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ADVOCACY AND NURSING EDUCATION IN THE TWENTIETH CENTURY

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This essay examines how advocacy has played a role in the history and development of the nursing profession. Advocacy is generally described as working on behalf of a person or system to bring about positive change. In current textbooks on nursing, the advocate role is emphasized as a special kind of clinical responsibility. The nurse is accountable for care and charged to act as the patient's spokesperson.[1] England links advocacy to group development and the use of power to produce societal change.[2] This position is defended by citing dilemmas associated with the advocate role: conflicts in interest and loyalty; communications barriers which interfere with positive action for consumers; tensions between individual and societal responsibility; and domination of consumers by health care providers. Because of these potential conflicts, England proposes that advocacy is not a role for neophyte nurses and therefore not integral to patient care.

The purpose of this essay, however, is not to argue whether generic students should be taught advocacy behaviors or whether advocacy is a discrete function of leadership; rather, it calls attention to documents which demonstrate that over the years advocacy behaviors have been directed toward protecting patients from inadequate or harmful nursing care and students from inappropriate and sub-standard educations. Specifically, this paper examines three reports which have studied nursing on a national basis: *The Goldmark Report*,[3] *The Brown Report*,[4] and *The Lysaught Report*.[5] In addition, this essay examines a position statement made by the American Nurses Association ("ANA") in 1965[6] and, position statements made by the National

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1. B. BIGELOW-KEMP & A. PILLITTERI, FUNDAMENTALS OF NURSING: A FRAMEWORK FOR PROTOCOL (1984); E. BRILL & D. KILTS, FOUNDATIONS FOR NURSING (1980).
2. D. ENGLAND, COLLABORATION IN NURSING (1986).
3. NURSING AND NURSING EDUCATION IN THE UNITED STATES 33 (C. Winslow ed. 1923) [hereinafter NURSING EDUCATION].
4. E. BROWN, NURSING FOR THE FUTURE (1948).
5. J. LYSAUGHT, AN ABSTRACT FOR ACTION 14 (1970).
6. American Nurses Association, Committee on Nursing Education, *First Position Paper on Education for Nursing*, 65 AM. J. NURSING 106-11 (1965).

League for Nursing ("NLN") in 1982[7] and 1985.[8] These documents were responses to public and professional demands for improvement in nursing education or patient care services and are illustrative of the tradition of advocacy within the profession.

Nursing education in the United States has its roots in the British military system. The force which gave impetus to modern nursing was stimulated by the civilian press who reported the wretched condition of the wounded at the Crimean front.[9] The War Office commissioned Florence Nightingale to recruit a group of nurses to go to the Crimea. The result of her advocacy on behalf of the British soldiers was most dramatically demonstrated in the reduction of mortality rates from a reported sixty percent at the time of her arrival to one percent at the end of the war.[10]

Nightingale's success made the public more aware of the need for programs to train nurses. Her work stimulated the creation of an endowment for The Nightingale School which opened in 1860. The Nightingale Fund enabled Ms. Nightingale to provide a special building for the school, pay the instructors, enter into contracts with hospitals, handle the business affairs of the school and authorize the curriculum. The faculty and students, which were selected with care, were expected to use a body of nursing knowledge, to practice separate from medicine, to participate in continuing education, and to use modern teaching methods and learning skills.[11]

The first agreement with the participating hospital of St. Thomas is interesting because it defined the cooperation to be provided by the hospital, the clinical units to be used by students, and the financial reimbursement to be made to the hospital by the Nightingale School. It also specified that experienced nurses be responsible for patient care and that skilled charge nurses be available to direct and teach students and staff. One indication of the

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7. NATIONAL LEAGUE FOR NURSING, POSITION STATEMENT ON NURSING ROLES — SCOPE AND PREPARATION (1982) [hereinafter POSITION STATEMENT ON NURSING]. *See* L. KELLY, DIMENSIONS OF PROFESSIONAL NURSING 592-93 (5th ed. 1985).

8. NATIONAL LEAGUE FOR NURSING, A LETTER TO THE MEMBERS (1985).

9. G. TREVELYAN, HISTORY OF ENGLAND 653 (1929).

10. ROYAL COMMISSION APPOINTED TO ENQUIRE INTO THE REGULATIONS AFFECTING THE SANITARY STATE OF THE ARMY, REPORT: MORTALITY OF THE BRITISH ARMY AT HOME AND ABROAD AND DURING THE RUSSIAN WAR, AS COMPARED WITH THE MORTALITY OF THE CIVIL POPULATION IN ENGLAND Appendix LXXII (1858). The Appendix was prepared originally as an anonymous publication of Florence Nightingale entitled MORTALITY OF THE BRITISH ARMY. *See* E. COOK, LIFE OF FLORENCE NIGHTINGALE 314-15, 376-77, 439 (1942). *See also* J. DOLAN, M. FITZPATRICK & E. HERRMANN, NURSING IN SOCIETY: A HISTORICAL PERSPECTIVE (15th ed. 1983) [hereinafter J. DOLAN & M. FITZPATRICK] for further discussion and analysis of this period in nursing history.

11. J. DOLAN & M. FITZPATRICK, *supra* note 10, at 164-65; J. DOLAN, NURSING IN SOCIETY: A HISTORICAL PERSPECTIVE 270 (13th ed. 1973).

importance with which Ms. Nightingale viewed nursing education is evident in a contract provision which required the hospital to accept and respect the director of the program and the clinical instructors.[12]

Efforts were made in the United States to pattern early schools of nursing after the Nightingale model. But physicians, who managed most of the hospitals, were opposed to the Nightingale system. Significant differences developed between the American and British systems of nursing education. In the United States there was no Nightingale Fund. The superintendents of nurses were responsible for both hospital nursing and training schools; the schools provided hospitals with nursing services rather than payment for educational programs; the focus of education was on sick nursing rather than upon prevention or well nursing; and the demands of the hospital often superseded the learning needs of the students. It was soon apparent that the mission of the schools and that of the hospitals were not in agreement. Hospitals won the battle for control. Student nurses, less expensive than hired nurses, and more easily disciplined and controlled, became the hospital nursing staff.

Although hospital training schools for nurses proliferated from four in 1873 to four hundred by the turn of the century,[13] the quality of these programs was poor. It soon became apparent that changes were needed. This was especially true regarding the admission criteria. In addition, the conditions for learning were so deplorable that a Committee on Education, consisting of nurses and public members, was formed to study American training schools in 1918.[14]

Although the term advocacy was not used, the establishment of the Committee was motivated by the need to protect the public from poorly trained nurses and to prevent the exploitation of students. The Committee, at the suggestion of Ann Goodrich, planned to ask the Carnegie Foundation to support a comprehensive study of nursing education similar to that done by Flexner for medicine in order to set standards for the profession.[15] Because of the onset of World War I, it was not possible to initiate the study and the plans were discontinued.[16] After the war, the need for reform was still recognized. The Rockefeller Foundation agreed to finance a survey of nursing

12. *See* J. DOLAN, *supra* note 11.

13. U.S. BUREAU OF EDUCATION, II REPORT: NURSES TRAINING SCHOOLS 1077 (1909).

14. *See* PROCEEDINGS OF THE SEVENTEENTH ANNUAL CONVENTION OF THE AMERICAN SOCIETY OF SUPERINTENDENTS OF TRAINING SCHOOLS FOR NURSES 75 (1911).

15. A. FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA (1910); Flexner, *Is Social Work a Profession?*, in PROCEEDINGS OF THE NATIONAL CONFERENCE OF CHARITIES AND CORRECTIONS 576-81 (1915).

16. *See generally* J. DOLAN & M. FITZPATRICK, *supra* note 10.

education under the direction of C. E. A. Winslow, Professor of Public Health at Yale School of Medicine. His final report, known as the *Goldmark Report*, concludes with ten recommendations related to the education and recruitment of nurses.[17] It suggested the definition and grades of licensure of staff nurses and the initiation of university-based programs in nursing.[18]

There were some direct and visible results from the *Goldmark Report*. Two famous collegiate schools of nursing were endowed: the Yale School of Nursing and Frances Payne Bolton School of Nursing at Case Western Reserve University. The forty-eight hour week became more common in training schools and high school graduation was considered to be a requirement for admission. Certainly, not all schools were sensitive to the recommendations of the *Goldmark Report*. Brown's assessment of nursing education between 1920 and 1940 was that it was totally inadequate to meet the needs of society for nursing care, especially in the areas of clinical specialties.[19] Nutting's report on student learning provides additional evidence of poor educational practices.[20] The report stated:

> Heavy demands of the wards made it impossible for all students to attend their weekly lectures and it was always arranged that some students would choose to take very full notes and read them later to the assembled groups of less fortunate. Lectures came under the category of privileges like "hours off duty" to be granted, "hospital duties permitting."[21]

Nursing failed to implement many of the recommendations of the *Goldmark Report*. This omission is most evident in the recommendations about baccalaureate education. Today the majority of nursing education is still not at the baccalaureate level.[22]

Over the next fifty years two national studies of nursing and nursing education were completed. In 1942 the National Nursing Council for War Service was formed. At the end of the war this council continued under the title of National Nursing Council and implemented three studies: a history of its own accomplishments, an economic survey of the nursing profession by the Bureau of Labor Statistics, and a study of nursing education by Esther Lucille Brown.[23] Brown, a Director of the Department of Studies in the Professions at the Russell Sage Foundation, had conducted similar studies on

17. NURSING EDUCATION, *supra* note 3.
18. *Id.*
19. *See generally* E. BROWN, *supra* note 4.
20. A. NUTTING, A SOUND ECONOMIC BASE FOR SCHOOLS OF NURSING (1926).
21. *Id.* at 339-40.
22. AMERICAN NURSES ASSOCIATION, FACTS ABOUT NURSING 1982-83 at 121 (1983).
23. *See* E. BROWN, A THOUSAND THINK TOGETHER (1948). *See generally* E. BROWN, *supra* note 4.

the role of education in other professions, such as social work, medicine, engineering and law in order to determine how professional education could be molded to meet the needs of society.[24] She visited fifty schools of nursing and held three regional conferences in Washington, D.C., San Francisco and Chicago.[25] In an attempt to address the frustrations experienced by nursing educators, Brown asked basic questions about how professional schools of nursing should be organized, administered, controlled and financed. The introduction to the *Brown Report* portrays the climate of the times in that it states: "For a quarter of a century leaders of nursing education have striven with almost unparalleled zeal but with distressingly small results, many of them believe, to create a sound and socially motivated form of nursing education."[26]

The final report contained twenty-eight guidelines for the development of nursing education.[27] Of primary importance was the recommendation about the placement of professional schools of nursing in degree-granting institutions.[28] In line with the Nightingale model, Brown recommended that university schools should be autonomous, seek contracts with the best clinical agencies and emphasize student education rather than responsibility for patient care.[29] Brown also recommended that periodic examinations of schools be conducted and lists of accredited schools be published and distributed.[30]

The *Brown Report* was challenging, stimulating and, for the most part, ignored. Its advocacy for university-based education was offensive to grass roots constituencies. Although the national nursing organizations tried to implement the recommendations of the Brown study, it became an historical document.

In 1970, the *Lysaught Report* again endorsed the placement of nursing education within the mainstream of American baccalaureate education.[31] It recommended that state committees composed of nurses, educators, other health professionals and the public, be created to ensure that this position was advanced.[32] Priorities for change identified in the Report included improved educational systems, a curriculum based on research into the practice and education of nurses, clarification of roles, joint practice with other

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24. *Id.*
25. *See generally* E. BROWN, *supra* note 23.
26. *See* E. BROWN, *supra* note 4, at 7.
27. *Id.*
28. *Id.*
29. *Id.*
30. *Id.*
31. J. LYSAUGHT, *supra* note 5.
32. *Id.*

health professionals, and increased financial support for nursing.[33] The Report also recommended that strong hospital schools be encouraged to seek and obtain regional accreditation and degree granting power.[34] Other hospital schools were advised to seek cooperative arrangements with collegiate institutions.[35] The *Lysaught Report* also highlighted the lack of public and professional clarity about practice areas and levels of responsibility for patient care.[36]

In a follow-up report, the Commission proposed an open curriculum or career ladder, the need for research to enlarge nursing's knowledge base and for the certification of advanced clinical competence with new approaches of reward for expert nursing practice.[37]

While these reports were being written, professional nursing organizations were struggling with nursing roles, the utilization of graduates from various nursing programs and the improvement of hospital schools of nursing. Strong support for diploma education continued until 1965 when the ANA distinguished among professional nursing practice with a baccalaureate degree in nursing, technical nursing with an associate degree in nursing, and nursing assistants with intensive, pre-service programs in vocational educational institutions rather than on-the-job training.[38] Response to the ANA's statement could be described as an adversarial one.[39] The Position Paper was said to be degrading and insulting.[40] Later, the Board of Directors of the ANA seemed to reverse their position on baccalaureate education and described diploma nurses as "filling critical leadership positions having qualified to do so through experience, self-development and continuing education . . . neither the license nor formal education credentials are measures of the quality of a nurse's practice, nor is the professional label such a measure, although they are often so misused."[41] However, pressure to close the hospital schools came from several sources in addition to the Position Paper of 1965: the increasing demands and standards of the NLN;[42] the cost of the

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.*

37. J. LYSAUGHT, ACTION IN AFFIRMATION: TOWARD AN UNAMBIGUOUS PROFESSION OF NURSING 191 (1981).

38. *See generally* American Nurses Association, *supra* note 6.

39. *See generally* D. ENGLAND, *supra* note 2.

40. K. CAFFERTY & L. SUGARMAN, STEPPING STONES TO PROFESSIONAL NURSING (5th ed. 1971).

41. American Nurses Association Board of Directors, *ANA Issues Statement on Diploma Graduates*, 73 AM. J. NURSING 1135 (1973).

42. NATIONAL LEAGUE FOR NURSING, DEPT. OF DIPLOMA PROGRAM, TOWARD EX-

programs;[43] and the difficulty in obtaining qualified faculty.[44]

Between 1964 and 1984, the number of accredited diploma-granting hospital schools decreased from eight hundred thirty-three to two hundred seventy-three; at the same time, the accredited associate degree program ("AD") increased from one hundred thirty to seven hundred seventy-seven.[45] AD programs, designed to prepare technical nurses, were developed on an assumption that nursing practice could be divided into assisting or technical and professional responsibilities.[46] Associate degree education gained prestige and acceptance when the ANA Position Paper of 1965 promoted the concept of the technical nurse.

Until 1982, the National League for Nursing continued to endorse all levels of nursing education. That year the Board supported the baccalaureate degree as the minimal preparation for nursing practice.[47] However, in a 1985 letter to its members, the NLN expanded its position to support two levels of nursing practice, professional and associate.[48] The organization issued a call for unity and placed itself in the midst of the new educational debate.[49] The NLN's stated goal in its 1985 statement was to provide a voice for its constituent members which represent baccalaureate, associate degree, diploma and practical nurse education while ensuring that patients have the finest nursing care available during a period of transition.

The twentieth century is ending and nursing and the public it serves have three levels of preparation for professional education and three educational routes of passage to the National Council of State Board Examinations. Employment agencies make little administrative or clinical distinction among the holders of the registered nurse license. Both the ANA and the NLN have modified their positions on the issue of basic entry into nursing. Nursing has not marketed education for professional nurses at the baccalaureate level within its own community. More significantly, consumers, often unable to distinguish nurses from other health workers, demonstrate little interest in categories of nurses. Nursing has been unable to convince the

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CELLENCE IN NURSING EDUCATION: A GUIDE FOR DIPLOMA SCHOOL IMPROVEMENT 4-37 (2d ed. 1971).

43. Wilkinson, *Hospital Schools of Nursing: Profits Counterpoint Costs*, 50 HOSPITALS 95, 96 (Apr. 16, 1976).

44. V. CONLEY, CURRICULUM AND INSTRUCTION IN NURSING 22 (1973).

45. NATIONAL LEAGUE FOR NURSING, BASIC NURSING EDUCATION: ANNUAL SURVEY (1985) [hereinafter BASIC NURSING EDUCATION].

46. Montag, *Debate: Ladder Concept in Nursing Education*, 19 NURSING OUTLOOK 727 (1971).

47. *See generally* POSITION STATEMENT ON NURSING, *supra* note 7.

48. *See generally* BASIC NURSING EDUCATION, *supra* note 45.

49. *See generally* NATIONAL LEAGUE FOR NURSING, *supra* note 8.

general public that baccalaureate education will enhance their nursing care. Yet, as Florence Nightingale demonstrated, public support is essential to finance nursing education and mold its future to meet the health needs of consumers.

As this essay is being written, yet another study group makes its first report[50] (National Commission Nursing Implementation Project, 1986) on its goal to provide leadership to implement key recommendations of the 1983 National Commission on Nursing — an interdisciplinary group charged by the American Hospital Association to study nursing at the height of a critical nursing shortage in the early eighties — and the Institute of Medicine's report to Congress on Nursing and Nursing Education (Division of Health Care Services, 1983).[51] The National Commission Nursing Implementation Project ("NCNIP") is directing its work toward the development of the characteristics of the professional nurse, the technical nurse and formulating a plan for nursing programs for the future.[52]

Difficulties in predicting future needs for nurses and shaping nursing's role in the health care environment are acknowledged by the NCNIP including: shifting payment systems, increased proportion of the aged population, increased competition among health care providers; increased complexities of client needs and severity of client conditions, and government intervention in cost containment.[53] These issues are so broad and so complex that it is appropriate that members of the commission include leaders in nursing as well as those in the consumer movement, medicine, hospital administration, health insurance, education, and public as well as private health care agencies. It is an excellent omen for progress in meeting its goal that the major nursing organizations, the American Association of Colleges of Nursing, American Nurses' Association, American Organization of Nurse Executives and the National League for Nursing are collaborating to create the process to implement the recommendations for change. Consensus is the major thrust of the project.

This paper on advocacy in nursing education over the past sixty years could be interpreted as an essay about failure. This is not true. With each report and statement, learning conditions improved, students were less exploited, patients received more sophisticated and skillful care, and more

50. National Commission Nursing Implementation Project (Nov. 1986) [hereinafter Nursing Implementation Project].

51. DIVISION OF HEALTH CARE SERVICES, INSTITUTE OF MEDICINE, NURSING AND NURSING EDUCATION: PUBLIC POLICIES AND PRIVATE ACTIONS (1983).

52. NATIONAL COMMISSION ON NURSING, SUMMARY REPORT AND RECOMMENDATIONS (1983).

53. *See* Nursing Implementation Project, *supra* note 50, at 4.

nurses assumed leadership roles on the health team. This essay has examined one dimension of advocacy in nursing education and synthesized the perseverance and tenacity required in the advocacy role. The constancy of support for nursing education at the baccalaureate level is a tribute to those who have spoken over the years. The task for future advocates will be to develop better strategies for soliciting support from consumers who are informed and understand the need for professional nurses who have the foundation of a baccalaureate education as well as the caring and technical competencies to provide the complex nursing care required for the twenty-first century.