern states, on the other hand, depended almost exclusively on an agrarian economy for their survival. This region was also very dependent on outside sources for its manufacturing needs. Quite obviously, when its source of labor, the slaves, was threatened by governmental action, the rich landed gentry had no other option than to secede from this government that was attempting to destroy their way of life. Because the United States government was not willing to go along with this plan, the Civil War erupted in 1861 when the armies of the South took several federal forts by force.

The Civil War was the most costly war ever for the United States in numbers of American dead and injured. The existing healthcare services were soon overwhelmed by large numbers of wounded and dying. Neither side had any organized first aid battlefield services or

any medical or nursing corps. Medical supplies were impossible to obtain, and many surgeries, such as amputations and removal of bullets, were performed under filthy battlefield conditions without anesthesia. On both sides, postinjury infections killed as many as did actual wounds.

As in all wars where there are large numbers of wounded and sick, the demand for nurses increased dramatically. Some of the sisters from the religious nursing orders attempted to meet these needs, but even their numbers were inadequate. Shortly after the war started, the practice began of large numbers of women volunteers following the armies as they went from battlefield to battlefield and providing some basic nursing care. The North had as many as 6,000 of these volunteers at the height of the war, and the South had about 1,000. Most of the volunteers were untrained. What little nursing knowledge they had came from trial-and-error experiences and from observing and mimicking the care provided by the few religious nursing sisters who were among their numbers. These volunteers cleaned and dressed wounds, prepared meals and fed wounded soldiers, gave what few medications they had at their disposal, and tried to keep the temporary hospitals that were set up in abandoned churches, barns, and schools as clean as possible. Their services generally went unappreciated or were even ridiculed by the few medical doctors that the armies had pressed into service.

Several major advances in medical and nursing care did occur during the Civil War. The origins of Navy nurses can be traced to this period when a transport ship, the *Red Rover*, was converted to a hospital ship and staffed by the Sisters of Mercy. The American Red Cross and the Army Nurse Corps also have their beginnings during this period, started under the guidance and planning of individuals who would later become important leaders in nursing. Among the volunteers in the North was a group of Black women. Their dedication and service opened the

door for members of their race to enter the healthcare field.

The Civil War allowed large numbers of women out of the home and into the hospitals—women who would not have been in such positions were it not for the War. Despite the slurs and derogatory remarks of corrupt army medical officers, the public image of nurses improved markedly during the Civil War because of the selfless efforts of the volunteers.

## Changes in American Society

The problems associated with the population concentration in American cities was intensified by the large number of immigrants (30 million) who arrived in America between 1800 and 1900. These immigrants, escaping from famine, wars, and the general poverty found in a number of European countries, initially settled in the growing port cities along the East Coast. As the rail system was completed, many immigrants migrated West, seeking a new life in the wilds of the Central Plains and the picturesque Rocky Mountains.

Despite, or maybe because of, the many changes in society taking place during this period, technology and science began making major strides. Electricity was discovered and electric lighting invented. New techniques were invented for making steel more cheaply and of better quality than had been available before. Out of these developments came such inventions as the refrigerator, telephone, phonograph, and automobile.

Medical science was also moving ahead but at a somewhat slower pace. Notably, various plants were being to make medications, such as morphine and codeine for the control of pain, quinine for the treatment of malaria, strychnine for the control rodent populations in the cities, and atropine for a variety of conditions and purposes.

As the population grew, the need for health care increased. Hospitals sprang up in the cities to meet the needs of the citydwellers. Without external controls or standards, there was a noticeable range of quality in these institutions. Where there are hospitals, there is a need for nurses. Many of the newly established hospitals instituted their own schools of nursing to meet the need. Much of the health care was still being given in the home. To help meet this need, community health programs were developed, and visiting or in-home care became the preferred type of nursing of the period. Many of the early nursing leaders lived during this time period and made major contributions to health care in general and to the profession of nursing in particular.

Health Care and Nursing During and After World War I (1914–1918)

Wars often bring about great changes in society, including changes in social conditions, development of new scientific knowledge, and invention of new technology. By its nature, war also produces large numbers of sick, injured, and dying who require care. Usually, the healthcare establishments of peacetime are severely stressed in war conditions, and changes in nursing and medical care are required. Although prior wars had produced marked changes in health care, the effects of the changes associated with World War I are still felt today.

There were only about 400 nurses in the Army Nurse Corps at the beginning of World War I. Through the increased number of Army hospital nursing schools and programs such as the Vassar Training Camp, that number swelled to 21,000 by 1917. The American Red Cross also contributed a large number of nurses to the effort, and as many as 10,000 Red Cross nurses were involved in providing nursing care to military personnel overseas.

Despite the best efforts of the nursing leaders of the time to provide high-quality nursing education for the many nurses who were being trained, many hospitals recruited untrained

women from the lower classes to provide basic care. In response to this trend, a committee on nursing was organized to establish standards, and eventually the Red Cross began a training program for nurses' aides.

This educational program, which taught women from all classes and education levels how to provide basic care for the sick at home, was universally opposed by the nursing leaders and nursing organizations of the time. The practice seemed to imply that with only a minimal amount of training, anyone could be a nurse and that nursing was really a job only for women, much as housekeeping and having children were women's work. The nurses' aide program was strongly supported by physicians.

**Question for thought: Are women genetically predisposed to be nurses? Why are there so many more women than men in nursing?**

Despite several major advancements in medical technology, particularly in the areas of anesthesia and surgery, World War I had an overall negative effect on health care in general and professional nursing in particular. The best efforts of the nursing leaders of the time to improve the quality of education for nurses was negated to a great degree by its dilution through the large number of nurses' aides programs that developed.

This tendency for nursing to "quick-fix" a nursing shortage situation by developing shorter programs with fewer education requirements is a scenario that was repeated over and over again throughout the years following World War I. The nurses' aide program, initially developed to provide care in the home, was viewed by hospital administrators as a quick source of cheap labor. Why wait two or three years for an educated nurse who commanded a relatively

high salary when a less prepared nurses' aide could do almost as much for half the cost? Nurses' aides soon began replacing trained nurses in the hospital setting. Although the quality of care was lowered to some degree, the powerful physician groups did not complain because the less trained aides were more submissive and less likely to threaten the physician's authority.

In the years that followed World War I, the profession of nursing seemed to be trying to tear itself in two. While a segment of the profession was dedicated to improving its educational standards and quality of nursing care, another segment seemed bent on destroying nursing's image and what little power it had gained during previous years. A close look at the profession of nursing today also reflects the split-personality nature of the profession that can be traced back to the post–World War I years.

On the positive side, nurses began to recognize that due to their large numbers, they could, if organized, exert a significant impact on social and healthcare reforms. Private home care and public health nursing represented about 90% of the nursing care being provided at this time. Only about 10% of nurses worked in hospitals, and hospitals still had a reputation for being places of last resort to obtain health care. Public health nursing grew during this period, with the development of the U.S. Public Health Service, the Veterans Bureau, and the Indian Health Service. Rural areas were targeted because of the lack of quality health care.

There was also a growth in university-based schools of nursing, but at a much reduced pace than during World War I. Nurses began expanding practice to industry and other branches of the federal government outside of the military.

On the negative side, many of the nurses who were trained and worked in the military services left nursing after the War because of the poor image nursing was developing from the

widespread use of undertrained aides. This exodus created a nursing shortage that was largely met by increasing the number of nurses' aides.

Despite gaining the right to vote in 1920, except for a few dedicated leaders, nurses as a group seemed uninterested in organizing and expanding their power base. Overall, the standards of nursing education were low, and external quality controls such as licensure and accreditation were almost nonexistent. Anyone could work as a nurse as long as he or she did not use the title Registered Nurse (RN).

The stock market crash of 1929 and the Great Depression that followed sent economic ripples across the nation that had a profound effect on health care and nursing. Many nurses who had been employed as private duty nurses by wealthy individuals lost their jobs as the funds available to pay them decreased. These private duty nurses migrated to the hospitals but found that jobs there were also scarce because the hospitals tended to use their own students as free labor and nurses' aides a cheap labor. Many nurses ended up working for room and board just so they had a place to sleep and eat. Nursing was viewed as a female occupation, and men were not admitted to nursing schools. The money for college-based nursing programs also dried up, and many schools of nursing closed. The few that remained open had difficulty finding qualified nurse educators.[4]

Out of the general chaos of this period developed several important trends that would affect future nurses. The federal government became one of the largest employers of nurses. Under Roosevelt's Federal Emergency Relief Administration (FERA), some 10,000 nurses were put to work in hospitals, clinics, and public health. The Joint Committee on the Distribution of Nursing Services was organized to deal with nursing and healthcare problems. This commission

recommended that the small, substandard nursing schools be closed to reduce the number of unemployed nurses. They advocated that graduate and registered nurses, not nursing students, staff hospitals. In an attempt to increase the number of nurses being employed, the Joint Committee suggested reducing the work day from 12 hours to 8 hours. The committee's recommendations were not widely implemented, and the underlying problems remained until World War II.

The real trend toward using hospitals as the central point of health care also began during this time period. A combination of a lack of private home care plus a population that was increasing in age and developing chronic diseases led to a focus on hospital care. Hospital insurance programs also furthered the idea that the hospital was the place to receive health care, and more nursing jobs became available in hospitals as the size of the institutions increased.

Health Care and Nursing During and After World War II

World War II again produced large numbers of sick and wounded, and another nursing shortage resulted. Several measures were undertaken to meet the need. The Bolton Nurse Training Act was passed by Congress, and the Cadet Nurse Corps was established. Students who entered the program were sent to nursing schools near their homes, with all expenses paid. Upon graduation, they were obligated to work actively in nursing either in a hospital or in military service for 2 to 4r years. This program also established minimum educational standards that the nursing programs had to meet and forbade discrimination on the basis of race, creed, or sex.[4] The Bolton Act also provided for shortening of the traditional hospital-based program from 36 months to 30 months. Although initially concerned about the quality of these shortened programs, many schools revised and improved their curriculums to meet the new standards.

Inactive nurses were strongly recruited back into active nursing during World War II. This practice opened the door for married nurses to actively practice nursing and encouraged hospitals to start the novel practice of hiring, on a part-time basis, nurses who had families. To encourage more nurses to enter the military, full commissioned status was granted, making them officers and raising their status. Unlike nurses in World War I, these nurses were also given the same pay as men with the same rank. Toward the end of the War, all discrimination was forbidden and black and men nurses were also admitted to the services with full military rank.

World War II brought about many changes and advancements that affect health care today. There was a rapid increase in medical knowledge during the war, including the development of antibiotics, tranquilizers, new surgical techniques, dialysis, and the use of specialty units such as intensive care units, obstetrical units, operating rooms, and recovery rooms. Healthcare services were greatly expanded with the development of X-rays, laboratory tests, transfusions, and emergency room care. Hospitals became the focus of health care, and physicians became increasingly dependent on the services they provided, particularly where high-tech, expensive equipment was involved. The traditional belief that all nurses were interchangeable in the workplace began to be challenged. Nurses in the specialty units needed highly specialized and progressive education to meet the needs of the clients' unique to the units. The revered philosophy long held by hospital administrators and physicians that "a nurse is a nurse is a nurse," while probably never really true, was dealt a death blow during and after World War II.

The need for nurses increased even more dramatically after World War II when many of the military nurses and most of the nurses under the Bolton Nurse Training Act opted to leave

nursing to marry and raise families. Typically, nursing met this challenge by advocating the quick-fix method it had used before. The origin of the Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), and many practical nursing programs can be traced to this time. Designed to provide technical, bedside nurses in just 1 year, the hospitals saw it as a way of staffing their wards with inexpensive workers. The widespread acceptance of the team nursing concept can also be traced to this time period. The RN was the team leader who supervised the client care being provided by the LPNs, LVNs, and aides. Although this was a very efficient type of management style, it removed the most qualified of the nurses, the RN, from direct client care.

Other quick-fix measures for the postwar nursing shortage included hiring nurses from other countries and the development of technical nursing programs that granted associate degrees in nursing at two-year community colleges. These measures were designed originally to be only temporary, short-term solutions to the nursing shortage problem, but as hospitals expanded, the baby boom took hold, and the population increased, the need for nurses continued to grow. Under circumstances like these, quick-fix measures soon become permanent solutions. Although the importation of foreign nurses leveled off and actually began to decline as practice standards were tightened, the AD nursing programs, originally designed to prepare nurses at an intermediate level between the professional BSN and the technical LPN, swelled in number. By the mid 1960s, the AD programs outnumbered both BSN and diploma programs. With their ever-increasing numbers and the political power that the large numbers brought, they lobbied for and obtained the right to take the same licensing examination as the RN graduates from diploma and BSN programs.

**Questions for thought: Why does the nursing profession continue to use quick-fix solutions**

**for nursing shortages? How do physicians solve the physician shortage problem?**

Despite these changes, the post–World War II period brought an interest in raising nursing to a professional level. With the healthcare system becoming increasing complicated, forward-thinking leaders in nursing saw the inadequacy of 1- or 2-year LPN and ADN education programs to meet the demands of modern health care.[4] Interest in baccalaureate nursing education began to grow, and new nursing programs were established at a number of four-year colleges and universities. As the number of BSN graduates slowly increased, there was a corresponding slow but steady expansion of advanced nursing education at the graduate level that provided master's degrees and even doctorate degrees in nursing.

Many of the medical practices that were initiated during the war in Korea were further developed during the war in Vietnam. In Korea, the Mobile Army Surgical Hospital (MASH) and the use of the helicopter played important roles in saving lives. In Vietnam, the Medical Unit, Self-Contained, Transportable (MUST) hospitals replaced the MASH units because of the lack of distinct battle lines and a secure road system. The MUST units consisted of inflatable rubber shelters that were completely self-contained and generally located some distance from the combat areas. These hospitals were staffed with Army physicians, nurses, and a number of ancillary help.

The first of some 5,000 nurses to serve in the war started arriving in Vietnam in 1962. To encourage nurses to serve in the armed forces, the Warrant Officer Nurse Program was developed so that nurses who were graduates of two-year AD programs could be commissioned as Warrant Officers during the war. Up to this time, only nurses with BS degrees could be commissioned into the armed services.

The nurses who served and cared for the wounded during the Vietnam War showed a high degree of professionalism, independence of practice, and great courage. They were an essential part of the healthcare team, an important morale booster for the troops, and participated in the development of new techniques for the care of the severely wounded. Four Navy nurses were awarded the Purple Heart for injuries they received when the Viet Cong bombed Saigon in 1964. One Army nurse, First Lieutenant Sharon Lane, was killed on June 8, 1969, during an attack on the Hospital at Chu Lai. Only recently have the efforts of these nurses and other women who served in Vietnam been recognized in the Vietnam Woman's War Memorial.

Obviously, there have been many changes in nursing and health care since the end of the Vietnam War. The issues involved in these changes are still ongoing and are discussed throughout the current edition of *Nursing Now: Today's Issues, Tomorrow's Trends*.

Many of the advancements, trends, and problems in the healthcare system of the 21st century are a direct result of the conditions that existed after World War II. As the healthcare system grew, it became increasingly expensive. Government became involved in paying for health care and demanded a say in regulating quality and costs.

## Part III Nursing Leaders

The profession of nursing as it is practiced today owes much of its form and orientation to a number of outstanding nurses who had a vision for the future. As the profession of nursing continues to move through the 21st century, it is important to look back at those nurses who built the first few rungs of that ladder in their attempt to overcome the problems and obstacles of their day. Although some of their accomplishments may not seem very impressive in today's fast-

paced and rapidly developing healthcare system, it should be remembered that they were making changes in a social structure in which women were considered second-class citizens and did not even have the right to vote.

Florence Nightingale (1820–1920)

Immortalized as the "Woman with a Lamp," in Longfellow's famous poem by the same name, it would be more appropriate, if less poetic, to have called Florence Nightingale the "Woman with a Brain." She is universally credited with being the founder of modern nursing. Although English by nationality, she was born in Florence, Italy, while her parents were on a business trip. Her father was a wealthy merchant who traveled widely and believed in taking his family with him. Contrary to the prevailing Victorian beliefs about the role and place of women, he also believed in educating his daughters. Florence was taught by tutors during her childhood and adolescence and was considered highly educated for her time.

Through her travels with her family, she became acutely aware of the substandard health care that existed in many countries, including her own England. She began to study health care throughout England and the European continent and was particularly interested in home healthcare nursing. She also observed and learned in the substandard public hospitals and the higher quality religious hospitals run by the nursing orders of the Catholic Church in Italy, France, and Spain. She became particularly interested in the church-run hospital at Kaiserwerth, Germany, and after receiving her parents' consent in 1851, was allowed to attend its 3-month nurses' training program. Although impressed with the organization and dedication of the institution, she came to believe that a 3-month nursing education program was not sufficient. She

attempted to obtain additional education at the Sisters of Charity hospital in Paris but became ill and could not finish the course of study.

After she recovered from her illness, she assumed the charge position in a private nursing home for sick governesses and soon reorganized the nursing home so that it ran smoothly and provided first-rate care for the residents. She again became interested in hospitals and improving the education standards required for nurses. She realized that the only way to improve health care was to educate young women to be reliable and high-quality nurses. She was contacted by other healthcare reformers and a few visionary physicians about developing plans for some type of school of nursing in England. These plans were interrupted when a widespread cholera epidemic broke out in England in 1854. Florence Nightingale volunteered her services to care for the sick and dying. From this experience, she learned a great deal about the spread of diseases and methods to contain that spread.

The year 1854 saw another major social upheaval in Europe. That was the year that the Crimean War started when the Russians attempt to take over the Crimean Peninsula and the water access to the Black Sea; the attempt was thwarted by the British, French, and Turks. As in the wars that preceded it, the health care provided to the wounded and sick soldiers was horrid. The major difference with this war was that a number of British correspondents were at the front lines and began sending reports back to England about the wretched conditions found in the field hospitals.

The public outcry that resulted from these reports forced the British politicians into action. By this time, Florence Nightingale had become recognized as a leader in health reform and was a logical candidate to try to improve the health care being provided by the British army.

Nightingale’s request to take a group of volunteer nurses to the battlefield near Scutari was finally accepted by the Minister of War, Sir Sidney Herbert. Nightingale selected 37 outstanding nurses from several different nursing orders and arrived at the field hospital in October 1854. Initially, the British medical officers who were running the hospital saw no need for the services of this intimidating group of women and refused them admission to the wards.

Nightingale patiently waited while correspondents’ reports were published about the nurses’ treatment and the ever-increasing mortality rates among the wounded soldiers. Eventually, the physicians allowed the nurses into the wards, and an immediate improvement was seen in the health care being provided.

The conditions the nurses found when they began their care were worse than they had imagined. As many as 3,500 of the sick, wounded, dying, and dead were all crowded into dark, damp, foul-smelling wards, often lying on cold stone floors. Many were in the same bloody and dirty uniforms in which they had been wounded, now fouled with stool and urine. Medical supplies were not available, food was scarce, and water and sewage systems were inadequate. Hoards of rats roamed freely throughout the wards, feeding off whatever or whomever they could find. Four out of every ten soldiers who entered the wards died.

The first order of business for Nightingale and her nurses was to improve the sanitary conditions of the hospital and separate those soldiers who had infectious diseases from those who had wounds. The physicians strongly resisted her efforts, not seeing the need for these measures, and temporarily forced the nurses out of the hospital.

The nurses who left under pressure from the physicians soon returned, but only after an agreement was made there would be no more interference from the medical staff. One

concession that Nightingale made was to agree to be under the supervision of the Chief Medical Officer and to have control only over her own nurses.

The nurses cleaned and bandaged wounds, cleaned the wards, and cooked meals that they fed to those who were unable to feed themselves. Over a 6-month period, using just these relatively simple nursing measures, the mortality rate fell from 42.7% to 2.2%.

Nightingale extended the reform of the British Military medical system to other areas. She established a consistent line of supply for such items as beds, medicines, and bandages, as well as started a military post office so that soldiers could communicate with their families. Nightingale expanded the healthcare system to include convalescent camps for long-term recovery and facilities where the families of soldiers could live. At the height of her endeavors during the war, she supervised some 125 nurses in several large hospitals.

After the rear area hospitals were running smoothly under the supervision of her nurses, Nightingale began to improve the care provided at the front lines and helped prevent many of the complications she observed in the wounded by the time they reached the hospital. However, her efforts at the front lines were cut short when she contracted Crimean fever (probably typhoid fever) and almost died. Although she had a protracted recovery period, she remained in Crimea until all her nurses had left Scutari. Nightingale never completely recovered from this severe illness, yet her accomplishments were recognized by the Queen of England, and she was awarded the highest of the English awards given to civilians, the Order of Merit.

Florence Nightingale's experiences with her basic nurses training, supervision of the nursing home, and her ordeal in the Crimean War only strengthened her convictions that nursing education required major reforms. She believed that nursing schools should be run by nurses,

independent of hospitals and physicians. She advocated an education program of at least 1 year for nurses and stressed that this education should include information about basic biological sciences as well as techniques to improve nursing care and actual supervised practice. Nursing education should be a lifelong endeavor, she believed, and the status of nurses should be raised above that of housemaids and servants. She also felt that educated nurses should not spend their time doing menial jobs such as cleaning and cooking but should spend most of their time providing nursing care directly to the clients.

Although she remained in a state of self-imposed semi-isolation for the rest of her life, Nightingale worked tirelessly for the reform of health care and nursing. She was appointed to a number of committees and commissions dealing with healthcare reform and improvement. She was a prolific writer and wrote extensively about improving hospital conditions, sanitation needs, health care in general, and nursing education. Her famous Nightingale Training School for Nurses opened in 1860 and trained nurses who were in great demand all over Europe and the United States.

Although the Nightingale School received strong opposition from physicians who felt that nurses were overtrained already, it flourished. The main goals of her school were to educate nurses who could provide hospital care and home care and who also could educate other nurses. Many of the early graduates from this school went on to become important nursing leaders in their own right. A Registry of Nurses who had graduated from the school was established (Registered Nurses), and these nurses were certified as having achieved at least the minimum level of required education. She emphasized health maintenance and health promotion in her school and advocated the philosophy that nursing was both an art and a science.

She taught that each person should be treated as an individual and that nurses were to meet the needs of the clients, not the demands of the physicians. High ethical and moral standards are stressed in the Nightingale Pledge that was written by a Canadian nurse, Lystra Gretter, in 1893 to reflect Nightingale's philosophy and beliefs.

**Questions for thought: Nightingale stressed that nurses should meet the "needs of the client, not the demands of the physicians." Is that concept still valid in today's healthcare system? How do physicians respond to nurses who put the client's needs before the physician's demands? What in the Nightingale Pledge is relevant to nursing today? What is not?**

Despite the many forward-looking and progressive ideas that she advocated, Nightingale was a product of her time in history and held some ideas that seem strange by today's standards. For example, she never completely accepted the germ theory as the cause of disease even though she had extensive experience caring for clients with all types of contagious diseases. She opposed establishing a national licensure procedure for nurses, perhaps because she thought the national licensure standards would be lower than her own registration standards. Her standards for admission to her school were very strict, and only unmarried women of good character were admitted to the school. Any indication of moral weakness was grounds for dismissal.

Florence Nightingale had dedicated her long life to the improvement of health care and nursing standards. Through these efforts, she formed the foundation upon which the practice of modern nursing is built. This philosophy includes an emphasis on health maintenance and promotion, and not just sick care; treating each person as an individual and as the center of nursing care; raising the status of nursing to a collegial level with that of medicine; and requiring

that nurses be educated in all the sciences in formal schools of nursing. Although her ideas were diluted and lost to some degree during the first 50 years of the 20th century, they since have resurfaced and are now being evaluated in the light of a rapidly changing healthcare system.

Isabel Adams Hampton Robb (1860–1910)

As a teacher in her home city of Ontario, Canada, Isabel Hampton felt unfulfilled, and in 1881, her restlessness and ambition led her to the Bellevue Hospital Training School in New York City to become a nurse. Her orientation while she attended school centered on the academic rather than the clinical side of nursing. Shortly after graduation, she moved to Rome, Italy, where she became the superintendent of a hospital that provided care for American and British travelers. During her 18-month tenure as superintendent, her conviction that nurses need a solid theoretical education as the foundation for their nursing practice grew.

From that point on, Hampton dedicated her life to raising the standards of nursing education in the United States. She accepted the directorship of the Illinois Training School for Nurses and soon made major changes in its curriculum. This school was unique for its time. Unlike the majority of nursing schools that were hospital based, this school was university based and had academic leaning as its main goal. The curriculum was changed so that simpler concepts were presented first, and the more complex ideas were presented later in the program. She also arranged for clinical education in a number of hospitals so that the students could practice those skills learned in the classroom.

Word of Hampton's revolutionary ideas about nursing education quickly spread throughout the country, and she was offered a succession of prestigious and important positions.

In 1889, she accepted the directorship of the newly founded Johns Hopkins Training School for Nurses. She instituted her ideas about the need for theoretical nursing education and also proposed the novel idea of limiting the student nurses' days to 12 hours, which included 2 hours for recreational activities. She also eliminated the free private duty services that were often provided by nursing students.

Her next position was the chairmanship of the nursing section of the Congress of Hospitals and Dispensaries in 1893, consisting of a group of nursing leaders who were attempting to form some type of national organization for nurses. Under Hampton's leadership, a group of superintendents of the key American nursing schools was brought together and organized the American Society of Superintendents of Training Schools for Nurses. Hampton was elected chairman of the group. In this organization are found the seeds of what was eventually to become the National League for Nursing, dedicated to improving the standards of nursing education.

Many of her contemporaries felt that her marriage to Dr. Hunter Robb in 1894 would be the end of her nursing career. Nursing at that time was not an occupation for married women, particularly those with a relatively high social standing. But Hampton Robb did not let these archaic ideas interfere with her active pursuit of her goals for the future of nursing.

**Questions for thought: Should nurses marry physicians? What are some of the problems in this type of relationship?**

Shortly after her marriage, she organized a separate group for staff nurses in active practice. She became the first president of the group in 1896 and called it the Nurses Associated Alumnae of the United States and Canada. This group would later become the American Nurses

Association (ANA), which is dedicated to the improvement of clinical practice. A few years later, she helped develop the *American Journal of Nursing*, the first professional journal dedicated to the improvement of nursing. It became and still is the official journal of the ANA.

Unfortunately, her dedication and work to improve nursing were cut short by a fatal accident at the age of 50. Yet, her contributions to nursing education had an influence that lasts to this day. Her belief that nurses need both theoretical and practical education, and her recognition of a need for separation of nursing education from medical education, were not well accepted by the medical community of her times. Through her efforts, nursing made major strides in its attempt to emerge as an important and separate healthcare profession.

Lillian Wald (1867–1940)

Born into middle class Ohio society, Lillian Wald was well educated and lived the early part of her life in relative comfort. She attended the New York Hospital School of Nursing between 1899 and 1901, and after graduation, she worked for a short time as a hospital nurse. She became interested in medicine and entered medical school, but left after an experience on the New York docks that opened her eyes to the plight of sick poor people.

Wald, with the help of Mary Brewester, opened the famous Henry Street Settlement, a storefront clinic in one of the poorest sections of New York City that provided both clinic and home nursing care for the poor. Through this clinic, nurses were sent into the homes of the poor to visit the sick and to offer instruction in how to improve living conditions to help stop the spread of contagious disease. These early community nurses paid special attention to the children and aimed many of their teaching and preventative efforts at helping children remain healthy.

From her experiences with the inner city poor and her attempts to get funding for her clinic, Wald developed into a dedicated social reformer and an effective fund raiser. She became politically active and was recognized as an eloquent speaker, particularly when supporting candidates for public office who agreed with her healthcare reforms. Although women still did not have the right to vote, her political involvement and influence were felt nationwide.

Under her auspices, New York's Columbia University developed courses that prepared nurses for careers in public health. From her community health experiences, Wald also became a strong advocate of wellness education. Because the medical community did not seem to be interested in the wellness aspect of health care, she saw it as becoming one of the important functions of nurses and nursing. The Metropolitan Life Insurance Company saw the value of her belief in health maintenance, and she was asked to organize the nursing service branch of the company. She is also credited with beginning the Town and Country Nursing Service of the American Red Cross, as well as developing the concept and practice of school nursing. In 1912, Wald founded and was elected the first president of the National Organization of Public Health Nursing.

As a pioneer in public health nursing, Wald demonstrated what type of influence one dedicated person can have on the health of a whole population. Over time, many of her farsighted ideas were adopted by the federal government. The many child health and wellness programs in use today find their origins in her efforts. In many of the current proposals for healthcare revisions, particularly those working under a capitated payment system like Health Maintenance Organizations (HMOs), many of Wald's ideas, including public health nursing, independent clinics, and health maintenance, are identified as important elements for the success

of the plan.

Lavinia Lloyd Dock (1858–1956)

Much like Florence Nightingale, Lavinia Dock was born into an upper-middle class family where education was highly valued. And much like Nightingale's family, Dock's family was stupefied when she selected nursing as her life's calling. In 1885, when she left her home state of Pennsylvania and entered the Bellevue Training School for Nurses in New York City, nursing was not considered an acceptable occupation for well-born and educated women. She did not find nursing school particularly difficult due to the high-quality primary and secondary education she had received as a child, but she observed that many of her fellow nursing students had a great deal of difficulty learning about the numerous medications that were becoming available at that time. She later wrote a medication text book for nurses, the first one ever published, called *Materia Medica for Nurses*. It sold some 100,000 copies.

Like many of the nursing leaders of this time period, Dock quickly became aware that the terrible social conditions of large segments of the population had a direct effect on their generally poor health. From this observation, she drew the conclusion that the poverty and squalor in which much of the population lived would have to be improved before their health care could improve. She too became a dedicated social reformer and tried to improve the conditions in the New York City slums by confronting legislators. Dock soon became disillusioned. Without the right to vote, and with the prevailing attitude that they were second-class citizens, women had little power and almost no influence over legislators' opinions.

Although Dock worked for a short time in the Henry Street Settlement with Lillian Wald

and was Isabel Hampton Robb's assistant supervisor at Johns Hopkins Hospital, she spent most of her nursing career in the pursuit of equal rights and an equal social standing for women. During some 20 years of her life, she cajoled, berated, and lobbied legislators at all levels about the need for women to have the right to vote. Her belief was that only through the right to vote would women ever gain the power they needed to influence social reforms and health care. She was also an avowed pacifist and argued against America's entrance into World War I.

Dock provides an excellent example of what nurses are capable of doing to achieve higher quality care, even if they are not at the bedside. Through a life dedicated to the improvement of society, women's status, and nursing, she is considered one of the most influential leaders in early 20th century history.

Annie W. Goodrich (1876–1955)

A contemporary of Lillian Wald and Adelaid Nutting, Annie Goodrich also was involved in the Henry Street Clinic in New York City after she received her nursing education from the New York Hospital Training School for Nurses. She was also known as an outstanding nurse educator and taught at or was superintendent of several nursing schools in New York City. In 1910, she was appointed as a state inspector of nurse training schools, a position that, until then, only physicians could hold.

She became interested in military nursing, and in 1918 Goodrich was asked by the Army to make a survey of its hospitals that had nursing departments. After observing the many difficulties and shortages in the Army nurse corps, she proposed that the U.S. Army organize its own nursing school. Later that year, when the school was opened, Goodrich was appointed as its

dean. Other Army nursing schools, based on the one designed by Goodrich, were established at army hospitals during World War I.

After America's reluctant entrance into World War I, the demand for trained nurses increased dramatically. The many hospital-based nursing schools of the period could not keep up with the demand. In responding to this need, Goodrich established the Vassar Training Program at Vassar College so that highly trained nurses would be produced after a 12-week classroom summer session of science and theory, followed by 2 years of clinical practice in a hospital. The response was tremendous, and after the war, other colleges and universities became interested in developing their own nursing programs.

Goodrich returned to home care nursing, where the majority of nursing care was still being provided, through the Henry Street Clinic after the war. She eventually moved on to nursing education in the university setting and was the dean at the Yale University School of Nursing until she retired in 1934. Her many writings about nursing education and her experiences with military nursing have made a great contribution to nursing education.[5]

Through the Vassar Training School, the viability of nursing education in a college setting was demonstrated, much to the dismay of the hospital-based schools of nursing. Physicians and the medical community still believed that nurses were overtrained, and they questioned the need for university-based education. Although university-based schools of nursing were slow to develop, Goodrich had demonstrated that classroom theoretical information was just as important as clinical practice in the education of highly skilled nurses.

Additional Contributions to the Profession

Other nurses who lived during this period made substantial contributions to the

profession of nursing. This small group was selected for presentation because they are representative of the great drive and dedication of individuals who produced changes and influenced the course and development of professional nursing even to this day. There are many extensive and well-written biographies of these early nursing leaders, and it is recommended that nurses at all levels read about these dedicated women's lives. Through understanding where they came from and what they attempted to achieve, a better understanding of many of the current difficulties in health care and nursing can be attained.

Looking back through history at how health care has been viewed, it is interesting to observe that while many elements change, others seem to stay the same. History does not have to be dull and boring if it is read and studied with a goal in mind other than passing a test. By looking at what is going on today and attempting to see where these current practices may have originated in the past, the student of history can became a detective, looking for clues that will unravel a complicated case.

References

1. Jenson, DM: *History and Trends in Professional Nursing*. St. Louis: CV Mosby, 1959.

2. Griffin, GJ, and Griffin, JK: *Jensen's History and Trends of Professional Nursing*. St. Louis: CV Mosby, 1973.

3. Larisey, MM: Attic Treasures: A Look at Nursing History. *Nursing Forum* 25(1):20–24, 1990.

4. Kalisch, PA, and Kalisch, BJ: *The Advance of American Nursing*. Philadelphia: JB Lippincott, 1995.

5. Mason, DJ: *Policy and Politics for Nurses*. Philadelphia: WB Saunders Co., 1993.

## Bibliography

Aaronson, LS: A Challenge for Nursing: Reviewing a Historic Competition. *Nursing Outlook* 37(6):274–279, 1989.

Auld, E, and Birum, LH: *The Challenge of Nursing*. St. Louis: CV Mosby, 1973.

Bullough, VL: *The Emergence of the Modern Nurse*. New York: Macmillan, 1969.

Cristy, T: The First Fifty Years. *American Journal of Nursing* 9(9):1778–1784, 1971.

Cristy, T: Portrait of a Leader: Lavinia Lloyd Dock. *Nursing Outlook* 17(6):72–75, 1969.

Cristy, T: Portrait of a Leader: M. Adelaide Nutting. *Nursing Outlook* 17(1):20–24, 1969.

Cristy, T: Portrait of a Leader: Isabel Hampton Robb. *Nursing Outlook* 17(3):26–29, 1969.

Cristy, T: Portrait of a Leader: Isabel Maitland Stewart. *Nursing Outlook* 17(10):44–48, 1969.

Dulles, FR: *The American Red Cross: A History*. New York: Harper and Brothers, 1950.

Frantz, AK: Nursing pride: Clara Barton in the Spanish–American War. *American Journal of Nursing* 98(10), 1998, 39–42.

Griffin, GJ, and Griffin, JK: *Jensen's History and Trends of Professional Nursing*. St. Louis: CV Mosby, 1973.

Jamieson, EM, Sewall, MF, and Suhrie, EB: *Trends in Nursing History*. Philadelphia: WB Saunders Co., 1968.

Jenson, DM: *History and Trends in Professional Nursing*. St. Louis: CV Mosby, 1959.

Kalisch, PA, and Kalisch, BJ: *The Advance of American Nursing*. Philadelphia: JB Lippincott, 1995.

Larisey, MM: Attic Treasures: A Look at Nursing History. *Nursing Forum* 25(1):20–24, 1990.

Mason, DJ: *Policy and Politics for Nurses*. Philadelphia: WB Saunders Co., 1993.

Nicoll, LH: *Nurses' Guide to the Internet*, 2nd ed. Philadelphia: Lippincott, 1998.

Nutting, MA, and Dock, LL: *A History of Nursing*. New York: GP Putnam's Sons, 1972.

Woodham-Smith, C: *Florence Nightingale*. New York: McGraw-Hill Co., 1951.

Electronic Resources

Agency for Health Care Policy and Research (AHCPR)
http://www.ahcpr.gov/ Contact: info@ahcpr.gov

ARL Directory of Electronic Journals, Newsletters, and Academic Discussion Lists
gopher://arl.cni.org/ Contact: Dru Mogge, mailto:dru@cni.org

CINAHL Information Systems
http://cinahl.com/ Contact: mailto:cinahl@cinahl.com

HepNet
http://www.hepnet.com/index.html Contact: mailto:Webmaster@hepnet.com

Jack's Sunshine Nurse's Site
http://www.mauigateway.com/~jackw/

National Health Information Center (NHIC)
http://nhic-nt.health.org/ Contact: mailto:NHICinfo@health.org

Nightingale
http://nightingale.con.utk.edu/index.htm Contact: mailto:mackbo@utk.edu

American Nursing Association History of Nursing (AAHN)
http://users.aol.com/nsghistory/AAHN.html Contact: Janet L. Fickeissen,
mailto:NsgHistory@aol.com

Center for the Study of the History of Nursing
http://www.upenn.edu/nursing/facres_history.html Contact: mailto:nhistory@pobox.upenn.edu

Country Joe McDonald's Tribute to Florence Nightingale
http://www.dnai.com/~borneo/nightingale/ Contact: Country Joe McDonald,
mailto:joe@www.countryjoe.com

Men in American Nursing History
http://www.geocities.com/Athens/Forum/6011/index.html Contact: Bruce Wilson,
mailto:wilson@hiline.net

Critical Thinking Exercises

1. Select one event or person in the history of nursing that seems to have had the greatest influence on its development. What could that person have done differently, or how might that event have been altered to change the profession of nursing as it is today?
2. Apply the convictions of the early nursing leaders to the nursing profession as it is practiced today. Identify the similarities and the differences.
3. Wars have always had a profound effect on health care and nursing. Discuss the common elements found in the Crusades, Revolutionary War, Civil War, World War I, and World War II that influence today's healthcare and nursing practice.
4. What elements of primitive and ancient health care are important to health care today? Are any of these elements a part of current practices?
5. Throughout history, religion has often had a profound effect on healthcare practices. Identify key religious practices that influenced health care in the past. Are there any situations today in which religion has an effect on health care?
6. Why are most nurses women in today's healthcare system? What are the historical

origins of this fact?

7. Rewrite the Nightingale Pledge so that it is appropriate for modern-day nursing.

The Hippocratic Oath

I swear by Apollo, the physician, and Aesculapius and Health, and All-Heal, and all the gods and goddesses that, according to my ability and judgment, I will keep this oath and stipulations:

To reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee of stipulation, and that by precept, lecture, and every other mode of instruction I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none other.

I will follow the method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

With purity and holiness I will pass my life and practice my art. I will not cut a person who is suffering from a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, bond or free.

Whatever, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not be spoken abroad I will not divulge, as reckoning that all such should be kept secret.

While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by men at all times, but should I trespass and violate this oath, may the reverse be my lot.

Nightingale Pledge

I solemnly pledge myself before God and in the presence of this assembly to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my profession. With loyalty I will endeavor to aid the physician in his work and devote myself to the welfare of those committed to my care.