Annual Report

and

Proceedings

of the

Forty-fourth Annual Convention

of the

National League of Nursing Education

KANSAS CITY, MISSOURI

APRIL 24-29, 1938

NATIONAL HEADQUARTERS

50 West 50 Street

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Winifred Kaltenbach  
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Children's Memorial Hospital, Chicago, Ill.
*Winifred Rand  
71 Ferry Ave., E., Detroit, Mich.

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Massachusetts General Hospital, Boston, Mass.

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Anne Radford
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508 Pere Marquette Building, New Orleans, La.
FORTY-FOURTH ANNUAL REPORT

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185 High St., Pittsfield, Mass.

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* Members of Executive Committee
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Edna S. Newman  
Saint Luke’s Hospital, Cleveland, Ohio

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306 S. Kingshighway, St. Louis, Mo.

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9514 69 Ave., Forest Hills, N. Y.

Stella Goostray  
The Children’s Hospital, Boston, Mass.

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18 E. Division St., Chicago, Ill.

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Effie J. Taylor  
Yale University School of Nursing, New Haven, Conn.

Claribel A. Wheeler  
50 W. 50 St., New York, N. Y.

Alma H. Scott  
50 W. 50 St., New York, N. Y.
PAST OFFICERS OF THE
NATIONAL LEAGUE OF NURSING
EDUCATION

The American Society of Superintendents of Training Schools for Nurses
was organized in Chicago, June, 1893. The officers of the preliminary
organization were:

ANNA L. ALSTON, President
LOUISE DARCHE, Secretary
LUCY L. DROWN, Treasurer

Officers elected in the years following have been:

1894 New York, N. Y., January 10–11.
   President, Anna L. Alston; Secretary, Louise Darche; Treasurer, Lucy L.
   Drown.

   President, Linda Richards; Secretary, Louise Darche; Treasurer, Lucy L.
   Drown.

   President, M. E. P. Davis; Secretary, Mary S. Littlefield; Treasurer, Lucy
   L. Drown.

1897 Baltimore, Md., February 10–12.
   President, M. Adelaide Nutting; Secretary, Lavinia L. Dock; Treasurer,
   Lucy L. Drown.

1898 Toronto, February 10–12.
   President, Mary Agnes Snively; Secretary, Lavinia L. Dock; Treasurer, Lucy
   L. Drown.

   President, Isabel McIsaac; Secretary, Lavinia L. Dock; Treasurer, Lucy L.
   Drown.

1900 New York, N. Y., April 30–May 2.
   President, Isabel Merritt; Secretary, Lavinia L. Dock; Treasurer, Anna L.
   Alline.

1901 Buffalo, N. Y., September 16–17.
   President, Emma J. Keating; Secretary, Lavinia L. Dock; Treasurer, Anna
   L. Alline.

   President, Iystra E. Grettler; Secretary, Lavinia L. Dock; Treasurer, Anna
   L. Alline.

1903 Pittsburgh, Pa., October 7–9.
   President, Ida F. Giles; Secretary, M. Adelaide Nutting; Treasurer, Anna
   L. Alline.

   President, Georgia M. Nevins; Secretary, M. Adelaide Nutting; Treasurer,
   Anna L. Alline.

1906 New York, N. Y., April 25–27.
   President, Annie W. Goodrich; Secretary, M. Adelaide Nutting; Treasurer,
   Anna L. Alline.

   President, Maudie Banfield; Secretary, Georgia M. Nevins; Treasurer, Anna
   L. Alline.

1908 Cincinnati, Ohio, April 22–24.
   President, Mary Hamer Greenwood; Secretary, Georgia M. Nevins; Treas-
   urer, Anna L. Alline.
President, Isabel Hampton Robb; Secretary, Georgia M. Nevins; Treasurer, Anna L. Alline.

President, M. Adelaide Nutting; Secretary, M. Helena McMillan; Treasurer, Anna L. Alline.

President, Mary M. Riddle; Secretary, M. Helena McMillan; Treasurer, Mary W. McKechnie.

1912 Chicago, Ill., June 3–5.
President, Mary C. Wheeler; Secretary, Jessie E. Catton; Treasurer, Mary W. McKechnie.

In June, 1912, the name of the Society was changed to the NATIONAL LEAGUE OF NURSING EDUCATION.

1913 Atlantic City, N. J., June 23–25.
President, Mary C. Wheeler; Secretary, Jessie E. Catton; Treasurer, Mary W. McKechnie.

1914 St. Louis, Mo., April 23–29.
President, Clara D. Noyes; Secretary, Sara E. Parsons; Treasurer, Mary W. McKechnie.

President, Clara D. Noyes; Secretary, Sara E. Parsons; Treasurer, Mary W. McKechnie.

1916 New Orleans, La., April 27–May 3.
President, Clara D. Noyes; Secretary, Isabel M. Stewart; Treasurer, Mary W. McKechnie.

1917 Philadelphia, Pa., April 26–May 2.
President, Sara E. Parsons; Secretary, Effie J. Taylor; Treasurer, Mary W. McKechnie.

1918 Cleveland, Ohio, May 7–11.
President, S. Lillian Clayton; Secretary, Effie J. Taylor; Treasurer, M. Helena McMillan.

President, S. Lillian Clayton; Secretary, Laura R. Logan; Treasurer, M. Helena McMillan.

1920 Atlanta, Ga., April 12–17.
President, S. Lillian Clayton; Secretary, Laura R. Logan; Treasurer, M. Helena McMillan.

1921 Kansas City, Mo., April 11–14.
President, Anna C. Jammé; Secretary, (Mrs.) Alice H. Flash; Treasurer, Bena M. Henderson.

President, Anna C. Jammé; Secretary, Martha M. Russell; Treasurer, Bena M. Henderson.

President, Laura R. Logan; Secretary, Martha M. Russell; Treasurer, Bena M. Henderson; Executive Secretary, Effie J. Taylor.

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President, Carrie M. Hall; Secretary, Ada Belle McCleery; Treasurer, Marian Rottman; Executive Secretary, Blanche Pfefferkorn.
1927 San Francisco, Calif., June 6-11.
    President, Carrie M. Hall; Secretary, Ada Belle McCleery; Treasurer,
    Marfan Rottman; Executive Secretary, Blanche Pfefferkorn.
1928 Louisville, Ky., June 4-9.
    President, Carrie M. Hall; Secretary, Ada Belle McCleery; Treasurer,
    Marfan Rottman; Executive Secretary, Blanche Pfefferkorn.
1929 Atlantic City, N. J., June 17-21.
    President, Elizabeth C. Burgess; Secretary, Stella Goosnay; Treasurer,
    Marfan Rottman; Executive Secretary, Nina D. Gage.
1930 Milwaukee, Wis., June 9-14.
    President, Elizabeth C. Burgess; Secretary, Stella Goosnay; Treasurer,
    Marfan Rottman; Executive Secretary, Nina D. Gage.
1931 Atlanta, Ga., May 4-9.
    President, Elizabeth C. Burgess; Secretary, Stella Goosnay; Treasurer,
    Marfan Rottman; Executive Secretary, Nina D. Gage.
    President, Elizabeth C. Burgess; Secretary, Stella Goosnay; Treasurer,
    Marfan Rottman; Executive Secretary, Claribel A. Wheeler.
1933 Chicago, Ill., June 12-16.
    President, Effie J. Taylor; Secretary, Stella Goosnay; Treasurer, Marfan
    Rottman; Executive Secretary, Claribel A. Wheeler.
    President, Effie J. Taylor; Secretary, Stella Goosnay; Treasurer, Marfan
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    Fleming; Executive Secretary, Claribel A. Wheeler.
    President, Nellie X. Hawkinson; Secretary, Stella Goosnay; Treasurer,
    Marfan R. Fleming; Executive Secretary, Claribel A. Wheeler.
1938 Kansas City, Mo., April 24-29.
    President, Nellie X. Hawkinson; Secretary, Stella Goosnay; Treasurer,
    Lucile Petry; Executive Secretary, Claribel A. Wheeler.

The Organization has affiliations with

American Association of Medical Social Workers, 18 East Division Street, Chicago,
Ill.
American College of Surgeons, 40 East Erie Street, Chicago, Ill.
American Council on Education, 744 Jackson Place, Washington, D. C.
American Dietetic Association, 185 North Wabash Avenue, Chicago, Ill.
American Hospital Association, 18 East Division Street, Chicago, Ill.
American Nurses' Association, 50 West 50 Street, New York, N. Y.
American Psychiatric Association, 2 East 103 Street, New York, N. Y.
American Red Cross Nursing Service, Washington, D. C.
American Social Hygiene Association, 50 West 50 Street, New York, N. Y.
American Society for the Control of Cancer, 1250 Sixth Avenue, New York, N. Y.
Association of Collegiate Schools of Nursing, Teachers College, New York, N. Y.
Association for Promotion and Standardization of Midwifery, New York, N. Y.
Council on Medical Education and Hospitals of the American Medical Association,
535 North Dearborn Street, Chicago, Ill.
Maternity Center Association, 1 East 57 Street, New York, N. Y.
National Committee for Mental Hygiene, 50 West 50 Street, New York, N. Y.
National Education Association of the United States, Washington, D. C.
National Organization for Public Health Nursing, 50 West 50 Street, New York,
N. Y.
National Tuberculosis Association, 50 West 50 Street, New York, N. Y.
PROCEDINGS
FORTY-FOURTH ANNUAL CONVENTION
NATIONAL LEAGUE OF NURSING EDUCATION
Kansas City, Missouri, April 24-29, 1938

Opening Business Session
Monday, April 25, 2:00 p.m.

Presiding: Nellie X. Hawkinson, R.N., President.

The opening business session of the Forty-fourth Annual Convention of the National League of Nursing Education was called to order by the President, Nellie X. Hawkinson. Since the roll call indicated that representatives from all but two states were present, the president declared the convention in session.*

REPORT OF THE SECRETARY

As is customary, the Board of Directors elected at the annual convention convened immediately following the meeting to appoint the committees for the year and to act on matters which had been referred by members in convention.

The Board accepted the recommendations of the convention which originated with the New York State League

That the National organization through its state and local branches:

a. Encourage better programs of publicity to interest desirable candidates to enter schools of nursing
b. Discontinue the discussion of graduate nurse unemployment
c. Advocate improvement of working conditions for graduate nurses.

These recommendations were also transmitted to the Committee on Subsidiary Workers and the Committee to Consider the Relationship of the Graduate Nurse and Her Place in the Hospital. The Board also requested the Nursing Information Bureau to assume responsibility for recruiting publicity.

At the convention the Committee on Accrediting was accepted as a Standing Committee and has gone forward with the work which the convention authorized—"determining standards and accrediting procedures for the accreditation programs in nursing education." As the statement in the By-laws did not give this Committee power to accredit schools, the Board referred the matter to that Committee with a recommendation for revision in order to make it clear that they have been delegated with the power to accredit schools.

The Board of Directors also notified the American Hospital Association that they would be glad to have them appoint a second consultant to the Accrediting Committee in order that the small hospital may be represented.

* By-laws—Article XI, Section 3—"Members from fifteen states shall constitute a quorum for the transaction of business at any annual convention."
The mid-year meetings were held as usual in January with all members and officers in attendance but one. Reports were received from all committees. The Board approved the recommendation of the Committee on the Child in Nursing Education that the name be changed to the Committee on the Care of the Child.

The Committee to Study Administration in Schools of Nursing, which was formerly a subcommittee of the Curriculum Committee, was organized following the convention as a Special Committee. This Committee has been authorized by the Board to direct a study of administrative procedures in schools of nursing with Effie J. Taylor as chairman and Elizabeth Pierce as full-time secretary. Through the generosity of a friend of the League, funds have been provided for this study.

By vote of the Board, the name of the Committee to Consider Lay Participation was changed to Committee on Lay Participation, and the following recommendations contained in the Committee's report, as amended by the Board, were adopted:

1. That the National League of Nursing Education recommend to the state and local leagues the organization of committees on lay participation similar to that now existing in the National League of Nursing Education.

2. Further that the state and local committees encourage the development of organized lay conference groups; the purpose of these groups would be to study the functions of nursing school councils and of nursing committees of hospital boards with a view to more active promotion of sound programs in nursing education. These conference groups could be invited, through the media of the Committee on Lay Participation, to plan for a program meeting at appropriate times in connection with the meetings of the state and local leagues.

On recommendation of the special committee appointed by the Board to consider the functions of the Curriculum Committee as interpreted by that Committee, it was voted that the functions be interpreted in general as follows:

a. Planning educational programs and organized curricula for graduate nurses (including the educational staff), as well as for students on the basic level.

b. Planning educational programs in the various areas of specialization unless some other organization or committee has been given responsibility for specific areas, as for example, public health nursing.

c. The planning of educational programs would include the study of objectives, content (including experience), methods of instruction, supervision, and guidance of same; organization and operation of educational programs with the measuring of outcomes; provision for all types of teaching aids and facilities.

d. This committee would also be expected to coordinate studies and activities that relate to the planning of educational programs for nurses and to keep in touch with studies in closely related subjects.

e. Activities of the state committees should be within the same area, the understanding being that the National Committee will cooperate closely with the state committees and will coordinate the activities of these committees so far as this is possible without restricting the freedom of these committees in the different states.
It was voted that we inform our state leagues that in line with our Certificate of Incorporation which states that the object of this Association should be to "consider all questions relating to nursing education . . . assist in furthering all matters pertaining to public health . . . to aid in all measures for public good by cooperating with other bodies, educational, philanthropic, and social," we consider it important that our National and state leagues keep informed of those activities related to nursing which are being carried on by various organizations, such as state departments of education, and that they stand ready to advise on such activities as occasion arises.

There are now 37 state leagues. South Dakota organized its League during the year, and the Oklahoma League has been reorganized. Ohio and Virginia have also organized leagues which have just been accepted.

We record with regret the names of the following members who have died since our last annual meeting:

- MARY CAMPBELL ........................................... June 5, 1937
- MAGDALENE JEFFREY ..................................... August 14, 1937
- SADIE J. O'BRIEN ....................................... August 26, 1937
- NELLIE M. SENCER ...................................... September 8, 1937
- MARY ELLEN HOWARD (MRS.) ............................ September 17, 1937
- IRENE NOLTING .......................................... September 26, 1937
- NELLIE M. ROBERTS ..................................... October 25, 1937
- MINERVA LUCE Dickey ................................... November 15, 1937
- MAY FOSTER SMITH ...................................... January 31, 1938
- MINA M. BOOBER ......................................... February 8, 1938
- MARY MAY PETERSON .................................... February 8, 1938
- CHRISTINE MACLEOD ..................................... February 11, 1938
- ANNA L. HANSEN ......................................... March 11, 1938
- ALICE P. KELLY ......................................... April 4, 1938
- MARY A. WELSH .......................................... April 12, 1938
- GRACE BREADON .......................................... April 23, 1938
- ELEANOR CECILIA BALTZLY ............................... May 16, 1938

Respectfully submitted,

STELLA GOOSTRAY, Secretary

FINANCIAL REPORT OF THE TREASURER

MRS. MARK L. FLEMING, Treasurer
National League of Nursing Education
50 West 50th Street, New York, N. Y.

Dear Madam:

Pursuant to engagement I have made an examination of the books of account of the National League of Nursing Education for the purpose of verifying by audit procedure the correctness of the transactions for the year ended December 31, 1937, and present herewith the following two exhibits and five schedules:

Exhibit "A"—Schedule "2"—Statement Showing Changes in the Fund for Carrying on Grading Committee Activities for the Year Ended December 31, 1937.


Exhibit "A"—Schedule "4"—Statement of Receipts and Disbursements of the Special Fund for Continuation of Curriculum and Accrediting for the Year Ended December 31, 1937.


Exhibit "B"—Schedule "1"—Statement of Headquarters Expenses for the Year Ended December 31, 1937.

In connection with the foregoing I examined or tested accounting records of the corporation and other supporting evidence including confirmation of cash and securities by inspection or certificate from the depositories. I also made a general review of the operating and income accounts for the year but did not make a detailed audit of the transactions.

In my opinion based upon such examination and subject to the approximate value of securities the accompanying two exhibits and five schedules fairly present the financial condition of the corporation at December 31, 1937, and the results of the operations for the year ended on that date.

Very truly yours,

(Signed) Frederick Fischer, Jr.,
Certified Public Accountant

New York, N.Y., January 21, 1938

EXHIBIT A

STATEMENT OF FINANCIAL CONDITION, DECEMBER 31, 1937

Assets

Cash:
Checking account ........................................... $10,052.44
Savings accounts ........................................... 12,731.96
Petty cash fund ............................................. 40.00

$22,824.40

Securities (at approximate market value at December 31, 1937):
$8,000 Plainfield Title & Mortgage Guaranty Co.
1st Mortgage Certificates 3% 1941-2 .................. $6,000.00 *
$5,000 Chicago Rock Island & Pacific R. R. Co.
4% 4/1/34 .................................................... 425.00

6,425.00

Accounts receivable—for sales of publications .......... 8.08
Loan receivable by the Special Fund for Continuation of Curriculum and Accrediting from the General Fund .......... 300.00

Total Assets .................................................. $29,357.48
Liabilities

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loan payable by the General Fund to the Special Fund for Continuation of Curriculum and Accrediting</td>
<td>$300.00</td>
</tr>
</tbody>
</table>

**Total Liabilities** $300.00

**Net Asset Value** $29,257.48

The Net Asset Value Comprises the Following Fund Balances at December 31, 1937:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Fund, per Exhibit &quot;B&quot;</td>
<td>$10,951.20</td>
</tr>
<tr>
<td>Special American Nurses' Association Fund, per Schedule &quot;1&quot;</td>
<td>1,217.42</td>
</tr>
<tr>
<td>Fund for Carrying on Grading Committee Activities, per Schedule &quot;2&quot;</td>
<td>895.09</td>
</tr>
<tr>
<td>Special Research Fund—Curriculum Committee, per Schedule &quot;3&quot;</td>
<td>382.61</td>
</tr>
<tr>
<td>Special Fund for Continuation of Curriculum and Accrediting, per Schedule &quot;4&quot;</td>
<td>11,079.37</td>
</tr>
<tr>
<td>Special Fund for Advisory Groups</td>
<td>4,731.79</td>
</tr>
</tbody>
</table>

**Total** $29,257.48

* Approximate value at December 31, 1937, furnished by Plainfield Title and Mortgage Guar-anty Co.
† The balance of this fund at December 31, 1936, in amount of $4,731.79 remained unchanged for the year ended December 31, 1937.

**EXHIBIT A—SCHEDULE 1**

**STATEMENT SHOWING CHANGES IN THE SPECIAL AMERICAN NURSES’ ASSOCIATION FUND FOR THE YEAR ENDED DECEMBER 31, 1937**

**Balance December 31, 1936** $856.34

**Add—Receipts**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions from the American Nurses' Association for 1937 projects</td>
<td>5,000.00</td>
</tr>
</tbody>
</table>

**Total** $5,856.34

**Deduct—Expenses for year 1937**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Study:</td>
<td></td>
</tr>
<tr>
<td>Salaries—Director, Statistician and Cler-ical</td>
<td>$3,280.00</td>
</tr>
<tr>
<td>Field travel</td>
<td>45.12</td>
</tr>
<tr>
<td>Printing, mimeographing, stationery, postage, etc.</td>
<td>182.56</td>
</tr>
</tbody>
</table>

**Total Cost Study** $3,457.68

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditing</td>
<td>25.00</td>
</tr>
<tr>
<td>Salary—Stenographic service</td>
<td>660.00</td>
</tr>
<tr>
<td>Committee on Mental Hygiene:</td>
<td></td>
</tr>
<tr>
<td>Travel</td>
<td>$47.90</td>
</tr>
<tr>
<td>Mimeographing and postage</td>
<td>14.60</td>
</tr>
</tbody>
</table>

**Total Expenses for the Year Ended December 31, 1937** $4,638.92
Balance December 31, 1937, per Exhibit "A"
Unexpended on balance of December 31, 1936 $171.34
Unexpended on contribution received for 1937 projects returnable to the American Nurses' Association 1,046.08
$1,217.42

EXHIBIT A—SCHEDULE 2
STATEMENT SHOWING CHANGES IN THE FUND FOR CARRYING ON GRADING COMMITTEE ACTIVITIES FOR THE YEAR ENDED DECEMBER 31, 1937

Balance December 31, 1936 $3,314.84
Add:
Receipts from sales of "Library Handbook" 800.25
Total $4,115.09
Deduct Expenses
Salaries $2,160.00
Auditing 25.00
Committee on the Child 35.00
Joint Committee on Community Nursing 1,000.00
Total Expenses 3,220.00
Balance December 31, 1937, per Exhibit "A" $895.09

EXHIBIT A—SCHEDULE 3
STATEMENT SHOWING CHANGES IN THE SPECIAL RESEARCH FUND—CURRICULUM COMMITTEE FOR THE YEAR ENDED DECEMBER 31, 1937

Balance December 31, 1936 $4,054.46
Add Receipts
Sales of "Bulletin" 87.52
Total $4,141.98
Deduct Expenses
Salaries $1,250.00
Secretarial assistance 878.77
Central Curriculum Committee:
Travel $308.70
Reporting Meeting 143.70
Miscellaneous 48.85
501.25
Production Committee:
Travel $396.32
Miscellaneous 59.67
455.99
Scholarship, Fellowship and Special Studies:
Salaries $177.65
Book list 142.34
Miscellaneous 24.72
344.71
Mimeographing 31.42
Supplies 48.59
Postage and express ....................... $49.47
Stationery ................................ 5.06
Telephone and telegraph ................. 16.58
Auditing .................................. 25.00
Miscellaneous ............................ 23.47
Cost of Editing "Curriculum" .......... 131.06

$3,759.37

Balance December 31, 1937, per Exhibit "A" $382.61

EXHIBIT A—SCHEDULE 4

STATEMENT OF RECEIPTS AND DISBURSEMENTS OF THE SPECIAL FUND FOR CONTINUATION OF CURRICULUM AND ACCREDITING FOR THE YEAR ENDED DECEMBER 31, 1937

Receipts
Contribution ................................ $15,000.00

Total Receipts ................................ $15,000.00

Disbursements
Salaries
Professional Secretary .................. $1,103.84
Office Secretary ........................ 297.60
Secretary—Committee on Administration of Curriculum .......... 2,000.00
Printing, mimeographing, stationery, postage and telegraph ........ 100.66
Equipment ................................ 147.42
Travel .................................. 260.18
Telephone ................................ 10.93

Total Disbursements ..................... $3,920.63

Balance December 31, 1937, per Exhibit "A" $11,079.37

EXHIBIT B

STATEMENT OF INCOME AND EXPENSES AND CHANGES IN THE BALANCE OF THAT FUND FOR THE YEAR ENDED DECEMBER 31, 1937

Income
Membership dues
State .................................... $12,895.00
Individual .............................. 1,398.00
Individual with application .......... 406.00

$14,699.00

Contribution .......................... 315.25
Interest from investments ............ 270.00
Interest from savings accounts ....... 236.55
Convention registration fees .......... 973.00
Fees for services—Department of Studies .... 873.00
Royalties ................................ 30.20
Sales of:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publications</td>
<td>$4,238.75</td>
</tr>
<tr>
<td>Photographs</td>
<td>101.75</td>
</tr>
<tr>
<td>Record forms</td>
<td>1,690.62</td>
</tr>
<tr>
<td>Slides</td>
<td>476.50</td>
</tr>
<tr>
<td>State League supplies</td>
<td>64.14</td>
</tr>
<tr>
<td>Publication &quot;Curriculum&quot;</td>
<td>11,013.84</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$17,585.60</strong></td>
</tr>
</tbody>
</table>

Expenses

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Officers and Board of Directors expenses (January, 1937)</td>
<td>$712.72</td>
</tr>
<tr>
<td>President's expenses</td>
<td>341.05</td>
</tr>
<tr>
<td>Executive Secretary's expenses</td>
<td>279.65</td>
</tr>
<tr>
<td>Premium on Treasurer's surety bond</td>
<td>12.50</td>
</tr>
<tr>
<td>Stationery</td>
<td>153.82</td>
</tr>
<tr>
<td>Attorney's fees</td>
<td>150.00</td>
</tr>
<tr>
<td>Auditing</td>
<td>75.00</td>
</tr>
<tr>
<td>Reporting Joint Board of Directors meeting</td>
<td>23.77</td>
</tr>
<tr>
<td>For Nursing Information Bureau expenses</td>
<td>300.00</td>
</tr>
<tr>
<td>Printing annual report</td>
<td>2,046.13</td>
</tr>
<tr>
<td>Printing Basic Book List</td>
<td>328.56</td>
</tr>
<tr>
<td>Photograph leaflets</td>
<td>57.89</td>
</tr>
<tr>
<td>Exhibits</td>
<td>108.65</td>
</tr>
<tr>
<td>Committees:</td>
<td></td>
</tr>
<tr>
<td>Lay Participation</td>
<td>$82.36</td>
</tr>
<tr>
<td>Finance</td>
<td>55.72</td>
</tr>
<tr>
<td>Nominating</td>
<td>8.81</td>
</tr>
<tr>
<td>Administration</td>
<td>10.62</td>
</tr>
<tr>
<td>Records</td>
<td>38.20</td>
</tr>
<tr>
<td>Revisions</td>
<td>4.75</td>
</tr>
<tr>
<td>Studies</td>
<td>21.10</td>
</tr>
<tr>
<td>Subsidiary Workers</td>
<td>5.03</td>
</tr>
<tr>
<td>Program</td>
<td>129.35</td>
</tr>
<tr>
<td>Sisters</td>
<td>1.50</td>
</tr>
<tr>
<td>Headquarters</td>
<td>33.40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>390.84</strong></td>
</tr>
</tbody>
</table>

Convention Expense:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Officers expense</td>
<td>$394.93</td>
</tr>
<tr>
<td>Printing convention reports</td>
<td>54.11</td>
</tr>
<tr>
<td>Printing By-laws revisions</td>
<td>158.00</td>
</tr>
<tr>
<td>Publicity</td>
<td>79.76</td>
</tr>
<tr>
<td>Reporting conventions</td>
<td>100.80</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>152.16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>939.76</strong></td>
</tr>
</tbody>
</table>

Printing and other expenses of publications, etc., for resale:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Photographs</td>
<td>$93.50</td>
</tr>
<tr>
<td>Slides</td>
<td>212.38</td>
</tr>
<tr>
<td>Record forms</td>
<td>889.75</td>
</tr>
<tr>
<td>State League supplies</td>
<td>51.51</td>
</tr>
<tr>
<td>Sundry League publications</td>
<td>1,835.03</td>
</tr>
<tr>
<td>Publication &quot;Curriculum&quot;</td>
<td>5,064.32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8,146.49</strong></td>
</tr>
</tbody>
</table>
CONVENTION PROCEEDINGS

Miscellaneous ........................................... $54.54
Headquarters Expenses, per Schedule "1" ............. 19,606.77

Total Expenses ........................................... $33,728.14

Excess of Income over Expenses ......................... $1,256.46

Balance of General Fund December 31, 1936 .... $9,944.74
Deduct: Additional depreciation in estimated value
of securities ........................................... 250.00

9,694.74

Balance of General Fund December 31, 1937, per Exhibit "A" ........... $10,951.20

EXHIBIT B—SCHEDULE 1

STATEMENT OF HEADQUARTERS EXPENSES FOR THE YEAR
ENDED DECEMBER 31, 1937

Headquarters Expenses

<table>
<thead>
<tr>
<th>General</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$7,939.98</td>
</tr>
<tr>
<td>Rent</td>
<td>2,245.07</td>
</tr>
<tr>
<td>Special office care</td>
<td>29.40</td>
</tr>
<tr>
<td>Telephone</td>
<td>379.28</td>
</tr>
<tr>
<td>Telegrams</td>
<td>56.76</td>
</tr>
<tr>
<td>Supplies</td>
<td>287.59</td>
</tr>
<tr>
<td>Shipping service</td>
<td>645.73</td>
</tr>
<tr>
<td>Postage and express charges</td>
<td>1,920.14</td>
</tr>
<tr>
<td>Mimeographing and multigraphing</td>
<td>327.37</td>
</tr>
<tr>
<td>Extra stenographic services</td>
<td>580.22</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>206.28</td>
</tr>
<tr>
<td>Library service</td>
<td>150.00</td>
</tr>
<tr>
<td>Entertainment</td>
<td>50.70</td>
</tr>
<tr>
<td>Insurance</td>
<td>33.73</td>
</tr>
<tr>
<td>Reference books and reports</td>
<td>29.26</td>
</tr>
<tr>
<td>Equipment</td>
<td>30.39</td>
</tr>
<tr>
<td>Moving</td>
<td>324.16</td>
</tr>
<tr>
<td>Membership campaign</td>
<td>203.01</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$15,439.07</strong></td>
</tr>
</tbody>
</table>

Department of Studies

Salaries:
- Director of studies .................. $2,409.98
- Statistician ......................... 750.00
- Clerical ............................. 780.00
- Field travel ........................ 45.13
- Printing, mimeographing, postage and stationery .... 182.59

**Total Headquarters Expense, per Exhibit "B"** ........... $19,606.77
GENERAL FUND—FINANCIAL REPORT—JANUARY 1 TO MARCH 31, 1938

Net Asset Value, January 1, 1938 ........................................... $29,257.48

<table>
<thead>
<tr>
<th>Income</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum</td>
<td>$1,253.76</td>
</tr>
<tr>
<td>Publications</td>
<td>792.55</td>
</tr>
<tr>
<td>Photographs</td>
<td>38.25</td>
</tr>
<tr>
<td>Records</td>
<td>569.22</td>
</tr>
<tr>
<td>Slides</td>
<td>212.50</td>
</tr>
<tr>
<td>Guide for the Use of League Records</td>
<td>90.40</td>
</tr>
<tr>
<td>Contributions</td>
<td>100.25</td>
</tr>
<tr>
<td>State League Supplies</td>
<td>29.05</td>
</tr>
<tr>
<td>Interest on Mortgage Certificates</td>
<td>120.00</td>
</tr>
<tr>
<td>Royalties</td>
<td>16.90</td>
</tr>
<tr>
<td>Dues: State</td>
<td>8,860.00</td>
</tr>
<tr>
<td>Individual</td>
<td>1,512.00</td>
</tr>
</tbody>
</table>

Sundry Accounts—Miscellaneous .................. 63.66

Total ....................................................... $42,915.79

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headquarters Appropriation</td>
<td>$8,000.00</td>
</tr>
<tr>
<td>Publications</td>
<td>65.27</td>
</tr>
<tr>
<td>Photographs</td>
<td>78.00</td>
</tr>
<tr>
<td>Slides</td>
<td>34.89</td>
</tr>
<tr>
<td>Reprinting Old Record Forms</td>
<td>308.23</td>
</tr>
<tr>
<td>Printing New Record Forms</td>
<td>2,277.21</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>26.38</td>
</tr>
<tr>
<td>State League Supplies</td>
<td>57.64</td>
</tr>
<tr>
<td>Holding Type for Curriculum</td>
<td>45.82</td>
</tr>
<tr>
<td>Auditor's Fees</td>
<td>150.00</td>
</tr>
<tr>
<td>Board of Directors Expenses—January meeting</td>
<td>586.64</td>
</tr>
</tbody>
</table>

Committees:
- Child ................................................... 7.85
- Joint Committee on Community Nursing Service | 167.73  |
- Curriculum ............................................ 23.58
- Finance .................................................. 28.20
- Lay Participation .................................... 2.35
- Membership ............................................. 4.10
- Records .................................................. 5.20
- Joint Com. on Relationships of Graduate Nurse | 4.10   |

Convention Expenses—Miscellaneous ............ 6.45

Department of Studies: Salaries ............... 205.02

Cost Study:
- Salaries ................................................ 827.49
- Field Travel .......................................... 69.66
- Postage, Mimeographing, Stationery, etc. .... 48.85

Special ANA Fund

Cost Study: Salaries ................................ 827.49
Field Travel ........................................... 69.66
Postage, mimeographing, stationery, etc. ........ 63.14

$960.29

$13,025.68
## Convention Proceedings

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis Study: Mimeographing</td>
<td>$1.94</td>
</tr>
<tr>
<td>Committee on Mental Hygiene—Mimeographing</td>
<td>3.80</td>
</tr>
</tbody>
</table>

**Fund for Accrediting**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$1,993.32</td>
</tr>
<tr>
<td>Travel Expenses</td>
<td>14.15</td>
</tr>
<tr>
<td>Survey Work</td>
<td>576.90</td>
</tr>
<tr>
<td>Printing, stationery, mimeographing, etc.</td>
<td>586.39</td>
</tr>
</tbody>
</table>

**Fund for Research in Nursing**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$750.00</td>
</tr>
<tr>
<td>Clerical Assistance</td>
<td>29.67</td>
</tr>
<tr>
<td>Postage, supplies, etc.</td>
<td>53.94</td>
</tr>
<tr>
<td>Travel Expenses</td>
<td>5.00</td>
</tr>
</tbody>
</table>

**Sundry Accounts—Miscellaneous**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>46.15</td>
</tr>
</tbody>
</table>

**Total Expenses**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$18,047.23</td>
</tr>
</tbody>
</table>

**Balance, March 31, 1938**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$24,868.56*</td>
</tr>
</tbody>
</table>

Respectfully submitted,

MARIAN R. FLEMING, Treasurer

---

* $8,000 Plainfield Title & Mortgage Company 1st Mortgage Certificates | $6,000.00
* $5,600 Chicago, Rock Island & Pacific R. R. Company Bond | 425.00

This amount, $6,425.00, market value as of December 31, 1937, is included in our balance, but can not be liquidated at the present time.

## Report of the Executive Secretary

### Introduction

A report of the activities of the National League of Nursing Education as carried on at headquarters since the annual convention in Boston is herewith presented.

The officers and directors of the National League of Nursing Education have ever before them goals to be reached and visions of things which seem at times unattainable, yet all progress in nursing education has been due to untiring endeavor in the direction of seemingly unattainable goals. The ends toward which we strive are often obscured by uncertainty and vague doubt, but after thought, discussion, and work, they crystallize and eventually become realities. So each year is recorded the birth or completion of some new enterprise as the League goes forward with an ever-expanding program for the improved preparation of nurses.

Undoubtedly, an important milestone reached this year in the progress of the League's work is the beginning of the accreditation program. When one glances back through the *Annual Reports* and the minutes of the meetings of the Board of Directors, one realizes what a long time it has taken to bring this dream to an actuality.

A second important milestone is the study of the costs of nursing service and nursing education in which the League is engaged with the American
Hospital Association. In the near future, we shall at last have something reliable for the use of hospitals and schools of nursing.

The study of the administration of nursing schools, one of our newest ventures, is a third milestone which should point the way to better administration in schools of nursing.

Cooperative relationships with other national organizations have been increased and strengthened. In this way the work of the League is becoming better known and appreciated by groups which are closely allied to nursing.

The nursing profession itself is becoming more League-minded as evidenced by the organization of new state and local leagues and the increase in League membership. This development of our branches is an indication of growth in the right direction, for a top-heavy national organization carrying on many activities which are not shared by state and local groups is not a sound organization. An effective program must be participated in by our members in every part of the country. This fact cannot be emphasized too often, since the chief support of the League, both moral and financial, comes from our branches and from our members in every state and community.

Your Executive Secretary has been greatly cheered by the welcome she has received in the states she has visited and by the eagerness with which some of our members have sought advice and suggestions from our national organization. Such visits point out the great need for a national representative who would be able to spend the major part of her time in the field.

Membership

The report of the Chairman of the Committee on Membership Campaign will give in detail the work which has been done in an attempt to secure new members. We have again failed to reach that long-cherished goal of 5,000. However, it is encouraging that 1,042 new members were admitted to the League last year, making a total of 4,574 members.

Activities in Headquarters Office

The headquarters personnel have been taxed to the limit of their capacities during the past year, especially last spring and summer when the proofreading, editing, and other details of publishing the new Curriculum Guide for Schools of Nursing were assumed by the office without any additional staff being employed.

During the summer the Annual Report, the Basic Book List, and the biographical sketches were prepared for the press. The booklet, How the NLNE Serves You, was revised and reprinted in the fall. In December a questionnaire was tabulated on student enrollment and the number of staff nurses employed in hospitals maintaining schools of nursing. At the same time we were swamped with orders for the Curriculum and other publications. The Manual of Office Procedure and Convention Procedure has been completely revised.
Every new activity and every new committee which the League takes on adds work for the general staff. Credit is due them for their untiring efforts and their willingness to stay on after hours when necessary.

The following analysis of mail shows something of the character of the correspondence which is carried on by the headquarters staff:

**Incoming mail (May, 1937 to April, 1938)**

- Educational ........................................... 7,375
- Publications, dues, etc. ............................. 8,234
- Department of Studies ............................... 1,896
- Committee on Accrediting (January to April) ..... 279

**Total (Incoming)** ........................................ 17,784

**Outgoing mail (May, 1937 to April, 1938)**

- Educational ........................................... 8,234
- Publications, dues, etc. ............................. 14,206
- Form letters .......................................... 8,764
- Department of Studies ............................... 2,560
- Committee on Accrediting (January to April) ..... 670

**Total (Outgoing)** ........................................ 34,434

It has not been possible to keep an accurate record of the conferences and interviews held by the Executive Secretary but there has been an increase in the number during the past year. With the amount of daily mail to be answered, the number of interviews and conferences to be held, to say nothing of the numerous committee meetings to be planned for and attended, the Executive Secretary often wishes she were two or three people instead of one.

**Committee Activities**

Since a report of all committee activities will be given by committee chairmen, they will not be considered in this report. Many committee meetings have been held in New York during the year which have been attended by the Executive Secretary who serves as secretary of a number of these committees. Much work in connection with these committees is done in the headquarters office.

**Work with State Leagues**

Considerable correspondence has been carried on with state leagues during the year. The following form letters have been sent out from headquarters to the leagues:

- Letter concerning revisions in the constitution and by-laws;
- Letter asking for suggestions for the biennial convention program;
- Letter with suggested program for 1937-38;
- Letter with list of names of eligible nurses which had been sent to us by heads of schools in response to an earlier letter;
- Letter asking for names of treasurers and local league officers;
- Letter to state league presidents asking for names of chairmen of committees on mental hygiene and psychiatric nursing;
- Letter (with supply of membership cards) calling
attention to necessity of sending dues to Headquarters promptly, also changes of address; letter (with list of 1936 lapsed members) calling attention to the fact that junior active membership is no longer limited to two years; letter to chairman of state committees on mental hygiene and psychiatric nursing giving suggestions for program they might work on during coming year; letters about the lay luncheon, presidents of leagues sitting on the platform, about the advisory council meetings and other matters pertaining to the convention in Kansas City.

Many states have sent in their revised constitutions and by-laws to be checked in our office.

Oklahoma discontinued its state league in 1936, but reorganized it again last fall. South Dakota, Virginia, and Ohio have formed new leagues, and several states are organizing new local leagues.

**Student Enrollment and Employment of General Staff Nurses**

To supplement some of the figures gathered by the Nursing Information Bureau in relation to student enrollment and the employment of general duty nurses, a simple postcard questionnaire was sent out to all accredited schools of nursing. The returns were most encouraging. One thousand, two hundred and sixty schools out of the 1,386 accredited schools reported. The results of the questionnaire on student enrollment were reported in the January number of the *American Journal of Nursing* and the returns on the employment of general staff nurses were reported in the February number.

It is interesting as well as significant to note that the enrollment of students in the schools has steadily increased since 1935 and that there has been an increase also in the number of graduate nurses employed by hospitals maintaining schools.

**Field Work**

During the fall the Executive Secretary, upon the invitation of the North Carolina League, attended the state convention in Durham. After the convention one day was spent visiting the school of nursing at Duke University. She was also invited by the Georgia State Nurses' Association and the Georgia League to be a speaker at their annual convention held in Rome. In addition, she was a guest of the District Association in Atlanta where she spoke to a large group of graduate nurses and students. The nurses had also made arrangements for her to visit the schools of nursing in Atlanta.

In November, upon invitation of the Maryland League, she spoke on the work of the League at their convention. She was a guest at Johns Hopkins Hospital for several days and had the privilege of observing the work of the school.

The contacts which a national representative makes in the field are most important. It is a way of establishing better rapport with our members, of clearing up misunderstandings, and of making the purposes and objectives of the League better known than through communications and reports. Attendance at conventions and speaking on the work of the League are one
way of bringing about better relationships, but another important way is by personal conferences with our members who have problems that they want to discuss with some one from headquarters. The secretaries of the Committee on Accrediting will undoubtedly meet this long-felt need in making their visits to the schools of the country.

On December 2 the Executive Secretary attended a meeting of the Council of Personnel Administration in Washington with representatives of the American Nurses' Association and the National Organization for Public Health Nursing. The meeting was for the purpose of setting up requirements for various positions under the Civil Service. A subcommittee on hospital positions was appointed.

The Executive Secretary also attended, with our President, the meeting of the National Advisory Committee on Red Cross Nursing Service held in Washington, on December 6.

THE LEAGUE AS THE DEPARTMENT OF EDUCATION OF THE AMERICAN NURSES' ASSOCIATION*

The League functioning as the Department of Education of the American Nurses' Association is carrying on the following activities:

1. Activities with state boards of nurse examiners
2. Activities in mental hygiene and psychiatric nursing
3. Activities connected with the study of costs of nursing service and nursing education
4. Activities connected with the study of tuberculosis nursing

Since these activities are all fully reported by the Director of Studies and the chairmen of the committees under which they are carried on, they will not be described in this report. Many of these activities would not be possible without the splendid support of the American Nurses' Association.

The League has now functioned as the Department of Education of the American Nurses' Association since 1932. These six years of close working relationship have brought our two organizations into closer harmony. It has served to clarify functions and lines of organization and has been mutually advantageous to the two organizations.

THE AMERICAN JOURNAL OF NURSING AND THE NURSING INFORMATION BUREAU

The American Journal of Nursing has been most generous, as always, in giving space to the League, and in cooperating with us in securing articles and material which we have needed.

The Nursing Information Bureau, in accordance with the request of the Board of Directors in May that the Nursing Information Bureau be asked "to assume responsibility for recruiting publicity, and to give more publicity

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* A full report of the Educational Secretary of the American Nurses' Association will be found in the convention proceedings of the American Nurses' Association.
to the opportunities for graduate nurses and the need for better preparation for these fields," sent out 40,000 letters and copies of the pamphlets, Nursing and How to Prepare for it, Nursing, a Profession for the College Graduate, and Nursing and the Registered Nurse. These were sent to schools of nursing; vocational counselors in high schools and colleges; editors of women's magazines, medical, educational, and hospital magazines; and to public libraries.

In addition, the Nursing Information Bureau sent out questionnaires on enrollment and the employment of general staff nurses to the schools. This was reported in the December Journal.

We are greatly indebted to the Editor of the Journal and her staff for the splendid work that they have done for the League. It is to be hoped that in the future more substantial financial support can be given by the League to the Nursing Information Bureau.

EXHIBITS

American Hospital Association Exhibit

The League shared a booth with the American Nurses' Association at the meeting of the American Hospital Association at Atlantic City, September 13 to 17. The Executive Secretary was in charge of the League exhibit with a representative from the American Nurses' Association.

The regular League publications were on display with charts of a study of the schools made by the Department of Studies.

Many hospital superintendents from the various states in the United States and Canada visited the booth. Some of the problems which these hospital superintendents discussed with us were, where to find qualified nurses for staff duty, and how to use subsidiary workers to supplement the services of nurses. The hospital superintendents showed a willingness to relieve both graduate and student nurses from non-nursing duties by the employment of hospital helpers under supervision. Their attitude toward increasing salaries to the predereession level and toward establishing a 48-hour week was favorable. Some superintendents said that they were not getting a sufficient number of qualified students in their schools. One thoughtful medical superintendent said that he hoped the schools would not lower their entrance requirements in this crisis; that if graduate nurses could not be secured in sufficient numbers, the lesser of two evils would be to introduce more helpers on the hospital wards and have them closely supervised by graduate nurses.

Exhibits at State Meetings

The same policy has been followed as last year in sending, with the American Nurses' Association and the American Journal of Nursing, a set of publications to all the state meetings. The American Journal of Nursing very generously furnished a responsible nurse to look after these exhibits if a Journal representative could not be present. The value of these exhibits at state meetings is great, for many nurses who are not League members and
who would not otherwise see or know about our publications have an opportunity to do so at these meetings.

Advisory Committee of the New York World's Fair 1939 on Medicine and Public Health

The Executive Secretary is a member of the Advisory Committee of the New York World's Fair, 1939, on Medicine and Public Health, which is a very large committee composed of representatives from those organizations who have a contribution to make to the World's Fair in the field of medicine and public health. She is also a member of a subcommittee on the Hospital Exhibit and of the committee appointed by the American Nurses' Association to consider the possibility of a nursing exhibit at the Fair.

Activities with Other Organizations

American Nurses' Association and National Organization for Public Health Nursing

The joint activities with the American Nurses' Association and the National Organization for Public Health Nursing have been the same as reported at the May meeting. The joint committee reports will be given by the committee chairman. The Executive Secretary continues to serve as a member of the Eligibility Committee of the NOPHN and as an ex officio member of their Education Committee.

The Education Committee of the NOPHN has appointed a Subcommittee on Affiliations with Public Health Agencies to consider the question of the most productive educational use of public health agencies for field service. The League has representatives on this committee.

Other Closely Allied Organizations

The American Social Hygiene Association has appointed a public health nurse consultant to their staff whose duties will be to conduct educational and consultant work among public health nursing organizations and schools of nursing throughout the country. The League has been asked to cooperate closely with the Association in this activity.

A further step in cooperative effort was made when the American Psychiatric Association invited members of the Committee on Mental Hygiene and Psychiatric Nursing to sit in with members of their Committee on Nursing recently. The joint studies with the American Hospital Association and the National Tuberculosis Association are further indications that we are becoming more closely affiliated with other national health groups.

The Future

A complete outline of the League's activities was given at the last convention and appears in the 1937 Annual Report. It is well to review the program as a whole, since it constitutes a challenge to our membership.

There are many serious problems confronting the profession today, such as the spirit of commercialism which is becoming manifest in our ranks, the
whole question of the use and control of subsidiary workers in nursing services, and the apathy and indifference on the part of some members of the profession engaged in educational work in schools of nursing. We must not rest content until some of these problems are solved and until schools of nursing all over the country are touched by the influence of the League and until their faculties feel the need of membership in the League.

"Science, philosophy, history, and common sense unite in testifying that progress is not a free gift of the gods, but something to be earned by clear vision and hard work; and that is a human contingency based upon human effort, foresight, and constructive utilization of human powers." Consequently if we are to reach these cherished goals, we must continue to pursue them with vigor. It is a privilege, as Executive Secretary, to serve both the Board of Directors and the membership in such a high purpose.

Respectfully submitted,

Claribel A. Wheeler, Executive Secretary

REPORT OF THE DIRECTOR OF STUDIES

Since practically all of Miss Pfefferkorn’s time has been concerned with the study of costs, her report is incorporated in the report she gave as director of the cost study. (See page 103.)

THE OUTLOOK IN NURSING EDUCATION

Nellie X. Hawkins, R.N., President

It is my happy privilege as President of the National League of Nursing Education to welcome you to this, the forty-fourth, annual convention of the association, and may I give a very special welcome to the members of our three new state leagues. At this time, on the occasion of our annual business meeting, it seems fitting that your President should bring you a brief report on the outstanding activities of the year and also a few observations on the outlook in nursing education.

There are many evidences that the adaptation of the League’s curriculum to local situations has been one of the most significant educational activities of the past year. Nursing school faculties, state and local leagues, and state boards of nurse examiners have all been at work on the job of interpreting and helping to make effective the recommendations of the Curriculum Committee, as set forth in the Curriculum Guide for Schools of Nursing.

This task of revising or reconstructing the curriculum is a complex and difficult one and one which, therefore, must be carried forward gradually. No school which has embarked on such a program this past year should feel discouraged if progress has been slow. Better one step at a time and that taken soundly than many steps taken hurriedly and without thoughtful consideration. Those schools may consider the year well spent which have succeeded in making a careful study of their present programs to locate strengths and weaknesses and in drawing up definite plans—both short-
range and long-range—indicating the changes which can be made effective immediately; those which must be made effective more gradually; and those which must be deferred for some time because of limiting factors such as poorly qualified students, inadequately prepared faculty, lack of adequate financial support, et cetera. This is an essential first step in any program of curriculum revision, and schools which have gone this far along the road toward improvement of their educational programs may well be satisfied with the year's accomplishment.

As direct outcomes of the League's curriculum project, the past year has seen many encouraging evidences of forward-tending steps in educational work in nursing. The philosophy of nursing education which takes into account social and student needs as well as hospital needs, although not yet generally accepted, is gaining ground and, as a result, schools of nursing in ever-increasing numbers are providing their students with more adequate preparation for community service through greatly broadened curricula.

This progressive development, which is adding to the curriculum new educational experiences, is not without problems, however. It has raised many questions to which answers must be found, and in so far as possible these answers must be based on experimental evidence and not alone on individual opinion. Significant among the questions raised are those which have to do with providing experience in community nursing.

How can the elements of public health best be included in the undergraduate curriculum? What types of experience are necessary? Can any of these be provided in the hospital? If so, what? How far can community public health nursing agencies go in providing experience to students in the basic course, and so on ad infinitum.

These important questions are pressing for solution, but we can be encouraged by the fact that some of our more progressive schools of nursing, as well as our nursing organizations, are already studying these problems and from their findings we may hope to secure sound answers to these questions as we look to the future in nursing education.

Closely related to the problem of providing a curriculum which is more comprehensive in scope is that of securing faculty members prepared to make such a program effective. At the League convention in Boston last year, I referred to the problem of faculty preparation as one of the most significant of those related to programs of curriculum revision, and suggested that state leagues might well turn their attention to it during the coming year. Several states followed this suggestion and, in planning their programs for the year, allowed considerable time for discussion of both preservice and in-service preparation of the faculty. The League's Committee on State Board Problems is also studying faculty preparation through a subcommittee working on the up-grading of nursing school faculties, and the Curriculum Committee is planning an extensive study of all types of postgraduate education. With changing aims of nursing education and changing nursing school curricula, the training of teachers for schools of nursing must also change. Nothing
is needed so much in nursing education today as increased emphasis on and a redirection of the training of nursing school faculties.

This past year has witnessed, also, increased efforts to raise the level of entrance requirements to schools of nursing and several state boards of nurse examiners as well as a considerable number of schools of nursing have found it possible to make some progress in this direction. Although only a limited number of schools have been able to raise their educational entrance requirements to two years of general education beyond high school, the academic background of students entering schools of nursing this year is, according to figures collected by the American Journal of Nursing, slightly better than last year and in certain areas of the country the per cent of students admitted who have had college preparation has jumped considerably.\(^1\) The Journal also reports that, of the students who were admitted this fall with four years of high school only, 68 per cent or approximately two-thirds of them stood in the upper third of their classes.\(^2\) Encouraging as these figures are, compared with earlier findings, there is still need for improving the educational quality of students entering schools of nursing with high school only, and to this need every school of nursing admitting students on graduation from high school should give its serious consideration.

As we look forward to advancing the level of educational entrance requirements, it is encouraging to note that there are now approximately 550 junior colleges in the United States and that the number is steadily increasing. We are told also that institutions of higher learning now register nearly 1,000 students per 100,000 population, or 1 in every 100. Then, too, there is the tendency for young people to stay in school for a longer period of time than they did even a few years ago, due to our machine age and other conditions in modern society. All of these developments are very definitely increasing the supply of students with educational preparation beyond high school and, under these circumstances, I believe we have every reason to be optimistic about the possibility of moving toward a higher educational entrance requirement for professional schools of nursing.

Although I am convinced that sound professional education in nursing cannot be built upon anything less than two years of general education beyond high school, I am also convinced that progress along this line cannot proceed rapidly. Nursing school curricula must first be strengthened and many conditions of work corrected before we can hope to attract into nursing in any considerable number young women with two or more years of college education. The greatest deterrent is without question not nursing as a field of service, but our educational system with its many concomitant educational weaknesses. To a correction of these weaknesses, we as a League must dedicate ourselves anew and thus keep faith with our founders and with our early nursing leaders.

significant in the League's program to further the development of nursing

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\(^2\) Ibid.
education is the work of the Committee on Accrediting. This committee, like all committees of the League, has as its primary objective the improvement of nursing service to communities through the improvement of nursing education. How the League hopes to achieve this outcome through the accreditation of nursing schools is outlined in the committee’s aims, which are as follows:

To help those responsible for the administration of schools of nursing to improve their schools.

To give public recognition to schools that voluntarily seek and are deemed worthy of professional accreditation.

To publish a list of accredited schools for the purpose of guidance of prospective students in their choice of schools of nursing and to aid secondary schools and colleges in their guidance programs.

To serve as a guide to state accrediting agencies in further defining their standards for recognition of schools and to promote interstate relationships in professional registration of nurses.

To make available to institutions admitting students or graduate nurses to advanced standing, information that will help in evaluating credentials.

To provide information which may be made available to lay and professional groups for the purpose of developing an understanding of the ideals, objectives, and needs of nursing education.3

As the work of this committee goes forward, it will without question have far-reaching effects upon the nursing schools of this country, and I am confident that as a result we may look forward to marked improvement in educational work in nursing.

Although we do not as yet have an answer to the often raised question, “What does it cost to educate a student nurse?” we are much nearer to a sound answer than we were a year ago. The study by the Committee on the Cost of Nursing Education and Nursing Service, started last year under the sponsorship of the National League of Nursing Education, the American Hospital Association, and the American Nurses’ Association, was continued during the past year under the direction of Blanche Pfefferkorn, Director of Studies of the National League of Nursing Education, and Charles Rovetta, representing the American Hospital Association. The work of the committee will be discussed during the Biennial at one of the league sessions (which plan, by the way, is being followed with relation to several other important League committees) in order that our members may have an opportunity to hear about this important activity from those who are actually participating in it.

At no time since schools of nursing were organized in this country has nursing education had the financial support which it merits. Many factors are responsible for this situation, but significant among them is the organization of schools of nursing as nursing services of hospitals rather than as independent educational units with their own budgetary needs. Under this type of organization accurate information concerning the actual cost of

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nursing education as apart from that of nursing service has not been available, neither has there been any vigorous attempt on the part of those responsible for schools of nursing to secure adequate funds for the support of nursing education.

When the Committee on Costs has completed its study and when information is available which will make it easier for hospitals to break down the costs of these two activities, nursing education and nursing service, is it too hopeful to expect that it may then be possible to interest the public, the consumer of nursing service, in helping to provide adequate financial support for the preparation of this important group of community workers? In this connection, may I recall to your minds Cassius' classic reply to Brutus, "The fault, dear Brutus, is not in our stars, but in ourselves that we are underlings." We, as a professional group, have been far too reticent about bringing to the attention of the public our professional needs. This responsibility is one which we must be ready to assume and, if we will to do so, I believe we can become as potent a social force in the life of our nation as is any other professional group and can claim the attention and financial support of the community, as do these other groups of professional workers.

During the past year the League has embarked on another very much needed study, that of the organization and administration of nursing schools. The committee delegated with the responsibility of making this study was appointed last May and is proceeding under the able leadership of Effie J. Taylor, with Elizabeth Pierce as secretary. It is fortunate, indeed, that generous financial assistance has made this study possible at a time when so many searching questions concerning the organization and administration of nursing schools have been and are being raised in relation to the revision and reconstruction of nursing school curricula.

Another very generous gift has been made to the National League of Nursing Education from a true and devoted friend, and may I express our deep appreciation of the continued interest in our work and the faith in us which this gift evidences and our gratitude for the opportunities which it affords for furthering studies in the field of nursing education. The gift, contributed through the Children's Hospital Research Foundation of Cincinnati, Ohio, is for research in nursing education and makes it possible for the League to go forward with the much needed study of organization and administration as it relates to schools of nursing.

There are many other committees of the League which have been actively at work during the past year making effective the League's program of action, but time does not permit a discussion of their work nor is it necessary since the chairmen of these committees have made available to you in their reports surveys of the work in which they have engaged and also their plans for the coming year.

In considering the present outlook in nursing education, we have reason to be encouraged by many significant trends other than those which are evident in our own special field. Among these is the steadily increasing number
of graduate staff nurses employed by hospitals operating schools of nursing. Figures published by the Nursing Information Bureau in the December, 1937, American Journal of Nursing indicated that since 1932 the number of hospitals with schools which employ graduate nurses for bedside care has increased by 55 per cent and that graduate staff nurses for general duty service are employed by 88 per cent of the hospitals with schools which replied to the questionnaire sent out by the Nursing Information Bureau. The number of graduate staff nurses in these institutions totaled approximately 20,500. Since good nursing education can only be made effective in a situation where good nursing is practiced, this is, indeed, an encouraging report.

Closely related to this increase in the number of graduate staff nurses employed by hospitals is the increase in the employment of those workers usually classed as the subsidiary group (a term, by the way, to which I am inclined to take exception). The implications of this trend for both nursing and nursing education are many and need to be studied thoughtfully by organized nursing. From the standpoint of nursing education alone, I believe this movement if carefully directed can become an essential factor in developing nursing on a professional level. The National League of Nursing Education should be alert to this possibility and should be prepared to accept the responsibility of active leadership in guiding this development.

Were time not so limited, I should like to bring to your attention certain activities in other professional fields which are of great import to us when reviewed in relation to the work of our own organization. There is, for example, the study of the existing program of federal aid for vocational education made by the Advisory Committee on Education appointed by the President, the report of which is now available through the Department of the Interior, Washington, D. C. On the basis of the recommendations of this study committee, it is quite possible that changes will be made in the provisions of the act dealing with vocational education which will allow greater flexibility in administration and a wider range of educational uses for these funds. If these recommendations are accepted, nursing schools connected with public institutions would then be able to apply for financial assistance without losing professional status. Since this whole question of federal support for education is up for discussion, may this not be a good time for us to get the idea of federal support for nursing education before the country and to consider seeking appropriations as is being done by many other educational groups?

There is also the report of the American Foundation Studies in Government entitled American Medicine and the draft by the Committee of Physicians for the presentation of certain principles and proposals in the provision of medical care issued subsequent to the publication of the report, which deserve the attention of our membership. As stated by the Committee of Physicians:

It seems to us probable that certain alterations in our present system of preventing illness and providing medical care may become necessary; indeed, certain changes have already occurred. Medical knowledge is increasing rapidly and is
becoming more complex. Changes in economic and social conditions are taking place at home and abroad. Medicine must be mobile and not static if medical men are to act as the expert advisers of those who convert public opinion into action.4

Whether we do or do not agree with the philosophy set forth in this report and with the principles and proposals of the Committee of Physicians, it is important that we, as representatives of a group which is vitally concerned with the health of the nation, be intelligently informed concerning the trend indicated in these publications and that we know where we stand with relation to it.

In closing this report, may I express my deep appreciation to Miss Wheeler, our most faithful and efficient Executive Secretary; to Miss Pfeifferkorn, our Director of Studies, and to the other devoted members of the headquarters staff; to the Board of Directors for their guidance and support, and to the chairman and members of all committees for carrying on so effectively during the past year.

In reviewing the year's work, we may well be proud of what has been achieved and as we look to the future we should be encouraged by the progress already made to work hopefully for the improvements still needed.

REPORT OF THE COMMITTEE ON ACCREDITING

Since the last meeting of the National League in Boston your Committee as a whole has not met; a meeting has been called for Tuesday, April 26. The affairs of the Committee have been carried on through the Executive Committee which has had seven meetings, and one with the consultants to the Committee, October 30, 1937. We have been in communication with the members of the Committee at large and have been fortunate in having Miss Pfeiffer of Virginia, Miss Urch of Minnesota, and Sister Berenice of Wisconsin with us at various times.

The Committee has been enlarged by one additional member, Miss Blanche Pfeifferkorn, who with Sister Mary Laurentine of Pittsburgh, Pennsylvania, has accepted membership on the Executive Committee. We are particularly fortunate in having Dr. William D. Cutter, Secretary of the Council on Medical Education and Hospitals of the American Medical Association represent the American Medical Association in our group of consultants.

Miss Quereau, who was appointed last spring, came to headquarters September 27, 1937, and has assumed the responsibilities of the office of Secretary to the Committee with great enthusiasm. Miss Barbara Thompson, a graduate of the University of Minnesota School of Nursing, was appointed Assistant Secretary to the Committee and began her work with us February 1, 1938. She brings to the Committee rich experience in nursing educational work in several of the leading schools of nursing in our country and has very successfully been carrying the activities of Director of the Bureau of

Nursing Education of the Wisconsin State Board of Health. Your Committee feels extremely fortunate in the appointments of Miss Quereau and Miss Thompson and is greatly heartened by the devoted service they are rendering, which we believe assures us of the success of the Committee.

The business of the Committee has centered around discussions relative to

1. A statement of policy for the Committee’s activities
2. A plan of procedure for this year as a basis for our future work of accrediting schools
3. A consideration of the financial implications of the project
4. A selection of a limited number of schools in which schedules may be tested, criteria for accrediting may be developed, and costs of accrediting may be studied
5. The drafting, study, and trial of schedules which may be used in the survey of schools
6. Publicity of our activities in professional journals.

The statement of policy has been carefully prepared, bearing in mind the National League’s objectives in accrediting and its acceptance of certain principles of nursing education and nursing service as indicated in its various publications, particularly The Essentials of a Good School of Nursing, The Essentials of Good Hospital Nursing Service, and the Curriculum Guide for Schools of Nursing with its many studies. This statement of policy, which was reviewed and revised after discussion with our consultants, has been accepted by your Committee tentatively as a basis for procedure for the coming year. It is recognized by your Committee that it may have to be revised of necessity year by year. The service of the consultants has been invaluable in setting up this statement and determining the procedures to be followed, and reassurance has been given the Committee by their wise guidance and encouragement.

Your Committee has decided that it would be the best procedure to devote the coming year to the study of a limited number of schools for the purpose of developing criteria and determining the costs of survey work. Therefore a selection of fifty-seven schools was made for this purpose, invitations to participate were extended to them, and wholehearted cooperation has been expressed in their response to us. The following factors were given consideration in the selection of the fifty-seven schools and a few alternates:

1. The geographical distribution in proportion to the number of schools in each area (The areas used are those of the Grading Committee)
2. Organization of the school in general and special, municipal and private, large and small hospitals, also those controlled by religious orders
3. The general content of the course offered and whether or not a degree is granted for all or some of their students
4. The type of students admitted, including male and colored students
5. The kinds of affiliations offered or sought
6. The general recognition of the school as a "good school."
As a consequence of these considerations the selections are as follows:

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<th>Region</th>
<th>Total Schools</th>
<th>Selected</th>
<th>Percentage</th>
</tr>
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<td>3.5%</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>296</td>
<td>10</td>
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<tr>
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<tr>
<td>Pacific Coast</td>
<td>73</td>
<td>5</td>
<td>6.8%</td>
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</table>

Your Committee wishes to record its great appreciation of the help of the membership of the National League in assisting in the selection of these schools.

It is the unanimous opinion of your Committee and consultants that surveys should be made by two individuals as that method secures the most satisfactory and objective study. It is also the opinion of your Committee that, for these first experimental surveys, the secretary and assistant secretary should undertake the work but that later, when accrediting procedures are carried out, various individuals in nursing educational work should be invited to participate in the surveys on a part-time basis. However it is realized that these individuals will need minimum instruction in accrediting procedures as determined by the Committee, and plans for the same will have to be made.

After determining our plan for the year our secretaries spent their time in preparing the schedules for these experimental surveys. Twenty-four schedules have been prepared for this purpose, conferences with individuals and small groups have been held for review and revision before sending them out to the state leagues for study by their committees on state board problems and before trying them out in these first surveys.

On March 6 our two secretaries left headquarters to begin their study of the schools in which these schedules will be tested. At the meeting to be held on Wednesday morning, April 27, under the general title "Accrediting," our secretary will present facts relative to our procedure, and we trust that an open discussion of pertinent questions may result in helpful suggestions for the future activities of the Committee.

The American Journal of Nursing has published releases from the Committee in its June and December, 1937, February and April, 1938, issues; Hospitals in its November issue. The editors of Hospital Progress, Modern Hospital, Church Hospital Journal, and Journal of the American Medical Association have indicated their willingness to accept for publication from time to time material released by the Committee. We are confident that the secretaries' work this year in visiting schools throughout the length and breadth of our country will further the progress of your Committee's work greatly, not only in establishing criteria for accrediting and in determining costs of accrediting procedures but in bringing about through personal contacts with
our members a much better understanding of the Committee's purposes and a greater knowledge of the help schools can secure through accrediting measures. We are sure our secretaries will return to headquarters greatly stimulated and inspired by these visits and will be much better prepared to carry out our future program.

In closing this report, as chairman of the Committee on Accrediting I wish to acknowledge with great appreciation the confidence our members have placed in us, the splendid cooperation and work of our Committee, the invaluable advice of our consultants, and the devoted services of our headquarters staff. With such support your committee hopes that next year's report may show some progress toward our primary purpose "To stimulate through accrediting practices the general improvement of nursing education and nursing practice in the United States."

Respectfully submitted,

ANNA D. WOLF, Chairman

REPORT OF THE CURRICULUM COMMITTEE

This has been a year of readjustment for the Curriculum Committee, after the intensive activities of the three-year curriculum revision program. There have been a number of odds and ends left over from the work of last year and some new projects have been begun. A small committee, composed of some old and some new members, has replaced the rather complicated organization which was necessary for the larger project. This committee has had two meetings: one in January and one in April. Because of its widely scattered membership, it has not been possible to get the whole group together at any one meeting.

The Committee decided that its first responsibility was to assist in every way possible in the interpretation of the Curriculum Guide and in the use of this and other publications prepared by the Curriculum Committee. From the evidence available, the favorable reviews in current journals, the astonishingly large number of sales, and reports and correspondence from the field, there would seem to be no question that these publications have been well received and that they are being widely used. Many local and state meetings and institutes during the year have been devoted to discussions on the Curriculum Guide and several Committee members have assisted in such programs.

Another activity of the Committee has been in connection with the program of this meeting in Kansas City. A special session will be held on Thursday morning to discuss the general topic, How the Nursing School Faculty Functions in Curriculum Revision. The Committee appreciates this opportunity to arrange and present a program which especially features a plan of staff education for the individual school, centered about curriculum revision. It is hoped that many schools will find the suggested program helpful in planning their staff education programs for next year.
This leads to another of the major activities of the Committee which is to assist in every way possible in the preparation of nursing school faculties for their share in curriculum construction and operation. The whole field of postgraduate education needs more careful study, including the development of advanced clinical courses for graduate nurses and the better preparation of head nurses for their part in the nursing school program. The present plan is to cooperate with the International Council of Nurses in its study of the education of the graduate nurse. The Committee hopes also to cooperate with other groups in promoting the preparation and use of new type tests and other measurement and guidance techniques. Such tests are much needed, both in basic and advanced nursing programs.

Some confusion has arisen in the state leagues because of the change in the title of the old Education Committees. The League was, therefore, asked to define the functions of the Committee on Curriculum, both in the national and state organizations. The National League of Nursing Education Board has issued the following statement in regard to these functions:

a. Planning educational programs and organized curricula for graduate nurses (including the educational staff), as well as for students on the basic level
b. Planning educational programs in the various areas of specialization unless some other organization or committee has been given responsibility for specific areas, as for example, public health nursing
c. The planning of educational programs would include the study of objectives, content (including experience), methods of instruction, supervision, and guidance of same; organization and operation of educational programs with the measuring of outcomes; provision for all types of teaching aids and facilities
d. This committee would also be expected to coordinate studies and activities that relate to the planning of educational programs for nurses and to keep in touch with studies in closely related subjects
e. Activities of the state committees should be within the same area, the understanding being that the national committee will cooperate closely with the state committees and will coordinate the activities of these committees so far as this is possible without restricting the freedom of these committees in the different states.

We believe that there should be the closest possible cooperation between national and state curriculum committees, and also between curriculum committees and others whose activities are related in some definite way with the work of these committees as, for example, the Committee on Accrediting and the Committee on State Board Problems. While the state curriculum committees are not expected to take the initiative in revising the minimum curriculum of the state, it is hoped that they may cooperate actively with the state boards of nursing examiners in such projects.

Respectfully submitted,

ISABEL M. STEWART, Chairman

APPOINTMENTS

The President at this time appointed the following:

Tellers: Lucy Germain, Michigan, chairman; Lutie C. Leavell, Georgia; Jessie Biddle, Oklahoma; Anne Radford, Washington.
Inspectors of Election: Marion Zilley, Louisiana; Blanche Graves, Wisconsin; Marie E. Luppold, Texas.

Committee on Resolutions: Olga Breihan, Texas, chairman; Marjorie Bartholf, Connecticut; Myrtle M. Hollo, Virginia; Sister Celestine, Louisiana; Dorothy Rogers, Illinois.

**REPORT OF THE COMMITTEE ON ELIGIBILITY**

The following states and territory of Alaska, where there are no state leagues and admission is through individual membership, have increased their membership in the National League of Nursing Education:

<table>
<thead>
<tr>
<th>State</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio</td>
<td>52</td>
</tr>
<tr>
<td>Connecticut</td>
<td>13</td>
</tr>
<tr>
<td>Montana</td>
<td>8</td>
</tr>
<tr>
<td>South Dakota</td>
<td>6</td>
</tr>
<tr>
<td>Alabama</td>
<td>6</td>
</tr>
<tr>
<td>Virginia</td>
<td>11</td>
</tr>
<tr>
<td>West Virginia</td>
<td>3</td>
</tr>
<tr>
<td>Alaska</td>
<td>2</td>
</tr>
<tr>
<td>Vermont</td>
<td>1</td>
</tr>
<tr>
<td>New Mexico</td>
<td>1</td>
</tr>
<tr>
<td>New York (India)</td>
<td>1</td>
</tr>
<tr>
<td>Mississippi</td>
<td>1</td>
</tr>
</tbody>
</table>

Total: 105 members

Eighty-three applications for active membership in the National League have been received, nineteen for junior active, two for sustaining membership, and one for associate. The associate member resides in India, but placed application through New York.

For a second year Ohio has far exceeded other states in memberships. Undoubtedly there must be a very active enrollment program under way, which might well be passed on to other states. Junior active membership has shown an increase over last year.

**Active Members**

Albright, Dorothy, 1600 Monument Avenue, Richmond, Virginia
Anderson, Elizabeth M., 2615 East Boulevard, Cleveland, Ohio
Aschliman, Adeline, 876 Amherst Road, N. E., Massillon, Ohio
Baker, Jennie A., 2060 West 85 Street, Cleveland, Ohio
Behrens, Grace E., King's Daughters Hospital, Brookhaven, Mississippi
Bohiman, Minnie, 3259 Elland Avenue, Cincinnati, Ohio
Boyd, Henrietta K., 5259 Elland Avenue, Cincinnati, Ohio
Carmody, Constance E., 2201 Cherry Street, Toledo, Ohio
Carroll, Harriet J., General Hospital, Ashatabula, Ohio
Cogshall, Sarah L., 1800 East 105 Street, Cleveland, Ohio
Cook, Mary R., Selby, South Dakota
Cosgrave, Ella B., Johnston-Willis Hospital, Richmond, Virginia
Dineen, Nora T., 1291 West 110 Street, Cleveland, Ohio
Dippel, Catherine L., 3358 East 137 Street, Cleveland, Ohio
Dunn, Elizabeth, Christ Hospital, Cincinnati, Ohio
Enright, Mary C., St. Vincent's Hospital, Birmingham, Alabama
Euler, Mary E., 3259 Elland Avenue, Cincinnati, Ohio
Faris, Jessie Wetzel, 3015 East Broad Street, Richmond, Virginia
Fisher, Irene M., Sioux Valley Hospital, Sioux Falls, South Dakota
Flora, Mary Louise, 3259 Elland Avenue, Cincinnati, Ohio
Fretter, Leona, 2622 North Moreland, Cleveland, Ohio
Gilchrist, Buena V., St. Vincent's Hospital, Birmingham, Alabama
Hannifin, Hortense, St. James Hospital, Butte, Montana
Harker, Goldia D., 2765 East 125 Street, Cleveland, Ohio
Heise, Henrietta J., 3212 Burnet Street, Cincinnati, Ohio
Hobson, Ruby L., Kennedy Deaconess Hospital, Havre, Montana
Hoover, Ferma E., 142 South Main Street, Danville, Virginia
Horton, Etta F., 45 Hawkins Street, New Britain, Connecticut
Hunt, Alice, 2654 North Moreland Boulevard, Cleveland, Ohio
Immele, Martha A., St. James Hospital, Butte, Montana
Jansen, Henrietta, 3751 Boudinat Avenue, Cincinnati, Ohio
Keistead, Hazel E., Brattleboro Memorial Hospital, Brattleboro, Vermont
Kendall, Margaret A., St. James Hospital, Butte, Montana
Lamberth, Bessie L., Johnston-Willis Hospital, Richmond, Virginia
Lill, Genevieve, University of Montana, Missoula, Montana
Lowe, Maye, Norwood Hospital, Birmingham, Alabama
Lowney, Mae C., St. James Hospital, Butte, Montana
Lynch, Beatrice R., 1845 Roxbury Road, East Cleveland, Ohio
Makin, Alena A., 2601 East Boulevard, Cleveland, Ohio
McAdoo, Terressa E., 13005 Thornhurst Avenue, Cleveland, Ohio
McClure, Dorothy C., General Hospital, New Britain, Connecticut
Mc Gonagle, M. Dean, 2613 East Boulevard, Cleveland, Ohio
McGonagle, Margaret D., Children's Hospital, Columbus, Ohio
Miller, Harriett A., 2210 Eldred Avenue, Lakewood, Ohio
Mitchell, Ellen M., Huron Road Hospital, East Cleveland, Ohio
Morison, Luella J., Good Samaritan Hospital, Dayton, Ohio
Moses, Evelyn K., Memorial Hospital, Danville, Virginia
Motok, Eugenia G., 421 Seventh Street, N. E., Massillon, Ohio
Overby, Eunice W., Johnston-Willis Hospital, Richmond, Virginia
Parden, Loretta A., St. Luke's Hospital, Aberdeen, South Dakota
Parsons, Anne F., Cabaniss Hall, Richmond, Virginia
Pickarski, Leone, Hampton Institute, Hampton, Virginia
Prendergast, Cecilia M., 2027 West 89 Street, Cleveland, Ohio
Roberts, Rose E., Norwood Hospital, Birmingham, Alabama
Rochelle, Glenn, Stuart Circle Hospital, Richmond, Virginia
Sandvall, Ruth, 380 Summit Avenue, Steubenville, Ohio
Schneider, Ida, Bethesda Hospital, Cincinnati, Ohio
Sister Alice Mary Leary, 370 Collins Street, Hartford, Connecticut
Sister Annette Sullivan, St. Joseph's Hospital, Albuquerque, New Mexico
Sister Catherine T. Rodgers, 370 Collins Street, Hartford, Connecticut
Sister Frances Maureen, Columbus Hospital, Great Falls, Montana
Sister Francis E. Hayes, 370 Collins Street, Hartford, Connecticut
Sister Mary Anacaria, St. James Hospital, Butte, Montana
Sister M. Annunciata Finnell, 370 Collins Street, Hartford, Connecticut
Sister M. Borgia, 2320 East 24 Street, Cleveland, Ohio
Sister M. Conception Hayes, 370 Collins Street, Hartford, Connecticut
Sister Mary Germaine Hanley, 370 Collins Street, Hartford, Connecticut
Sister M. Juliana Graf, Fourth Street, Yankton, South Dakota
Sister Mary Madelein Forcier, 370 Collins Street, Hartford, Connecticut
Sister M. Melania Bessler, Dakota Avenue, Pierre, South Dakota
Sister Teresa Austin Walton, 370 Collins Street, Hartford, Connecticut
CONVENTION PROCEEDINGS

Siegwarth, Mary C., 2366 Atkins Avenue, Lakewood, Ohio
Smith, M. Ruth, Grant Hospital, Columbus, Ohio
Smith, Pearl E., Huron Road Hospital, East Cleveland, Ohio
Storms, Garnet R., Hoonah, Alaska
Tatum, Dorothy B., Johnston-Willis Hospital, Richmond, Virginia
Tiber, Bertha M., Box 2822, Juneau, Alaska
Ward, Margaret, 1004 Pine Street, Yankton, South Dakota
Warlick, Hattie, 1127 South 12 Street, Birmingham, Alabama
Wedgeworth, Ola, Williamson Memorial Hospital, Williamson, West Virginia
Wolfe, Irene F., 391 East Town Street, Columbus, Ohio
Yausko, Mildred, 814 St. Francis Street, Mobile, Alabama
Yoder, Clara Mae, 3259 Elland Avenue, Cincinnati, Ohio

Junior Active

Andrew, Margaret, 3259 Elland Avenue, Cincinnati, Ohio
Ashcraft, Miriam P., 3259 Elland Avenue, Cincinnati, Ohio
Bedul, Jane J., Box 361, Middletown, Connecticut
Dillon, Mary J., 3259 Elland Avenue, Cincinnati, Ohio
Freier, Marie, 3259 Elland Avenue, Cincinnati, Ohio
Gooding, Freda Elizabeth, 128 West 8 Avenue, Columbus, Ohio
Goss, Laura Elsie, 3259 Elland Avenue, Cincinnati, Ohio
Grant, Helen Hanby, 3259 Elland Avenue, Cincinnati, Ohio
Hall, Jane L., 109 Main Street, Wheeling, West Virginia
Hyde, Virginia, 3259 Elland Avenue, Cincinnati, Ohio
Inman, Delpha M., 3259 Elland Avenue, Cincinnati, Ohio
Lindsey, Mabel R., 3259 Elland Avenue, Cincinnati, Ohio
Loupert, Virginia Marie, 84 Howard Avenue, New Haven, Connecticut
McDade, Nelle C., 98 Butterless Avenue, Columbus, Ohio
Price, Ruth M., 1545 North High Street, Apt. 10, Columbus, Ohio
Smith, Ruth M., 3259 Elland Avenue, Cincinnati, Ohio
Ullman, Jessie M., 1545 North High Street, Apt. 10, Columbus, Ohio
Wells, G. Pauline, 2654 North Moreland Boulevard, Cleveland, Ohio
Whittier, Virginia C., 672 Howard Avenue, New Haven, Connecticut

Sustaining

Prien, Elessa G., Rainbow Hospital, South Euclid, Ohio
Wilson, Jennie F., 1300 Byron Street, Wheeling, West Virginia

Associate

Craig, Margareta, 106 Morningside Drive, New York, New York

Respectfully submitted,

FRANCES HELEN ZEIGLER, Chairman

REPORT OF THE COMMITTEE ON FINANCE

The Committee on Finance submits the following budgets for the year 1938:

Budget for 1938

GENERAL ACCOUNT

Estimated Income

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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<tr>
<td>Publications</td>
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<tr>
<td>Photographs</td>
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<tr>
<td>Records</td>
<td>4,000.00</td>
</tr>
<tr>
<td>Item</td>
<td>Amount</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Slides</td>
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<tr>
<td>Royalties</td>
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<td>State League Supplies</td>
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<tr>
<td>Dues—State</td>
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<td>Individual</td>
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<td>Interest on Mortgage Certificates</td>
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<tr>
<td>Interest on Savings Accounts</td>
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<td>Registration Fee</td>
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<tr>
<td>Biennial Exhibits</td>
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<td><strong>Deficit</strong></td>
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<td>5,980.07</td>
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<tr>
<td></td>
<td><strong>$36,945.07</strong></td>
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</table>

**Estimated Expenses**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Annual Report—Printing and Mailing</td>
<td>$2,500.00</td>
</tr>
<tr>
<td>Attorney's Fees</td>
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<tr>
<td>Auditor's Fees</td>
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<tr>
<td>Board of Directors Meeting—Officers and Directors (January)</td>
<td>900.00</td>
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<tr>
<td>Exhibits</td>
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<tr>
<td>Committees: Child</td>
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<td>Community Nursing Service (Joint)</td>
<td>652.50</td>
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<tr>
<td>Curriculum</td>
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<td>Eligibility</td>
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<td>Finance</td>
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<td>Headquarters</td>
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<td>Lay Participation</td>
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<td>Nominating</td>
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<td>Records</td>
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<td>Revisions</td>
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<td>Sisters</td>
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<td>Studies</td>
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<tr>
<td>Subsidiary Workers (Joint)</td>
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<tr>
<td>Convention: Miscellaneous</td>
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<td>Officers' Expenses</td>
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<td>Program and Speakers</td>
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<td>Preprints of Reports</td>
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<td>Reporting Convention</td>
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<td>Reporting Joint Board Meeting</td>
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<td>Headquarters Budget</td>
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<tr>
<td>Miscellaneous</td>
<td>65.00</td>
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<td>Nursing Information Bureau</td>
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<tr>
<td>Photographs</td>
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<tr>
<td>Publications</td>
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<tr>
<td>Records—Reprinting old set</td>
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<tr>
<td>Records—Printing new set</td>
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<tr>
<td>Stationery</td>
<td>150.00</td>
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<tr>
<td>Travel Expenses—President</td>
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<tr>
<td>Travel Expenses—Executive Secretary</td>
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<tr>
<td>Printing Curriculum and Storage Charges</td>
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</table>
**Department of Studies—Cost Study:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$2,500.00</td>
</tr>
<tr>
<td>Clerical Assistance</td>
<td>1,050.00</td>
</tr>
<tr>
<td>Field Travel Expenses</td>
<td>350.00</td>
</tr>
<tr>
<td>Printing, mimeographing, postage</td>
<td>100.00</td>
</tr>
</tbody>
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*(Cost Study Budget is $8,000.00—one-half charged to A. N. A. Fund)*

**Department of Studies:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Salaries</td>
<td>820.00</td>
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<tr>
<td>Miscellaneous</td>
<td>200.00</td>
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<tr>
<td><strong>Total</strong></td>
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**HEADQUARTERS BUDGET**

*(1938)*

<table>
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<tr>
<th>Item</th>
<th>Cost</th>
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<tr>
<td>Salaries</td>
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<td>Supplies</td>
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<tr>
<td>Postage and Express Charges</td>
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<tr>
<td>Mimeographing and Multigraphing</td>
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<tr>
<td>Library Service</td>
<td>150.00</td>
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<tr>
<td>Shipping Service</td>
<td>600.00</td>
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<tr>
<td>Special Office Care</td>
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<td>Telegrams</td>
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<tr>
<td>Extra Stenographic Service</td>
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<tr>
<td>Miscellaneous</td>
<td>200.00</td>
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<tr>
<td>Entertainment Fund</td>
<td>50.00</td>
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<tr>
<td>Insurance—(Workmen’s Compensation)</td>
<td>50.00</td>
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<tr>
<td><em>(Fire—Expires April 7, 1938)</em></td>
<td>22.80</td>
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<tr>
<td>Reference Books and Reports</td>
<td>25.00</td>
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<tr>
<td>Equipment</td>
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<tr>
<td>League Share Cost of Adding Outside Door to Conference Room</td>
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<tr>
<td>Painting and Work in Reception Room, New Coat Room in N. L. N. E. etc.</td>
<td>100.00</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$17,981.39</strong></td>
</tr>
</tbody>
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**SPECIAL A. N. A. FUND**

*(Budget for 1938)*

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Balance on December 31, 1937</td>
<td>$1,217.42</td>
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<tr>
<td>Income from A. N. A.</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$5,151.34</strong></td>
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</table>

**Estimated Expenses**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$2,500.00</td>
</tr>
<tr>
<td>Clerical Assistance</td>
<td>1,050.00</td>
</tr>
<tr>
<td>Field Travel Expenses</td>
<td>350.00</td>
</tr>
<tr>
<td>Printing, mimeographing, postage, stationery, etc.</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$4,000.00</strong></td>
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</tbody>
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*(Cost Study—Budget $8,000.00, half charged to General Fund)*
Funds for Projects on State Board Problems .................. $271.34
Funds for Projects on Mental Hygiene and Psychiatric Nursing .......... 400.00
Tuberculosis Study ........................................ 500.00

$5,171.34

FUND FOR ACCREDITING
(Budget for 1938)

<table>
<thead>
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<th>Income</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Balance, December 31, 1937</td>
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<tr>
<td>Transfer from Funds for Carrying on Grading Activities</td>
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<tr>
<td>Refund from Fund for Research in Nursing</td>
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<table>
<thead>
<tr>
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<td>Survey Work</td>
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<tr>
<td>Office Expenses (Printing, Stationery, Postage, Telephone, etc.)</td>
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<td><strong>Total</strong></td>
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FUND FOR RESEARCH IN NURSING
(Budget for January 1 to April 30, 1938)

<table>
<thead>
<tr>
<th>Income</th>
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<tr>
<td>Contribution</td>
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<td><strong>$15,000.00</strong></td>
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<td>Travel expenses for Committee members for one meeting</td>
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<td>1937 Expenses to be returned to Fund on Accrediting and General Fund</td>
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<td><strong>Total</strong></td>
<td><strong>$3,210.62</strong></td>
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<td>Balance</td>
<td>11,789.38</td>
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<td><strong>Total</strong></td>
<td><strong>$15,000.00</strong></td>
</tr>
</tbody>
</table>

Respectfully submitted,

CARRIE M. HALL, Chairman

REPORT OF THE COMMITTEE ON HEADQUARTERS

The Committee on Headquarters meets to consider important problems arising during the interim between Board meetings and to act on applications from individual members so that the acceptance of their applications will not be too long delayed.
The Committee has held only two meetings this year—one on September 10, 1937, and the other on December 3, 1937. At these meetings the Executive Secretary reported on the activities at Headquarters and brought up special problems relating to the conduct of the League office.

The Committee has passed on the applications of 55 active members, nine junior active members, and one associate member during the year. It has also approved the acceptance of the South Dakota League of Nursing Education.

The Committee has made recommendations to the Committee on Finance concerning projects for which funds were requested from the American Nurses' Association for the League functioning as its Department of Education. It has made appointments to committees and transacted other business as occasion demanded.

The minutes of the meetings of the Headquarters Committee are sent to the members of the Board of Directors following each meeting.

Respectfully submitted,

NELLIE X. HAWKINSON, Chairman

REPORT OF THE COMMITTEE ON NOMINATIONS

The Committee on Nominations of the National League of Nursing Education submits the following report.

Nominating blanks were sent to the presidents of 34 state leagues, and the following nominees are the result. They have consented to allow their names to appear on the ballot.

President: Nellie X. Hawkinson, Chicago, Illinois
Treasurer: Faye Crabbe, Newton, Massachusetts
Lucile Petry, Minneapolis, Minnesota
Directors: Henrietta Adams, Seattle, Washington
Olga M. Breihan, Dallas, Texas
Elizabeth C. Burgess, New York, New York
Pearl I. Castile, San Francisco, California
Henrietta Froehlke, Kansas City, Kansas
Irene Murchison, Denver, Colorado
Edna S. Newman, Cleveland, Ohio
Effie J. Taylor, New Haven, Connecticut

Respectfully submitted,

MARGARET DIETER, Chairman

REPORT OF THE COMMITTEE ON PROGRAM

The Committee on Program has held two meetings in Columbia, Missouri. Letters were sent out from headquarters last July to the Board of Directors and to the state leagues asking for suggestions for the program. Several of the states sent in excellent suggestions. Since the Board of Directors had designated the subjects for several of the sessions for this year's convention, the task of the Program Committee was somewhat lighter than usual.
The Committee is indebted to the Misses Stewart, Pfefferkorn, Quereau, Kennedy, and Axelson for the arrangement of certain sessions and round tables.

A progress report was submitted to the Board of Directors at their January meeting. The final report will be found in your printed program for the convention.

Respectfully submitted,
HENRIETTA FROEHLKE, Chairman

REPORT OF THE COMMITTEE ON PUBLICATIONS

The Committee on Publications has held one meeting during the year, on January 10, 1938. The League has never had a more active year in handling publications than this past year. Since the last report was made to the Board of Directors in May, we have published the following:

- A Curriculum Guide for Schools of Nursing
- The Annual Report
- Basic Book List
- Biographical sketches of: Mary Breckinridge, Carrie M. Hall, Anna C. Jamme, Laura R. Logan, Louise M. Powell, Mary M. Roberts, Sister M. Domitilla, and Katharine Tucker
- A Guide for the Use of the League Records
- New in-school record forms

In addition there has been a reprinting of the Manual of the Essentials of Good Hospital Nursing Service, the Essentials of a Good School of Nursing, and the Nursing School Faculty. The demand for these particular publications was greatly stimulated by the publicity on the new curriculum. The American Journal of Nursing has been generous in giving space for announcing League publications.

The small pamphlet, How the N.L.N.E. Serves You, was revised and reprinted during the fall.

Four thousand copies of the Curriculum were ordered, and it has been necessary to order a reprinting of 1,000 additional copies. The type is being held at present at a cost of $13.92 per month. The work on the Curriculum in the League office was a time-consuming task. About 100 days were devoted to the editing and proofreading on the part of the League staff.

The following report of the sale of certain publications for the year 1937 will give some idea of the volume of work handled by the Headquarters office during the summer and fall:

- Curriculum Guide for Schools of Nursing: 3,683
- Basic Book List: 176
- Illustrative Materials: 521
- Nursing School Faculty: 614
- Essentials of a Good School of Nursing: 979
- Manual of Essentials of Good Hospital Nursing Service: 984
- Library Handbook for Schools of Nursing: 371
Since January 1, 1938, 345 copies of the Curriculum have been sold, making a total of 4,028 copies sold.

The biographical sketches, printed in the late summer, have sold well. Already from 260 to 300 copies of each sketch have been sold.

The League records have been bought in large quantities this year. Judging from the many requests for the new records and the Guide, the League will continue to do a thriving business in record forms during the coming year.

Report of sales during 1937 follows:

<table>
<thead>
<tr>
<th>Form</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-1</td>
<td>Instructions Concerning Use of Records</td>
<td>9,075</td>
</tr>
<tr>
<td>B-2</td>
<td>Application for Admission</td>
<td>29,628</td>
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<tr>
<td>B-3</td>
<td>Pre-entrance Medical Record</td>
<td>19,725</td>
</tr>
<tr>
<td>B-4</td>
<td>Pre-entrance Dental Record</td>
<td>21,960</td>
</tr>
<tr>
<td>B-5</td>
<td>Personality Report</td>
<td>20,485</td>
</tr>
<tr>
<td>B-6</td>
<td>Secondary School Record</td>
<td>16,044</td>
</tr>
<tr>
<td>B-7</td>
<td>Interview with Applicant</td>
<td>9,950</td>
</tr>
<tr>
<td>C</td>
<td>Cumulative Health Record</td>
<td>9,845</td>
</tr>
</tbody>
</table>

Since there are 90 copies of the 1927 Curriculum on hand, it was decided by the Publications Committee to put a notice in the American Journal of Nursing, stating that copies would be sent to schools for 25 cents to cover cost of postage.

The Committee has decided to proceed at once with the sketches of the nursing leaders which were voted on by the Committee some time ago.

The Headquarters office is in need of bibliographies on such subjects as staff education, ward teaching methods, administration in schools of nursing, case studies, rating of nursing practice, articles on tests and measurements, and references for the use of nursing school committees. It was decided to ask Miss Roberts, Editor of the American Journal of Nursing, to assist in securing articles on each of these subjects and to have included in them a carefully selected bibliography. Miss Roberts will be glad to cooperate in securing articles for the Journal.

During the year 1937 the amount received for publications was $4,238.75, not including receipts from the Curriculum Guide which amounted to $11,013.84.

The greater the number of publications the League issues, the greater the service to our members and the schools. The small amount which is made on our publications assists us in extending the services of the League.

Respectfully submitted,

CLARIBEL A. WHEELER, Chairman

REPORT OF THE COMMITTEE ON REVISIONS

The Committee on Revisions has not been particularly active during the past year since the staff at Headquarters has passed on the changes made in the constitutions and by-laws of state and local leagues as they have been submitted for approval.
The Executive Secretary was authorized by the Board of Directors in January to consult the League's attorneys regarding a provision in the by-laws making it possible for foreign nurses (particularly Canadian nurses) to become members of the League provided they meet the other requirements for membership. The attorneys agreed that under the present membership clause such nurses would not be eligible. The question of voting by majority or plurality vote was also taken up.

The Committee on Revisions has accepted the suggestions made by the attorneys and makes the following recommendations for revisions:

**First:** Amendment of the membership requirements in order to permit graduates of schools of nursing in foreign countries, who meet all other requirements, to become members of the League.

1. Amendment of Article I, Section 2, subdivision a, subhead (2), by adding the word "or" at the end of subhead (2).

2. Amendment of Article I, Section 2, subdivision a, by adding subhead (3) as follows:

   "(3) Having been graduated by a school of nursing in a foreign country, such school of nursing having been accredited by a board or other authority constituted for that purpose in the country in which such school of nursing is located."

3. Amendment of Article I, Section 3, subdivision a, subhead (2), by adding "or" at the end of subhead (2).

4. Amendment of Article I, Section 3, subdivision a, by adding subhead (3) as follows:

   "(3) Having been graduated by a school of nursing in a foreign country, such school of nursing having been accredited by a board or other authority constituted for that purpose in the country in which such school of nursing is located."

5. Amendment of Article I, Section 6, subdivision a, subhead (2), by adding "or" at the end of subhead (2).

6. Amendment of Article I, Section 6, subdivision a, by adding subhead (3) as follows:

   "(3) Having been graduated by a school of nursing in a foreign country, such school of nursing having been accredited by a board or other authority constituted for that purpose in the country in which such school of nursing is located."

7. Amendment of Article I, Section 6, subdivision d, by eliminating the words "in an accredited school of nursing, or."

**Second:** Amendment of article on elections, Article III, Section 2, which now reads, "All elections of officers and directors referred to in Section 1 of this Article shall be held at the annual convention. All elections shall be by ballot. A majority of active members present and voting shall
constitute an election,” by eliminating the last sentence thereof and substituting therefor the following: “All elections shall be had by plurality vote.”

Respectfully submitted,

ELsie M. Lawler, Chairman

The amendments to the articles of the by-laws as presented in this report were accepted by the convention body. An amendment to Article VII, Section 2, with reference to the Committee on Accrediting, was also presented and was accepted unanimously as required by the by-laws since it was not sent to the members with the call to the convention. Section 2 now reads: “The Committee on Accrediting. This committee is responsible for determining the standards and procedures for the accreditation of schools of nursing. It is also responsible for putting the program into operation and for its administration.”

REPORT OF THE COMMITTEE ON STUDIES

Because of the Cost Study, there is little else to report for the Committee on Studies at this time. During the year, six requests for studies have been received. Four of the six studies related to nursing service analyses, one was a part of a community nursing survey sponsored by a Public Health Federation. The scope of the Cost Study and the limitations of our staff have made it impossible to assume any special study commitments during the past twelve months.

The Department of Studies accepted the responsibility for the direction of a study on what constitutes adequate nursing of tuberculosis patients. This study is sponsored by a joint committee composed of representatives of the National Tuberculosis Association, the American Nurses’ Association, the National League of Nursing Education, and the National Organization for Public Health Nursing.

Respectfully submitted,

MARIAN ROTTMAN FLEMING, Chairman

REPORT OF THE COMMITTEE TO STUDY ADMINISTRATION IN SCHOOLS OF NURSING

The Committee to Study Administration in Schools of Nursing is presenting at this time a progress report only. While the Committee was appointed last year in Boston, its actual work was not begun till December 3, when the Executive Committee met with the President of the League to discuss the objectives and policies of the Committee and in a measure to consider how the work might be carried on.

The study which the Committee is undertaking has been made possible by another gift from Miss Johnston, to whom, as you will recall, we were indebted for financial support to carry to completion our very intensive cur-
riculum study. We are grateful to Miss Johnston, and I am very happy to recommend that we send her our deepest appreciation and thanks for the interest she continues to demonstrate in the "Research in Nursing Education" carried on by our organization. I would wish in this connection to state that Miss Johnston's interest is stimulated and kept alive by the inspiration she receives from the Secretary of the Committee, Miss Elizabeth Pierce.

The Committee was appointed with a view to experience, geographical distribution, and to interest in the kind of study the Committee was expected to make. As a great deal of preliminary work was necessary before incurring the expense of bringing the large Committee together, a small executive committee with members near enough to come together at frequent intervals was formed. The following, with the President, have acted during the interim in this capacity: Miss Nellie Hawkinson, ex officio, Miss Isabel Stewart, Miss Mary Roberts, Miss Claribel Wheeler, Miss Elizabeth Pierce, Secretary, and Miss Effie J. Taylor, Chairman.

At the first meeting of the Executive Committee the functions were agreed upon. Generally stated, they are:

1. To determine what are the most stable or satisfactory organizations by which the objectives of schools of nursing can be reached
2. To study the various methods of administration by which these organizations may be made effective
3. To consider in what types of institutions schools of nursing can best function
4. To compile the results in some usable form.

Several plans of procedure were discussed, and later studied in some detail, by which the functions of the Committee could best be carried on.

It was agreed, after conference with several experts in the field of educational research, that in obtaining information the personal approach would be more successful than that of a questionnaire. The procedure used by other committees was also given some consideration. Since, under the auspices of the League, several other studies were in progress which also required the personal approach, the Committee agreed to obtain as much information as possible concerning administrative practice through the visitors appointed by the Accrediting Committee and from other committees in the field. Such a recommendation was made to the Board of Directors at the January meeting and heartily endorsed. A very close relationship is now established with the Accrediting Committee, and by this means duplication in visits and in the use of resources will be avoided. Time will be saved, also, in gathering information which will provide material by which the work of the Committee will be further developed. The chairmen of the cooperating committees were authorized to confer and work out the necessary adjustments.

The Board also accepted the recommendation of the Executive Committee to employ such technical advice as will be needed, and in consequence the services of Dr. Helen Davis, now engaged in research in Teachers College, Columbia University, and exceedingly well prepared by past experience in
making studies of a similar nature in this and other countries, have been se-
cured at least until July of this year. Dr. Davis will act as a consultant and
will be present at the first meeting of the full Committee, at which time it
is expected that the temporary plans of the Executive Committee will be
reviewed, and, we trust, approved and enlarged.

Respectfully submitted,

EFFIE J. TAYLOR, Chairman

REPORT OF THE COMMITTEE ON THE CARE OF THE CHILD

During the past year the activity of the Committee has been of a three-
fold nature; assistance in an advisory capacity to the state committees on
the child in nursing education, work on studies, and participation in the work
of lay groups interested in the education and care of children.

Two new state committees have been organized, one in New Jersey with
Miss Dorothy Stevens, instructor at the Babies Hospital, Coit Memorial,
Newark, New Jersey, as chairman; and the other in Virginia whose chair-
man is Miss Ruth Henley, also Chairman of the Educational Section, Gradu-
ate Nurses’ Association of Virginia. There are now nine state committees,
the other seven being in Illinois, Minnesota, Michigan, Kansas, Pennsylvania,
New York, and Wisconsin.

The study of A Partial List of Courses in Child Development and Parent
Education Available to Graduate Nurses has been submitted by Miss Winifred
Rand, and work on a pamphlet on institutes concerning the care of
children is under way. Plans for the study on Clothing and Appliances for
Hospitalized Children have been changed to make possible a more com-pre-
hensive study than had at first been suggested. This will be carried on by
a subcommittee under the direction of Miss Hazel Bowles.

In October, 1937, the Committee was represented by Miss Winifred Rand
and Miss Virginia Kirk at the Biennial Conference of the National Asso-
ciation for Nursery Education held in Nashville, Tennessee, the subject being
Safeguarding the Early Years of Childhood. By invitation of the above
organization the Committee also sent an exhibit to this conference.

Miss Corinne Bancroft, as representative of the Committee, has assisted
Dr. A. Graeme Mitchell in a study of Postgraduate Courses in Pediatric
Nursing conducted under the auspices of the American Academy of Pediat-
ricks and reported in the Journal of Pediatrics for July, 1937. This report
calls attention to the fact that only three of the twenty courses analyzed, out
of the twenty-three available, are given with university affiliation. It rec-
ommends that more courses be organized with university affiliation and that the
National League of Nursing Education, with the advice of the American
Academy of Pediatrics, evolve standards which would be acceptable in grad-
uate courses in pediatric nursing.

The name of the Committee was changed to the Committee on the Care
of the Child at the meeting of the Board of Directors in January, 1938.
One general meeting has been held during the year in which, in addition to the above outlined phases of the work, the members voted to ask the Board of Directors to consider the vital need for advanced courses in the nursing of children, a need evidenced by the marked shortage of pediatric nurses for positions of supervisor, head nurse, and instructor. Until there are a sufficient number of well-prepared nurses to meet the demand in these positions the standards of the basic course as outlined in the Curriculum Guide cannot be generally adopted.

Respectfully submitted,

ALFHILD J. AXELSON, Chairman

REPORT OF THE COMMITTEE ON EXHIBITS

The Committee on Exhibits has held one meeting since the annual convention in June, 1937. At this meeting the following matters were discussed: (1) The selection of colors for covers of League publications which would fit harmoniously into the scheme for the combined exhibits of the national nursing organizations, and (2) the preparation of posters to show the functions and membership of the League.

The Committee concluded that the League should work toward blue and yellow folders for the League publications, eliminating red folders which are used by the American Nurses' Association, and green covers which are characteristic of the Journal publications.

The Committee planned and had made, by a professional artist and Miss Eleanor Hall of the Presbyterian Hospital staff, three charts:

1. Potential and actual membership of the League
2. A chart showing the membership of the League from 1893 to the present time, and
3. A chart giving the functions of the League.

The Executive Secretary reports that there continues to be appreciation of, and demand for, the classified collection of League publications.

Respectfully submitted,

VIRGINIA HENDERSON, Chairman

REPORT OF THE COMMITTEE ON LAY PARTICIPATION

The Committee on Lay Participation has held one meeting since the annual convention in May, 1937.

At this meeting the request of the Board of Directors of the National League, that this Committee present to the Board definite recommendations for some form of organization whereby lay persons interested in nursing education could work with the League, was given thoughtful consideration.

It was decided to recommend to the Board that state and local advisory committees of not more than eight members, composed of laymen (members of nursing school committees and hospital boards) and nurses, the ma-
jority of whom shall be laymen, with a lay chairman, be formed in states where there are state and local leagues; the function of these committees to be: (1) To work with the state and local leagues in the advancement of nursing education; (2) To interpret to the public the place of the professional nurse in the community.

The Committee voted to recommend that the name of the Committee to Consider Lay Participation be changed to the Committee on Lay Participation.

Arrangements for the program at the luncheon meeting in Kansas City, April 27, were considered. It was decided to carry out the procedure followed in other years of sending invitations to members of nursing school committees and councils in the nearby states.

A report of the Committee's progress was presented by the chairman to the Board of Directors at their January meeting. The members of the Board felt that some changes in the recommendation regarding the formation of state and local committees were advisable; therefore the following plan of procedure was adopted:

1. That the National League of Nursing Education recommend to the state and local leagues the organization of committees on lay participation similar to that now existing in the National League of Nursing Education

2. Further, that the state and local committees encourage the development of organized lay conference groups; the purpose of these groups being to study the functions of nursing school councils and of nursing committees of hospital boards, with a view to more active promotion of sound programs in nursing education. These conference groups could be invited, through the media of the Committee on Lay Participation, to plan for a program meeting at appropriate times in connection with the meetings of the state and local leagues.

The recommendation to change the name of the Committee was approved by the Board of Directors.

During the year resignations were accepted with regret from two members of the Committee—Mrs. Mary C. Eden of Philadelphia and Mr. Ernest Savage of Philadelphia.

The Committee wishes to express sincere appreciation to our Executive Secretary for her interest and help with the work of the Committee.

Respectfully submitted,

GRACE A. WARMAN, Chairman

REPORT OF THE COMMITTEE ON MEMBERSHIP CAMPAIGN

The Membership Committee has held two meetings during the year. At the fall meeting the Committee reviewed the results of the letter to principals of schools of nursing requesting the names of the faculty members eligible for the League. In response to this letter of January, 1937, about 5,500 names of faculty members were received at headquarters, each one of whom was then invited to join the League in a letter signed by Miss Hawkinson. Included with the letter were an application blank and the pamphlet, How the N. L. N. E. Serves You. A total of 179 new applications for
membership were received. The Committee was disappointed in the response and as a further step sent a letter to state league presidents emphasizing the following points:

1. That an effort be made to secure new members from the enclosed list of names of eligible faculty members sent in from schools in that state
2. That publicity be given to the change in by-laws regarding junior active members since most of the lapsed members for 1937 were in this group. A list was enclosed of members in each state who had not paid their dues
3. That Headquarters be notified of members who have left the state, giving present address if possible
4. That a stimulating program for league meetings be arranged to hold the interest of the members.

The other part of the year's program was to secure more sustaining members, of whom there were 200 in December, 1937. A letter explaining the advantages of sustaining membership was sent to each of the following:

1. Members of state boards of nurse examiners
2. Presidents and secretaries of state nurses' associations
3. Executive secretaries of state nurses' associations
4. Directors of public health nursing courses
5. Directors of departments of nursing education.

The results of this part of the campaign will not be known until the 1938 dues are received.

Altogether 1,042 new members were added to the League in 1937, making a total of 4,574 members as compared with 4,320 the preceding year. We had hoped to reach the coveted goal of 5,000 members in 1937, but since we did not, our slogan will be, "Five Thousand Members for 1938."

The Committee suggests that every member of the League make an effort to interest more nurses in becoming members of the League.

Respectfully submitted,

ELEANOR LEE, Chairman

REPORT OF THE COMMITTEE ON MENTAL HYGIENE AND PSYCHIATRIC NURSING

The Committee on Mental Hygiene and Psychiatric Nursing met at the headquarters of the American Nurses' Association in New York City on October 27, 1937. The geographical distribution of the membership is so widespread that only those members living in or near New York City were present.

Dr. George H. Stevenson, of London, Ontario, Chairman of the Committee on Nursing of the American Psychiatric Association, was an invited guest. He manifested great interest in the activities of our Committee and
participated in the discussions. His attitude toward our work and his assurance of the cooperation of his Committee in all our projects were most encouraging.

The subcommittee, under the leadership of Helena Willis Render, is still working on an annotated bibliography which has been greatly enlarged during the past year. It is hoped that sections of it may be completed and ready for distribution through the National League of Nursing Education headquarters within the next few months.

At the meeting in October there was considerable discussion of standards of school equipment, teaching personnel, and living conditions in hospitals offering graduate and affiliate courses. This subject was given special attention at that time because the Committee on Psychiatric Nursing of the American Psychiatric Association is going to have it as the chief topic of discussion at the Round Table of the Committee, which will be held during the annual meeting of the Association.

In the fall of 1936 our Committee voted to make a study of the nursing care of patients in mental hospitals. It was impossible for us to proceed with this work during the past year and the Committee unanimously voted that it should be a project for the coming year. As a result a small subcommittee of nurses living near New York was appointed to proceed with the study. Miss Pfefetterkorn has been asked to assist, and it is hoped that the results of this subcommittee's activities will be available during the year. Such information should be of value to those who are interested in staffing a hospital for the mentally ill and, incidentally, it is hoped that this project will be the means of setting higher standards of nursing care in mental hospitals. Several nurses who are at present in charge of the nursing service in large state institutions are interested and have offered to do much of the detail work which such a study involves.

The following program has been suggested to the state chairmen to guide them in their activities for the coming year:

1. Surveying facilities in the states for the preparation of undergraduate students in psychiatric nursing.
2. Encouraging the state and local leagues to include mental hygiene and psychiatric nursing in the programs of their regular meetings.
3. Sponsorship, whenever possible, institutes on mental hygiene and psychiatric nursing.

It was further suggested that the state committees work with the state hospital organizations and mental hygiene associations of their respective states in planning programs and institutes.

Elizabeth Bixler, Mary E. Corcoran, and your Chairman had the privilege of attending the annual meeting of the Nursing Committee of the American Psychiatric Association on December 27, 1937. The whole Committee was invited but it was impossible for all to accept the invitation. Dr. George H. Stevenson, Chairman of the Nursing Committee, had informed us that courses in psychiatric nursing for undergraduate students of general hospitals would be the main topic of the program, and he hoped that we would be prepared to participate in the discussion. Several weeks previous to the meeting your
Chairman sent the Curriculum Guide to Dr. Stevenson, calling his attention to the course in psychiatric nursing and suggesting that it be used as a basis for discussion at the meeting. Other pamphlets issued by the League were sent to him at the same time so that he might get an idea of what the National League of Nursing Education had done in setting up standards for schools of nursing.

The meeting was very interesting and our suggestions were most cordially received. Dr. Stevenson is preparing a report for the annual meeting of the American Psychiatric Association to be held in San Francisco in June and will incorporate in it the recommendations made by our Committee.

It was advised that all mental hospitals contemplating schools of nursing should give careful consideration to the programs they formulate so that they would meet in every detail the standards of the National League of Nursing Education in regard to:

1. Adequate clinical material
2. Qualified teaching personnel
3. Necessary equipment for teaching and care of patients
4. Courses of study and periods of practice
5. Living conditions for student nurses

The question of male nurses in psychiatry was also discussed at the meeting and it was the consensus of opinion that an endeavor should be made to raise the standard of nursing education for them and place it on the same plane as that for women nurses. Everyone believed that there is a place for the male nurse in the psychiatric hospital and that greater attention should be given to his preparation.

There was discussion of the scarcity of registered nurses in the hospitals for the mentally ill and it was urged that greater effort should be made to interest graduate nurses in taking postgraduate courses in psychiatry, with the hope that they would become interested and remain in that field, and to encourage general hospital schools of nursing to give more consideration to psychiatric nursing in the education of the nurse.

The Nursing Committee of the American Psychiatric Association discussed the possibility of having a nurse in some national organization who would devote all her time to mental hygiene and psychiatric work. Her chief functions for some time would be to interest nurses in general and directors of schools of nursing, in the hope that they will see the importance of all nurses being prepared to care for the mental as well as the physical aspect of illness. This nurse would also assist administrators in mental hospitals in planning affiliate and graduate courses, setting standards, and procuring qualified faculty members.

It was indeed a great pleasure to represent the National League of Nursing Education at the 93rd annual meeting of the American Psychiatric Association held in Pittsburgh. The program was most interesting and it seemed to your representative that the nursing care of the patient was emphasized more than at previous annual meetings. The paper on nursing education was cordially received and many favorable comments regarding it were made by superintendents and representatives of state hospitals.
The most interesting session was that on Friday morning when Dr. Manfred Sakel of Vienna discussed the use of hypoglycemia in psychosis. The whole morning was given to that subject and several doctors from the United States reported on their experiences with hypoglycemia treatment of schizophrenia.

It is hoped that more nurses will become interested in psychiatry so that these new treatments can be given by intelligent and skilled nurses. The psychiatrist will be greatly handicapped in his scientific work if he does not have qualified nurses to assist him. Although nurses are showing an increased interest in psychiatry and more schools are giving their students courses in psychiatric nursing, there is still great need for more education in psychiatry and for more and better qualified nurses to care for the mentally ill.

Respectfully submitted,

MAY KENNEDY, Chairman

REPORT OF THE COMMITTEE ON RECORDS

In February, 1938, the Committee on Records completed a set of nine forms for use during the nursing school course and a Guide which includes instructions for the use of both the old and the new records. There are now available 17 League forms: seven admission, one health, and the nine new records.

The Committee believes that the preparation of other types of records should not be undertaken until there has been opportunity to try out the new set. It is the Committee's hope that state boards of nurse examiners, committees of local and state leagues, and individual schools will obtain a copy of the Guide, study it, and send their comments to the Committee after the records have been introduced and tried out in the schools.

During 1937, orders were received for 137,000 of the admission and cumulative health records, the first set prepared by the League. These figures may be taken as an index of the utility of these records. It is hoped that the new forms will be found equally serviceable.

Respectfully submitted,

BLANCHE PFEFFERKORN, Chairman

REPORT OF THE COMMITTEE ON SISTERS' PROBLEMS

The Committee on Sisters' Problems held a meeting on Monday, May 10, 1937, and the question of the state committees was again discussed.

It was the opinion of the Sisters that since the Sisters are very active in the states, it is unnecessary to have state committees. The Committee believes that the Sisters profit by continuing the yearly meeting under the sponsorship of the National Committee.

The Committee during the next year will concentrate on the adaptation of the new Curriculum Guide for Schools of Nursing in Catholic schools.

Respectfully submitted,

SISTER M. OLIVIA, Chairman
REPORT OF THE COMMITTEE ON STATE BOARD PROBLEMS

The Committee on State Board Problems reports one meeting since the annual convention in May, 1937. This meeting was held at the Roosevelt Hotel, New York City, on Tuesday, January 25, 1938.

Isabel M. Stewart, Chairman of the Committee on Curriculum, and Clara Queeneau of the Committee on Accrediting, were present at this meeting.

Blanche Pfefferkorn, Chairman of the Committee on Records, explained the new League records. A small subcommittee was appointed to study these records with a view to recommending their use throughout the states.

The subcommittees on faculty upgrading and methods of surveying nursing schools continue to be active.

The work of the subcommittee to set up the essentials of postgraduate clinical courses to be used for the guidance of state board workers has been suspended for the present since it was felt that it might lead to confusion and duplication of work in other committees.

It was the opinion of the Subcommittee on State Board Examinations that their study could go no further. A new subcommittee to investigate what working with the Cooperative Test Service would involve in the way of expense and the benefits to be derived from it was appointed.

Respectfully submitted,

ELIZABETH E. SULLIVAN, Chairman

PROGRESS REPORT OF THE JOINT ADVISORY COMMITTEE ON LEGISLATION

(National League of Nursing Education and American Nurses' Association)

During the period which has intervened between the Biennial Convention held in June 1936 and the present date, the Joint Advisory Committee on Legislation has held three meetings. The first meeting was held on December 18, 1936, at which time representatives of a state nurses' association met with the committee to discuss a proposed revision of the Nurse Practice Act of that state. The second meeting was held on January 16, 1937 for the purpose of studying a report of the survey of existing laws which the committee had carried on since May 1936. The third meeting, held during the year 1937, was an informal one to discuss next steps for the committee.

This is a progress report as the committee is not yet ready to present definite recommendations. It desires, however, to be of greater assistance than it apparently has been up to this time and, therefore, wishes to bring before those concerned with the nurse practice acts over the country the fact that the committee stands ready to give consideration to the problems arising in the amendment of nurse practice acts. The material in the possession of the committee is not as yet in form to pass on to the American Nurses' Association as recommendations. It is material, however, which the committee feels it may draw upon in giving helpful advice in replying to specific inquiries. Believing that the committee can serve the associations through
individual conferences with those concerned with nurse practice acts, it invites such conferences and discussions.

At the conference for members of state boards of nurse examiners to be held during the 1938 Biennial Convention on Saturday, April 30th, the committee will take charge of the afternoon program and discuss some of the principles and policies which it is hoped will eventually be incorporated into the recommendations of the committee.

Respectfully submitted,

ELIZABETH C. BURGESS, Chairman

REPORT OF THE JOINT COMMITTEE ON THE COSTS OF NURSING SERVICE AND NURSING EDUCATION

(National League of Nursing Education, American Hospital Association, American Nurses' Association)

This Committee, which is composed of members of the American Hospital Association, the American Nurses' Association, and the National League of Nursing Education, was organized in the spring of 1937. At the first meeting of the Committee, March 19, 1937, it was voted to recommend to the boards of the several organizations represented that the Committee be known as the Joint Committee on the Costs of Nursing Service and Nursing Education. Other action taken at this meeting was to the effect that:

1. The major purposes of the study be accepted as (a) finding out the cost to an individual hospital of operating the nursing service with and without a school; (b) developing methods and criteria which will make possible a valid comparison of the costs in one institution with those in another

2. Nellie X. Hawkinson be appointed as Chairman of the Committee; Blanche Pfefferkorn, Director of the Study; and Charles A. Rovetta, Associate Director. Mr. Rovetta, whose services as associate director are contributed by the American Hospital Association, is an instructor in accounting at the School of Business of the University of Chicago

3. An executive committee be appointed composed of the three organization presidents.

Since the personnel of the Joint Committee is included in the committee list of the League Annual Report, the names of the representatives of the American Hospital Association, the American Nurses' Association, and the National League of Nursing Education are not included here.

A meeting of the Executive Committee was held on October 29, 1937. At this meeting, the Director of the Study gave a progress report and asked for the advice and approval of the Executive Committee on the next steps in the study.

On January 29, 1938, an all-day meeting of the whole Committee took place in New York City. The Director of the Study summarized the work
that she had accomplished during the year, and the Associate Director presented a plan of procedure for the accounting phase of the study. The directors' reports on progress and plans are not included in this report since there is a cost study session on the program of the convention at which both directors and a member of the Committee will speak.

The desirability of a nursing cost study by the national organizations has long been under consideration, and it is heartening to be able to report that the present project has been launched under especially favorable circumstances because of the interest and active participation of the American Hospital Association, the American Nurses' Association, and the National League of Nursing Education, and the expert guidance of the directors of the study, Blanche Pfefferkorn and Charles A. Rovetta. The project has many ramifications and must go forward rather slowly because of limited funds and staff. However, with time and tenacity of purpose, we are hopeful that the study will reveal much more about nursing costs than is available at the present time.

Respectfully submitted,

NELLIE X. HAWKINSON, Chairman

REPORT OF THE COMMITTEE TO SET UP STANDARDS FOR ADEQUATE NURSING CARE OF TUBERCULOSIS PATIENTS

(National Tuberculosis Association and the Three National Nursing Organizations)

The National Tuberculosis Association and the national nursing organizations received a number of communications from state nursing organizations stressing the lack of standards for tuberculosis nursing and requesting that the national organizations cooperate in setting up such standards.

As a result of these communications, a committee composed of members of the National Tuberculosis Association, the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing is sponsoring a study of the subject.

Accordingly, on June 18, 1937 a meeting of representatives of the National Tuberculosis Association, the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing was called. The conference revealed that there was no general standard for nursing care of patients with tuberculosis, and that such standards are necessary not only from the standpoint of good nursing care of tuberculosis patients, but to prevent the spread of the disease among those attending these patients. Claribel Wheeler was chosen temporary chairman for this meeting.

At a second meeting on November 8, 1937, Mrs. Mary A. Hickey was chosen chairman of the committee. The representatives of the above national associations were present at the meeting. Action was taken to the effect that;
1. A study be made to determine what constitutes adequate tuberculosis nursing and the approximate time necessary to give that care.
2. A nurse who has specialized in the care of tuberculosis patients be secured to make the study.
3. The study be under the direction of the Department of Studies of the National League of Nursing Education.

Esta H. McNett, who is Supervisor of the Lowman Memorial Pavilion, the Tuberculosis Department of the City Hospital, Cleveland, Ohio, was secured to undertake the project. She obtained a leave of absence for the time necessary to make the study.

The American Nurses' Association and the National Tuberculosis Association have provided a sum of money for the study in their budgets. The contribution of the National League of Nursing Education is the direction of and assistance in making the study.

The study was begun by Miss McNett February 1, 1938. The general plan provided for four weeks of preliminary preparation, four weeks of field work visiting selected institutions, and approximately four weeks for analyzing the information collected and writing the report. At a later meeting the time was extended.

Six hospitals, one voluntary and five public, located in different states and ranging in size from 60 to 401 beds, were selected to take part in the study. Letters were written to these institutions and very courteous responses were received from the Superintendents, each one offering Miss McNett the hospitality of the institution during her visit.

Other meetings of the committee were held on March 4 and March 28, 1938 and representatives of the National Tuberculosis Association and the three national nursing organizations were present.

Miss McNett, at the meeting on March 4, presented an outline of the plan for the study of the nursing care of tuberculosis patients.

This is a very worth while study and it is expected that upon its completion, quantitative standards for the care of tuberculous patients, which will give to them more nearly adequate nursing care, will be established.

Your chairman recommends that a similar study be made in the field of psychiatric nursing.

Respectfully submitted,

Mary A. Hickey, Chairman

REPORT OF THE INDEPENDENT COMMITTEE ON THE
ISABEL HAMPTON ROBB MEMORIAL FUND
(Three National Nursing Organizations)

Two important changes have taken place in the Committee of the Isabel Hampton Robb Memorial and the McIsaac Loan Funds. After many years as chairman, Elsie M. Lawler resigned and after equally many years as secretary, Katharine DeWitt resigned. Only the members of the committee who have been associated with these two women, know how generously they have given of their interest and time to this important professional...
task. The committee herewith wishes to record deep appreciation of both Miss DeWitt's and Miss Lawler's work.

It is difficult to measure the valuable contribution made by Miss DeWitt. There is so much detail and correspondence involved in the administration of the secretaryship of the Funds. Time, patience, steadfastness of purpose, logical thinking, a sensitive conscience, and knowledge of the history of the two Funds are required. Miss DeWitt has all these qualities and has given of them unsparingly. She has been the prime figure in the growth of the Funds. She was always understanding of the applicants for loans and scholarships and took infinite pains to help everyone, whether or not she was eligible for financial aid.

In September, 1937, Mrs. Mary C. Eden of Philadelphia was persuaded to add the difficult office of secretary to that of treasurer. A word of appreciation is due her, too, from the committee and the profession.

**Isabel Hampton Robb Scholarship Fund**

The usual business has been transacted during 1936-37.

In January, 1937, Elsie M. Lawler, Chairman of the Isabel Hampton Robb Scholarship Fund Committee and McIsaac Loan Fund Committee, reported contributions to the Isabel Hampton Robb Scholarship Fund amounting to $1,444.92 for the year. In 1937 contributions from alumnae, district, and state nurses' associations, and state leagues of nursing education amounted to $1,080.50.

The scholarships granted in 1936 were given in full in the 1936 *Annual Report* of the National League of Nursing Education. In 1937 there were seven scholarships of $300 each, granted to the following persons:

- Ida Baker, Auburn, Maine
- Frances S. Buck, Norway, Maine
- Henrietta Doltz, A.B., Portland, Oregon
- Mary Margaret Dunlap, B.A., Omaha, Nebraska
- Alma Elizabeth Gault, Ph.B., Fernwood, Ohio
- Mildred L. Montag, A.B., B.S., Estelline, South Dakota
- Selma Margaret Moody, Peyton, Colorado

**The McIsaac Loan Fund**

During 1936 contributions to the McIsaac Loan Fund amounted to $1,315.93, and repayments on loans amounted to $2,676.97. Fourteen loans were made amounting to $1,950.00, and since the establishment of the Fund 157 loans have been made.

In 1937 there were 25 loans granted to nurses from the following states:

<table>
<thead>
<tr>
<th>State</th>
<th>Loans</th>
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<tbody>
<tr>
<td>Pennsylvania</td>
<td>4</td>
</tr>
<tr>
<td>Connecticut</td>
<td>5</td>
</tr>
<tr>
<td>Massachusetts</td>
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<td>Maryland</td>
<td>1</td>
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<td>California</td>
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<td>New York</td>
<td>2</td>
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<td>Ohio</td>
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<td>Illinois</td>
<td>1</td>
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<td>Minnesota</td>
<td>1</td>
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<tr>
<td>Nebraska</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
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There were granted—15 loans of $200 each .......... $3,000
2 " 150 " .................................. 300
7 " 100 " .................................. 700
1 " 75 " .................................. 75

25 " amounting to ................................ $4,075
Contributions from alumnae, district, and state nurses' associations, and state leagues of nursing education amounted to $945.50. Repayments on loans amounted to $3,829.20. To date 182 loans have been granted.

The following is an excerpt from Miss Lawler's report of 1936:

We have all heard with deep regret of the passing of Mary Riddle. Since the appointment of this committee in 1911 until her death she was a loyal and interested member filling the position of Treasurer from 1911 to 1932. Miss Riddle's wisdom, steadfastness of purpose, and calm dignity will always be remembered by those who have been privileged to work with her.

Respectfully submitted,

MARY C. EDEN, Secretary-Treasurer;
for ALTA E. DINES, Chairman

REPORT OF THE JOINT COMMITTEE TO CONSIDER THE RELATIONSHIPS OF THE GRADUATE NURSE AND HER PLACE IN THE HOSPITAL, INCLUDING STAFF EDUCATION

(National League of Nursing Education and American Nurses' Association)

The first meeting of this committee was held in New York, January 24, 1937, at which time it was agreed that the committee should begin its work by compiling information from various studies which had been made within the past five years and from agencies whose work is relevant.

No other meeting of the whole committee was held during 1937, but at a meeting of Mrs. Alma H. Scott, Claribel A. Wheeler, Mrs. Nellie S. Parks, and the Chairman on December 23, 1937 the consensus of the group was that a recommendation should be made to the Joint Board of Directors that the committee should:

1. Concentrate its efforts and limit its work at this time to the general staff nurse rather than study the problems of the entire graduate group
2. Use the Manual of the Essentials of Good Hospital Nursing Service as a guide
3. Base its recommendations on principles already laid down in the guide

It was also thought advisable to begin a survey of available sources of information immediately and, in accordance, Mrs. Parks was asked by the ANA to make a preliminary collection of material for consideration at a meeting of the Joint Committee with representatives from the American Hospital Association and the Catholic Hospital Association.

A meeting of the Joint Committee with representatives from the hospital associations was held in New York on February 21, 1938 at which meeting the information collected on the general staff nurse was discussed. It was voted that a report be prepared and submitted to each of the groups represented for criticism and suggestion, after which time another meeting will be called.

Respectfully submitted,

LAURA M. GRANT, Chairman

The reports of the Joint Committee on Community Nursing Service and the Joint Committee to Outline Principles and Policies for the Control of Subsidiary Workers in the Care of the Sick will be found on pages 250 and 255.
Joint Opening Session

American Nurses' Association
National League of Nursing Education
National Organization for Public Health Nursing

Monday, April 25, 8:30 p.m.

Presiding: Susan C. Francis, R.N., President of the American Nurses' Association.

The invocation was given by the Very Reverend Monsignor James N. V. McKay, St. Peter's Rectory, Kansas City, Missouri, and the welcome to Kansas City by the Honorable Bryce B. Smith, Mayor of Kansas City, Missouri. The Memorial Boys Choir of Grace and Holy Trinity Cathedral sang under the direction of Mabelle Glenn accompanied by Edna Scotten Billings.

Greetings from the State

CLARA LOUISE WRIGHT, R.N., President, Missouri State Nurses' Association

On behalf of the Missouri nurses I am most happy to bring greetings tonight to our distinguished guests from all parts of the country, fellow members and to our future leaders, all student nurses.

The last time our convention met in Missouri was April 23-29, 1914, in St. Louis. At that time Margaret McKinley was honorary president of the Missouri State Nurses' Association, Sally Bryant was president, and our own Major Stimson, Chairman of Arrangements. And all of these women are here tonight, still active, still contributing to our profession.

We, of Missouri, claim characteristics of the State's mascot, the famous Missouri mule, and after twenty-four years of watching the West Coast nurses go through our state to the East Coast and the same trek of the Eastern nurses, we finally had our invitation accepted and tonight are glad to welcome you to Missouri, a state long known as the Mother of the West.

We are just folks, who always have a friendly "howdy" for you. For here the rule of life is happiness in simplicity in a region where there is room enough for all. For life is good in Missouri. The motto of Missouri "Show me" we change to "We would like to show you" and hope you find time before returning home to visit some of our most interesting places, for example, Mark Twain State Park, which preserves the birthplace of Mark Twain and is situated on beautiful bluffs overlooking the Salt River. Our chief institution of higher learning is the State University of Missouri at Columbia, presided over by the six noted columns.

In the Ozark region, renowned for its scenic beauty, we have the picturesque Arcadia Valley, numerous caverns, Mammoth Springs, balanced rocks, a natural bridge, and a large amphitheater with remarkable acoustic properties. Also there you will find lead, zinc, onyx and marble mines, and extensive deposits of iron ore, the largest at Pilot Knob and Iron Mountain.

A warm and glowing lamp is the symbol of our profession and it is with
a warm and glowing feeling that we greet you tonight. We have tried to
plan for your physical comfort and hope you accept our hospitality and sin-
cerely trust that your stay among us will be a week of pleasure, yet of benefit
to you and our profession.

ADDRESS OF WELCOME

SUSAN C. FRANCIS, R.N., President, American Nurses' Association

It is my privilege to speak for the three national nursing organizations in
acknowledgment of the cordial greetings extended to us by our hostess
state—Missouri—through the speakers by whom we have been so heartily
welcomed.

I am confident that in accepting these greetings that I speak for all the
members of our associations here assembled, as well as for the guests whom
we are proud to have with us.

I speak, too, for our members at home whose thoughts are with us
throughout the Biennial week. We must not fail to carry back to them
something of the inspiration that will be imparted to us through participation
in the deliberations of an assembly such as this whose aims are common
and in the interest of others. All of you have come hoping to receive help
each in accordance with her individual needs. I trust that you will be
generous in your giving; for, as I need not remind you, giving means
receiving.

I have frequently heard it said by some of us who have been attending
biennial conventions for a generation or so, "We just keep on discussing
the same old problems. I get tired hearing about them. I should like to
listen to something new."

The problems do sound the same, but are they the same?

Human nature and human relationships have changed but little, as we
know; and the problems which they present are much the same as always;
but what about the methods of dealing with them?

Have they not changed and will they not continue to change with changing
social philosophy to such an extent that the problems themselves almost
seem to be fresh and hitherto unconsidered?

You have been advised that your week of deliberations will be devoted
in the main to the consideration of “the individual nurse, her needs and her
responsibility for the progressive development of her profession.”

Your program committee has provided the machinery for these delib-
erations. The local arrangements committee, we know, has provided adequate
and comfortable settings. You are the cast. Do not forget that the cast
needs prima donnas. Not too many of you may remain content to sing
in the chorus.

Some weeks ago, I heard a sermon by a great preacher. His subject, as I
recall it, was, “The Religious Life and the Secular Life.”

My interpretation of those two terms was the spiritual life each one of us
lives in accordance with his individual religious faith, and the practical
everyday life of each of us. The speaker discussed the proneness of people to live the two separate and apart from each other. In the development of his argument that this could not represent successful living on the part of any group or any individual, he put the question, "Is medicine all secular?"

I then asked myself, and I now ask you, "Is nursing all secular?"

We know that in its early development nursing was all religious.

Should we not, during the week we shall spend in this city which you in Missouri have named "The Heart of the Nation," dedicate ourselves to a re-capture of some of the early spirit underlying our profession and so blend it with the present-day secular or maybe scientific spirit as to result in a harmoniously balanced nursing life? We need the balance for which the preacher pleaded; a balance which permits neither an overzealous selfless devotion to duty on the one hand, nor an inconsiderate demand for rights on the other, but a sane and constant blending of the two—the religious and the secular.

Thank you again, Miss Wright, and all the members of the Missouri State Nurses Association for all your thought and preparation for our coming and for your hearty welcome.

I am directed on the program to welcome you. This I do most heartily, each and every one of you. Will you forgive me if I seem to have taken advantage of you and preached to you a bit on what I believe should be our spirit of approach to this convention week?

GREETINGS

IDA F. BUTLER, R.N., Director, American Red Cross Nursing Service

It is a privilege to extend warmest greetings to the members of the three national nursing organizations assembled this evening for the Biennial Convention of 1938. Two years ago at this opening meeting of the Biennial, Mary Roberts read to you the message which Clara Dutton Noyes had prepared just previous to her death on June 3. Since that time, many plans have been considered and thoughts have been given to establishing a memorial to Miss Noyes. It is with deep gratitude that I am privileged to announce to this audience that the Central Committee of the American Red Cross on April 4, voted to establish in memory of Clara Dutton Noyes, until her death the Director of the American Red Cross Nursing Service, an annual award of two scholarships for a period of five years, in order that two nurses may attend the Florence Nightingale International Foundation courses in London—one scholarship to be awarded to an American nurse and the second to a nurse from another country, each to be known as the "Clara Dutton Noyes Memorial Nurse." No more fitting tribute to Miss Noyes could have been conceived than these scholarships. One of the outstanding nurses in the world, her interest in young nurses and her endeavor to help them to prepare themselves fittingly for their life's work proved one of the deepest interests in her life. For many years she had extended a helping hand to our sisters across the seas. She was responsible for the establish-
ment of schools of nursing in Czechoslovakia, Poland, and Bulgaria. To other organizations which were concerned in the promotion of nursing education in foreign lands, she gave generously of her time, advice, and interest. Her interest in and devotion to her life work brought many distinguished men and women in Europe to her for advice and help in their nursing problems. What more fitting then, that an American and a foreign nurse should each year be given the privilege of these scholarships?

The American Red Cross, through its interest in the students who will be selected for this course, will place upon their shoulders the mantle of this great woman and will remind them "that the dead are dead only when we stop thinking about them."

This year has indeed been eventful in the history of the American Red Cross Nursing Service. Our late beloved chairman, Admiral Cary T. Grayson, because of his great interest in the Service and a desire to see his vision realized in helping to develop a fine reserve corps of nurses, was able to have a study made of the nursing services by Alta E. Dines. While it is with deepest regret that I must announce that Admiral Grayson was never able to read Miss Dines' thoughtful, sympathetic, and searching report, it is our hope that his vision of the Service may be realized and that through the adoption of Miss Dines' study, we may become, as our late chairman so often expressed it, "The Greatest Nurse Corps in the World."

It is also my privilege to announce the appointment of Norman H. Davis as chairman of the American Red Cross, to succeed the late Admiral Grayson. Mr. Davis brings a wealth of experience to the organization. Our first contact with him leads us to believe that he has the human kindly attitude that endeared his predecessor to everyone. I am sure that Mr. Davis will appreciate the service you have rendered in helping Miss Dines with her study when she called upon you for your advice and suggestions and for our new chairman, we express the hope that you will continue with your kindly interest and your willingness to help in order that "The Greatest Nurse Corps in the World" may be a vision realized.

THE NURSE AS A MEMBER OF HER PROFESSION

Effie J. Taylor, R.N., Dean, School of Nursing, Yale University, New Haven, Connecticut

In thinking about the subject of this paper, I was impelled to reframe the title that we might think together in the first rather than in the third person. "Our Responsibility as Nurses to our Profession" makes us partners in whatever we may enjoy of success or whatever we may have to face in the light of failure.

You and I are "the nurses" to which we are wont to refer, and it is we who must share the joys, shoulder the burdens, and assume the responsibilities which are thrust upon ourselves and our professional colleagues.

We no longer are a little band of sisters following Saint Vincent de Paul,
but a great army of professional women scattered throughout the world, still holding sacredly to the ideals of service which motivated the works of mercy and love of the earliest of our leaders.

We are members of one vast sisterhood united by tangible bonds of human service woven in and out of every phase of life; a great body of professional women now bound together by the broad ultimate objectives of our nursing associations. When we are assembled at one of our biennial conventions, we are conscious of a oneness of spirit; we are at home with each other for the reason that we are a family and feel a sisterly relationship.

Our experiences, though different in many respects, have been similar, and we understand the language of life in joy, in sorrow, and even in death. As nurses we live with human beings in life’s varied experiences and share with them the trials and vicissitudes of life, with their resulting disciplines. Nursing is intrinsically interpreted through the story of the Good Samaritan and through the teachings of Him who charged His disciples to minister unto all those who called upon them for help.

In this age of confusion, in the midst of scattered and irresponsible thinking, we seem not to remember that the profession of nursing is different from that of many other vocations, and that its problems, which are never static, cannot be solved by similar arbitrary and mechanical means. Consequently, nurses cannot endeavor to meet these problems according to a definite standardized pattern. Our responsibilities change as life changes with us. As we grow older we are prone to act in given situations in accord with familiar patterns of behavior, forgetting that to meet life’s changes we must learn a series of new responses in place of those which have lost their value and often even their usefulness. It is never safe to assume that what has been must always continue to be.

The youth of today are born into a world different from that of many of us who are attempting to mold their professional lives and dictate the pattern they are to follow. After groping and deep heart-searching we have found it wise to discard, one after another, certain of our cherished traditions because they cannot be accepted by our colleagues of this new era. We have come to realize that what satisfied the needs of yesterday will not satisfy the needs of today.

Nursing is characterized by its own culture and its own traditions. It has been stated by certain observers that a nurse can be differentiated from women in other professions by her personal attributes and the training and education she received in preparation for the particular service she must learn to render. The prevailing or traditional education which for more than a half-century has been given to student nurses and the requirements of their service after graduation have undoubtedly left a stamp upon their personalities and have set them apart in a class by themselves. Those of us who possess these characteristics are not always aware of them, but when we seek to analyze our reactions we are amazed that we have so many in common with other members of our profession. Traditions and traditional methods of
teaching are evaluated not only in the light of changing needs but in the ability of the student educated under these conditions to personally cope with the requirements which society makes upon her in her professional service.

Our earlier form of education or, as it was more often termed, "training," discouraged initiative on the part of students. In consequence, as graduates they frequently lacked ability to contend with life situations involving such economic and social problems as did not fall within their routine field of experience. Our former methods and traditions required a revaluation in the light of changing conditions resulting from the chaos of war, financial boom, economic depression, and our greatly expanding industrial era. These so influenced the situation in the home and in the school system that during the past decade or two students have brought to the beginning of their professional nursing careers an entirely different background which demands a new approach to the teaching of nursing.

To analyze all the factors of personality, environment, and education which go into the development of an individual would carry us far afield from this discussion. Nevertheless, in considering the making of a nurse we must remember that the students who are today in schools of nursing will become the nurses of tomorrow, and their endowment of personality and background is of exceeding importance. They will conform to, improve upon, or perchance will make the existing conditions infinitely more complicated and difficult. The problems of the present, therefore, cannot be considered without envisioning the potential students who will in the future interpret the worthwhileness of nursing.

As we review the policies which have brought us to the present-day stage of perfection or imperfection in our system of nursing education, we are appalled at the lack of vision we have so frequently demonstrated in evading the real and vital issues. The transitory satisfaction experienced in meeting insistent immediate needs has too often overshadowed our judgment. We literally have taken one mortgage after another on the future and have put off inevitable experimentation in the hope of finding a more propitious time to face the difficulties.

Such a time arrived when the National League of Nursing Education began the study of the curriculum. We then awakened to the fact that schools of nursing were universally awaiting an inspirational rebirth which could only come from a source outside the environment in which they were held fast by tradition and necessary ministry to immediate needs. In such an environment the educational requirements of the student, the potential nurse for the future, were too often set aside and frequently forgotten.

In constructing a curriculum for a school of any type the fundamental purpose of the school must be defined. The content of knowledge required to accomplish the objectives must be selected from the vast amount of knowledge available. In addition, the equipment and tools by which the students may be encouraged and assisted to learn should be given careful study and
consideration. In schools of nursing, we had rarely in the past followed this procedure and we had excused our failure on the basis of former tradition and present economic barriers. In very truth, an important inhibiting influence was the unwillingness of our own profession to stand firmly upon the principles we believed were sound. The fear of public opinion, and often that of our associated colleagues, and lack of faith in ourselves have been paramount obstacles to our achievement of ideals.

The nursing profession (says Dr. Livingston Farrand) has come in the past twenty-five years to be an integral part of everything which has to do with the advance of human welfare. There is a tendency in all professions to think of themselves as separate, and with destructive aim, but it is becoming increasingly evident that no activity can so separate itself in the world today. The nurse is no longer simply a bedside nurse or a public health nurse. She is now allied with the other groups concerned in medicine.¹

Further, may I say that the nurse is concerned with every kind of activity in which human beings are engaged and she must needs be a resourceful, versatile, and competent person whose judgment and reactions can be counted upon when she is removed from the safeguards which are thrown around her in the school and in the wards of a hospital. It is not enough that nurses leaving our schools of nursing should be skilled in technics. They should be skilled as well in meeting the problems and difficulties which no other group of women have to meet so constantly in their association with people in every social stratum. It is in this latter interpretation that we have not, as educators or as standard bearers, been wholly alive to our obligations and to our responsibilities. In consequence, we are faced today with problems which might have been avoided had we been alive more keenly to the changing social trends taking place about us.

Twenty years ago, as formerly stated, the outlook on life was changed for nurses as it was for all human beings in this and other countries. We have lived since that time under constant emotional strain and have not yet reached a level of stability where our natural responses to even commonplace situations are unhampered by personal feelings and prejudices. The world seems to have lost its sense of values and the pathetic unrest in families, in institutions, in national and international governments, is reflected upon us as professional women.

The desire of society to settle its problems through aggression has to some extent permeated nursing. Confronted with the solving of perplexing questions, we can but wonder whether the loyalties which activated our predecessors have not been broken down and whether we have not substituted for things spiritual more than the rightful proportion of things selfish and material. It oftentimes appears as though we have forgotten that the fundamental rock upon which our profession stands is altruistic service in the interests of humanity.

Nursing in its very nature is a profession, an art, and a high calling, and its ideals are in conflict with imposed authority and arbitrary control. We are saddened to learn that nurses have believed it advantageous to unite with non-professional organizations in an endeavor to further their rights and interests and to secure conformity to certain conditions of work which seemed to them of primary importance. We must find a way to manage our vexatious tangles without resorting to aggression. We have observed in this country, as well as in Europe, a growing tendency in nursing to become imbued with the spirit of the confused and unstable world in which we live. We have seen a number of our colleagues seek outside the boundary of our own associations for sympathy and for help in solving the exigencies of employment, and we await with some anxiety the reactions which inevitably will follow. The world is emotionally unstable and insecure only in so far as we, the people, are so. The world itself is as beautiful as ever and its resources are greater than ever before.

Perhaps in our race for individual and national domination we have overlooked the spiritual and religious elements in our own lives and in our human relationships and also in the lives of those who control the state and national affairs. It may be possible that the desire for the supremacy of the individual and the group has transcended the usefulness for which human beings were created and for which nations were established. None of us would wish to evade the truth that the majority of nurses must be self-supporting, and no one would dispute the fact that every human being has a right to remuneration commensurate with work and with ability to serve. The element of humanity, however, is so much bound up in nursing that assertive measures seem unsuited to our professional ideals.

"Much of our religious thinking in recent years," says Rabbi Silver, "has been characterized by nervousness and timidity."

Would it be profitable, therefore, to consider whether or not the situation of itself is chaotic? It may be that our thinking, characterized by nervousness and timidity, has made it so. Our reactions and responses may be at fault and we may need an adjusted and a more inclusive point of view. We know the value of group action and group thinking and, if instead of separating ourselves into aggressive and opposing camps, we joined together for our common good the world might become a better place in which to live and a happier place in which to work and serve.

The American Nurses' Association is nearly one hundred fifty thousand strong, but it should exceed this number. There are nurses throughout the land who should be joining hands with this, the greatest professional nursing organization in the whole world. There are standards of membership which must be met, but no organization would be worth its name if such were not the case. Probably there are one hundred thousand eligible nurses to whom the privilege of membership is available, but who are not enjoying the advantages of this association. It is not necessary that all should think alike. Those whose opinions may not be cast in the same conventional
mold may have much to contribute to its welfare. They might assist con-
structively in breaking down, if such be needed, old and worn-out policies
which may be hampering our progress and our usefulness to both our pro-
fection and to society.

The nurses of the world should be united in purpose and in integrity.
An organization is no stronger than its component parts, and the members
whose names are entered upon the rolls of the American Nurses’ Association,
the National League of Nursing Education, and the National Organization
for Public Health Nursing virtually determine their strength and their in-
fluence.

I am sure we are agreed that striving for personal advancement is not the
first ambition of the nurse. Probably there is not a home represented among
us but has reason to be grateful for the selfless devotion of some private duty
nurse as she ministered to their sick. While we are not primarily seeking
for the promotion of individual interests, we do look for justice and an
opportunity to serve under conditions which will bring satisfaction to our
personal lives as well as help us to bring comfort to others.

The private duty nurse and the public health nurse go in and out of
the homes of the people, and upon them rests a grave responsibility for for-
warding the ideals of healthful living.

If the inhabitants of the world today were composed of healthy men and
women capable of clear and logical thinking, who also had well-balanced
minds and altruistic natures, stability, security, and peace would be every-
where assured. Since nurses are great factors in the restoration and con-
versation of health, the function of nurses is supremely important and we
should take our responsibilities with seriousness, particularly as we realize
that nothing in Nature stands still.

Hospitals in recent years have taken a most progressive step in establishing
the principle of graduate staff nursing through which to provide for the bed-
side care of the sick. England long since adopted this policy, and in visiting
nurse organizations it has always been in practice. Nursing service in hos-
pitals for too many years was entirely contributed by students and it became
a fixed and almost inalterable tradition that it should not be done in any
other way.

In a recent study made by the League, it was discovered that, in 1937,
twenty-seven thousand graduate nurses were engaged in the care of the sick
in twelve hundred hospitals connected with schools of nursing. When we
look back to the studies made by the Grading Committee in 1927, at which
time 73 per cent of the existing hospitals reporting had no graduate staff
nurses, we are amazed and gratified at the change which has taken place
in the point of view of hospital executives and administrators.

The advance which has thus been made in improving the nursing care of
patients in hospitals has been phenomenal. When one considers that hos-
pitals in the main are community and philanthropic institutions and few of

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them are sufficiently endowed to meet their barest needs, we are enthusiastic in commendation of the far-reaching step which has been taken, and it gives us courage to face the future. We can but realize that we are passing through a phase in hospital organization for which no previous preparation was made, and it will take time to complete the adjustments.

We are deeply conscious that conditions are in no wise ideal, but much depends upon the attitude and cooperation of nurses during this period of reorganization to make them so. One cannot read the reports which come to national nursing headquarters without a keen sense of satisfaction that one institution after another has found a way to administer the nursing service on the basis of an eight-hour day, and that many have materially increased the salaries for the general staff of graduate nurses.

We know of course that there are still many institutions where such progress has not been made, but since perfection cannot be achieved in the twinkling of an eye, particularly where economic conditions and human beings are involved, we should wait with patience and bend all our energies toward solving the problem in a way commensurate with the objectives of our profession.

It is conceivable that our state and national associations may not have contributed their utmost in assisting the graduate staff nurse to find her rightful place in the nursing service of hospitals. It is also conceivable that the organizations have not put forth their best effort in helping the schools to share with the graduate staff nurse responsibility for nursing policies, particularly as they relate to the instruction of students. If such be true, it is not too late to make amends. Our great organizations exist only to be helpful and useful in affording service.

To develop plans for maintaining an excellent nursing service in any institution will require the joint cooperation of the nurses themselves, the hospitals, and our state and national associations. To make for satisfactory conditions, tenure of service will play an important part in successful planning and during the time of adjustment some patient waiting and perhaps, in certain cases, some sacrifices will be required of us.

The tendency is growing in schools today to encourage young graduates to seek their first appointments as staff nurses in their own or other hospitals, and it will not be long before the appointment of general staff nurses will have been established on as secure and happy a relationship as that of other positions in the hospital. That nurses should always maintain the responsibility for the quality of their own performance is obvious. It is not quite so obvious that they also have a deep sense of obligation toward the support of their own professional associations, which have struggled for almost half a century for the advancement of nursing standards and ideals, as well as for the protection of nurses in the practice of nursing.

The creation and maintenance of interest in the work of our professional associations and the extension of knowledge concerning their activities are centered within the state, district, and local associations. These organiza-
tions hold key responsibilities, as they are closely associated with the schools of nursing, the hospitals, and the immediate community. They also are the interpreters of professional standards to the graduate nurse and it is through the local associations that nurses receive their first impressions of the vastness and importance of our professional relationships and our national and international unity in service. To these organizations young nurses must look for support, encouragement, and leadership, and communities will likewise count on them for guidance and cooperation.

In reviewing "our obligations to our profession," it must be remembered that success will be ours only in so far as we maintain our loyalty to it and to ourselves; for success, like religion, is really a certain way of looking not at one but at all things. A short time ago I came upon a new interpretation of the thought: "Your young men shall see visions and your old men shall dream dreams." I will leave with you a transposition as it may be related to nursing: When young nurses have vision the dreams of old nurses come true.

PRESENTATION OF THE WALTER BURNS SAUNDERS MEMORIAL MEDAL

LOYAL DAVIS, M.D., F.A.C.S., Professor of Surgery, Northwestern University Medical School, Chicago, Illinois

Sometime soon, I hope, a member of your profession will have the opportunity of presenting before a like body of the medical profession an address of evaluation of the members of the latter profession. The reverse situation, of which this paper is an example, is far too frequent an occurrence. This is, I suspect, because the medical profession, composed chiefly of men, has absorbed a larger share of the public's attention and regard. But you have at least the satisfaction of knowing that yours is the older and because of that, the more honorable calling.

That may surprise some of you because I find frequent reference to the "new profession" of nursing. If so, let me call your attention to the fact, first pointed out by Sir William Osler, that in one of the lost books of Solomon, a touching picture is given of Eve, then an early grandmother, bending over the little Enoch, and showing Mahala how to soothe his sufferings and to allay his pains.

Other women have performed self-sacrificing labors, seeking neither reward nor recognition, down through the years. It seems strange that so long a time elapsed before one who cared so much for service to others and so little for recognition of herself, was singled out to make it possible for many others of like kind to give themselves to service in an open world instead of in a cloister. It is now eighty-eight years since Florence Nightingale paid her first visit to that institute of Protestant deaconesses at Kaiserswerth on the Rhine and there and then became convinced that nursing might be made a "calling" for ladies.
The instinct to care for the sick and, to a basic extent, the ability to do so, is inherent in all women, but Miss Nightingale set herself the task of raising the art of nursing from the menial occupation of a Sairey Gamp to an honorable vocation. As you know, her opportunity came with the Crimean War and when, after her return from those hard years in the barracks hospital at Scutari, she could have had a nation’s adulation, she chose to sanction as the only public recognition of her services, the raising of a fund to establish a training school for nurses. Thus it was that in 1860, the Nightingale Training School for Nurses at St. Thomas’s Hospital, London, came into being.

**WHO GIVES NURSING CARE?**

This picture has been multiplied many times until today “nursing” includes the institutional nurse who cares for the sick in hospitals; the public health nurse, who cares for and teaches patients the importance of sanitation in their homes; the educational nurse, who devotes her life to teaching novitiates in the art and skill of nursing; and, the private duty nurse, who cares for one patient in his home or in the hospital.

It is the “bedside” nurse, a hypothetical individual as far as we are concerned at the moment, of whom I wish to speak here.

May a doctor look at a bedside nurse? This hypothetical person is just entering a course of training which will fit her to be that type of nurse who comes more closely in touch with the sick individual than do her fellows engaged in other more specialized fields of service. In many cases she is closer to and understands the patient far better than does the doctor who directs her. Let us look at her in relation to the doctor, the hospital, and her patient.

**THE BEDSIDE NURSE AND THE DOCTOR**

In the gradual and progressive division of labor by which our present civilization, if any, has emerged from barbarism, the doctor and the nurse have been evolved as rather useful accessories in the incessant warfare upon disease in which mankind is engaged. Working side by side, often when both know the battle has already been decided, the doctor expects of the nurse far more than he would of another woman. He feels that the eyes of her soul have been opened, the range of her sympathies has been widened and that her character has been molded by events in which she has participated during her formative years of training. He instinctively looks to her for the transmission of that maternal quality of care and solicitude to his patient which he, no matter how skilled or brilliant, is unable to transmit. Though he may not express that desire and may, by his actions and words, seem to be quite self-contained, you may know that the poor fellow would give anything to be rid of the inferiority complex which keeps him from asking directly for that help. And so, our hypothetical nurse provides it without the asking.

She soon learns, if she is alert to the many possibilities of her relationship to the doctor, that she is in partnership with him for the moment to bring
about a successful termination of their temporary union of energy, ability, and intellect. Cultivating that characteristic which makes the union of men and women successful regardless of its aim, she soon learns that she may guide and indeed direct the application of his plan of treatment. To do this, she remembers that every man, to be happy, must be made to believe that he alone initiates all of his ideas and acts, but that by diplomacy, tact, and interest she may suggest and plan changes in nursing methods which she knows to be to the best interest of the patient. But, man being as perverse an animal as he is, woe unto her if by word or action, he is made to feel that he is being directed. This quality in our ideal bedside nurse, may become one of her greatest assets and it is surprising that so many of our nurses forget this most useful trait. In other words, the bedside nurse must in a sense take the doctor beneath her maternal wing as she does her patient.

She must observe at all times that fundamental trait which every successful parent or teacher exhibits toward his child or pupil. No matter how important the slight slip in another's judgment or action may seem to appear at the moment, she should never exhibit her irritation before her patient or his relatives. Nothing, in my opinion, is so likely to destroy that successful union of forces as the evidence of a lack of confidence or criticism. Doctor and nurse, each must learn the other's personality. What will she or he do under certain conditions? How can she best prepare the way when he enters the sick room and how can she best set the stage to show his personality and ability to its highest degree? Our bedside nurse may accomplish these things and still remember that doctor and nurse are simple stage accessories in a drama, playing minor but highly essential parts.

THE BEDSIDE NURSE AND THE HOSPITAL

What of the relationship of our bedside nurse and the hospital in which she receives her training and perhaps carries on her work? Nothing could be truer than the statement, "There are three sorts of nursing schools in this country; a few very good ones, a few which are very poor and a good many which are neither good nor poor." 1 You have given the prospective bedside nurse sound advice as to how to choose the hospital from which she is to be graduated.

But, may I say that often the nurse forgets that hospitals have personalities? This is an intangible thing which makes one hospital with a distinctive character differ from another like it in its bricks and mortar. It is the combined individualities of the nurses, doctors, and working personnel of a hospital rather than their individual contributions to medical or nursing science which gives the hospital its particular flavor, tone, and color. It represents the fusion of the countless personalities of all those who are associated with the hospital, no matter how lowly his or her position, and its quality improves with age. Example has much to do with the perpetuation

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1 Nursing Schools Today and Tomorrow. Committee on the Grading of Nursing Schools. 1934. p. 150.
of traditions and our bedside nurse must have her sense of responsibility quickened to that fact for it is in the power of the least important cog to modify that personality. In her course of training she must be willing to do something more than follow the prescribed routine; she must merge herself with the active indoor life of the institution, sometimes giving even at a personal sacrifice of her time and energies.

She must remember that "handsome is as handsome does"; that outward or inward trappings have little to recommend them, and that actually, fine habiliments may prove a handicap if, in this world of competitive effort, others working in their shirt sleeves pass them by. It is not the inherited wealth, social position, or location of an institution which brings it renown. It is the character of the service which its staff gives to its patients that counts. And here again the bedside nurse can contribute her share toward making a place for her hospital in the sun. She must not forget that an act of kindness, no matter how small, reflects the character of her hospital and her training, as well as her own personality.

THE BEDSIDE NURSE AND THE PATIENT

Most important of all is the relationship between our hypothetical nurse and her patient. She must realize that no man cares to be taken off guard, so to speak. "Sickness dims the eye, pales the cheek, roughens the beard, and makes a man a scarecrow, not fit to be seen by his own wife let alone a strange woman in white," said Osler. Man is never so helpless as he is when his clothes have been taken from him. Under such conditions, even in this modern age, it requires a wise combination of firmness and tact to win his confidence.

While the nurse may not be the recipient of all the secrets of the household, she cannot help but learn many of the miseries which cannot be hidden and so she becomes the involuntary possessor of the family's innermost confidences. She should learn that part of the Hippocratic oath which enjoins secrecy as to all things heard and seen in the sickroom. As Osler has said, she should be taught two maxims: "I will keep my mouth as it were with a bridle," and "If thou hast heard a word let it die with thee." Discreet silence is a virtue not overly cultivated.

Things medical and surgical are sometimes gruesome and have a peculiar attraction for many lay people particularly in their days of convalescence. To talk of diseases with her patient is a sort of entertainment to which no discreet nurse will lend her talents. Nowadays our little bodily woes and worries are apt to be broadcasted from the housetops and too many of us forget what George Sand once said: "People knew how to live and die in those days, and kept their infirmities out of sight. You might have the gout, but you must walk about all the same without making grimaces. It was a point of good breeding to hide one's suffering." Doctors as well as nurses are sinners in this respect and we are much too fond of "talking shop."
Finally, our ideal bedside nurse must learn to measure and temper her sympathy finely. Her individual temperament will struggle to control the situation and if she be mobile, she may have a difficult lesson to learn in subduing her emotions. She will see some of her colleagues in whom the continuous panorama of suffering tends to dull the fine edge of sympathy. This she will avoid, as she avoids the opposite extreme. Perhaps in all of her relationships to her patient, she will depend upon the golden rule of humanity as announced by Confucius: “What you do not like when done to yourself, do not do to others.”

And now, at the conclusion of these remarks which I am sure I feel more strongly than I have been able to express clearly and convincingly, it becomes my very great pleasure to present the Walter Burns Saunders Memorial Medal, awarded for distinguished service in the cause of nursing. Awarded seven times previously to women of the nursing profession whose achievements in their chosen field of work have been outstanding, the award this year will be an innovation. I will ask Helen McDonough, Chairman of the Private Duty Section of the American Nurses’ Association, to receive this memorial medal in the name of bedside nurses, an ideal example of whom I have endeavored to picture for you.

It gives us all great pleasure to realize that a great band of women are being honored for the dignity and worth of their service to humanity. These women go about their work quietly, without ostentation, and frequently without recognition for work well done. To them is presented this medal upon which is inscribed: “Those who have devoted their professional lives to sympathetic and intelligent bedside nursing—April 1938.”

ACCEPTANCE OF THE
WALTER BURNS SAUNDERS MEMORIAL MEDAL
HELEN McDONOUGH, R.N., Chairman, Private Duty Section
American Nurses’ Association

It is with a feeling of deep humility that the Walter Burns Saunders Memorial Medal is accepted for

Those who have devoted their professional lives to sympathetic and intelligent bedside nursing.

It is fitting that appreciation be expressed for the attributes of character manifested by these nurses. Their unfailing performance of daily tasks at all times and in all places is worthy of this recognition.

The kind of nursing characterized by this citation is based on sympathy as a motive and not on sympathy as an emotion. Intelligent bedside nursing is the result of constant vigilance and thoughtful attention to all the needs of the patient and to his immediate environment. It is dependent upon constant effort toward self-improvement on the part of the nurse.

The significance of such a tribute, so beautifully given, will be an inspiration to thousands of nurses. At this moment many of them are trans-
mitting to their patients, through effective service, the spirit symbolized by this award.

The ideals of those who have gone on before, continue to live in the hearts of nurses. With sincerity of purpose they will endeavor to meet the challenge of the Walter Burns Saunders Memorial Medal Award for 1938.

Open Session Conducted by the Advisory Council
Tuesday, April 26, 9:00 a.m.

Presiding: Nellie X. Hawkinson. R.N., President.
The roll call showed that representatives were present from every state league and educational section.

Reports of State Leagues of Nursing Education
This year we have 37 state leagues. South Dakota was accepted as a league in the fall and Oklahoma reorganized its league. The educational sections in Virginia and Ohio have organized leagues which were accepted at this convention.

Arkansas
Members: 7
New members in 1937: none
Activities: Limited because there are only nine members. One meeting held in October with the state nurses’ association.

California
Members: 333
New members in 1937: 45
Local leagues: Three—Northern section—San Francisco, Virginia Dunbar, President Southern section—Los Angeles, Dorrit D. Sledge, President Northern Valley section—Sacramento, Helen F. Hansen, President
Special committees: Committee on Mental Hygiene and Psychiatric Nursing
Committee on Lay Participation
Activities: Membership campaign; vocational guidance program in every high school and junior college in the state; formulating standards for an affiliate course in psychiatry; formulating standards for a postgraduate course on psychiatry and other fields; study and discussion of the new Curriculum Guide.

Colorado
Members: 73
New members in 1937: Not reported
Activities: Annual meeting and seven other meetings. Topics of particular interest were: Ways to use the interest and help of lay groups to further the progress of nursing education, how to secure better prepared students, how to meet expenses involved in installing the new curriculum, staff education and how it would affect student education, newer trends in general education, comparative study of the nursing school library with the Basic Book List.

* Number of members in each state whose 1938 dues had reached headquarters by July first.
DELAWARE

Members: 26
New members in 1937: 2
Special committees: Committee on State Board Problems
                   Committee on Mental Hygiene and Psychiatric Nursing
Activities: Course of lectures for senior students on public health through cooperation of directors of schools of nursing and visiting nurse associations; two meetings at which new curriculum was discussed; address and lantern slides on bronchoscopy; educational program for the head nurse, demonstration of Wangensteen suction.

DISTRICT OF COLUMBIA

Members: 100
New members in 1937: 33
Special committees: Committee on State Board Problems
                   Committee on Mental Hygiene and Psychiatric Nursing
                   Committee on the Care of the Child
                   Committee on Lay Participation
                   Committee on Nursing Information
                   Committee on Special Membership
                   Joint Committee on the Subsidiary Worker
Activities: Six meetings were held during year. At first meeting reports of those who attended the Congress of the International Council of Nurses in London were given; at another meeting, the chairman of the Committee on Nursing Information presented sources of information for young women interested in nursing careers and the film, Nurses in the Making, was shown. Other subjects discussed were: Value and technique of self-cooperative surveys in schools of nursing, some findings concerning interests and attitudes in the field of guidance, inclusion of health nursing in the basic curriculum. One meeting was devoted to a dinner and Christmas party, and in the future programs are planned on mental hygiene and psychiatric nursing, the care of the child in nursing education, and reports from the Kansas City Convention.

FLORIDA

Members: 26
New members in 1937: 12
Local leagues: One—Orlando, Vida Nevison, President
               Another local league is being formed in West Palm Beach
Special committees: Committee on Mental Hygiene and Psychiatric Nursing
Activities: Membership campaign; formation of one local league; meetings at which the following topics were discussed: need for local leagues, reports of annual convention of National League in Boston, training and qualifications for teachers of nursing, and the modern concept of medical nursing in nervous and mental diseases.

GEORGIA

Members: 39
New members in 1937: 4
Local leagues: One—Atlanta, Lutie C. Leavell, President
Special committees: Committee on Mental Hygiene and Psychiatric Nursing
                   Committee on State Board Problems
Activities: Formation of a local league, formation of liaison committee with state board of nurse examiners; study of the Curriculum Guide; continuation of summer session at University of Georgia with nursing courses offered; attempt to interest each district in offering a scholarship for a student in the summer session.
ILLINOIS

Members: 393
New members in 1937: 103
Special committees: Committee on State Board Problems
                     Committee on Mental Hygiene and Psychiatric Nursing
                     Committee on the Care of the Child

Activities: Institute on pediatric nursing for two districts of the state nurses' association sponsored by the Committee on the Care of the Child; aid in securing revision of the public health nursing act and the nursing act; appointment and development of activities of special committees on mental hygiene and psychiatric nursing, state board problems, and Sisters' problems.

INDIANA

Members: 69
New members in 1937: 15
Special committees: Committee on State Board Problems

Activities: Four meetings held in different cities of the state with programs on the following: practical application of the Curriculum Guide to Indiana schools of nursing, correlation and evaluation of theoretical and practical work, discussion of isolation technique, good bedside nursing. A two-day institute on the curriculum was held on March 18 and 19.

IOWA

Members: 137
New members in 1937: 25
Special committees: Committee on Mental Hygiene and Psychiatric Nursing

Activities: Joint meeting with Iowa Hospital Association; other meetings at which the following topics were discussed: The nurse in this widening field of education, resources suitable for ward teaching, professional preparation for the profession of nursing, ways and means of building up a nursing school library, demonstration of Wangensteen suction and gravity aspiration.

KANSAS

Members: 46
New members in 1937: 15
Local leagues: One—Eastern Kansas, Evalyne Collins, President
Special committees: Committee on Mental Hygiene and Psychiatric Nursing
                     Committee on Lay Participation

Activities: Institute in Topeka, October 26 and 27, for discussion of new Curriculum Guide.

KENTUCKY

Members: 59
New members in 1937: 10
Special committees: Committee on State Board Problems
                     Committee on Mental Hygiene and Psychiatric Nursing

Activities: Membership drive; four regular meetings at which staff education and the subsidiary worker and her place in the hospital were discussed.

LOUISIANA

Members: 93
New members in 1937: 10
Local leagues: Two—New Orleans, Harriet Mather, President
        Shreveport, Mrs. E. F. Fry, President

Activities: Shreveport Local League organized; annual meeting, November 22-24, at which the following topic was discussed: The adaptation of the new curriculum to the individual school and the preparation of the faculty to put the new curriculum into effect; two-day institute on mental hygiene.

MAINE

Members: 26
New members in 1937: 5

Activities: Two meetings, one on the Curriculum Guide and the other on the problems of directors of schools of nursing. An institute is planned for May.

MARYLAND

Members: 101
New members in 1937: 10

Activities: Five meetings were held, exclusive of those held jointly with the state nurses’ association; cooperated with the state association in placing the American Journal of Nursing and publicity material from headquarters in the Enoch Pratt Library of Baltimore and in the libraries of several colleges; as result of previous studies and recommendations, the state association is ready to appoint an executive secretary and educational director for Maryland.

MASSACHUSETTS

Members: 229
New members in 1937: 48

Special committees: Committee on State Board Problems
        Committee on Mental Hygiene and Psychiatric Nursing

Activities: Institute for principals of schools of nursing in Massachusetts sponsored by the Committee on State Board Problems; revisions of by-laws; two-day institute, April 7 and 8; plans for students’ night in May; special committee to study plan for introducing courses in nursing education in School of Education at Boston University in September, 1938.

MICHIGAN

Members: 185
New members in 1937: 31

Local leagues: One—Detroit, Erma Taylor, President

Special committees: Committee on State Board Problems
        Committee on Nursing Information

Activities: Institute at Grand Rapids on ward teaching and ward administration; cooperated with Michigan State Nurses’ Association and Michigan Organization for Public Health Nursing in planning institutes on maternal care in Flint, Saginaw, Kalamazoo, Traverse City, and Grand Rapids. The Detroit League has planned four meetings at which techniques of incidental teaching and problems involved in the education of the student nurse were discussed. Institute on clinical subjects planned for May.

MINNESOTA

Members: 258
New members in 1937: 82
CONVENTION PROCEEDINGS

Special committees: Committee on State Board Problems
Committee on Mental Hygiene and Psychiatric Nursing
Committee on the Care of the Child
Committee on Lay Participation
Committee on Rating Student Practice

Activities: Eight monthly programs devoted to discussion on the use of the new Curriculum Guide; integration of work of league with state association and public health nursing organization through use of state headquarters, integrated program at annual convention, and joint committees; study of rating student practice; participation in community studies by helping finance the study of Duluth and Blue Earth counties by the Joint Committee on Community Nursing Service; membership drive; revision of constitution and by-laws in accordance with recommendations of the NLNE.

MISSOURI

Members: 111
New members in 1937: 19
Local leagues: Two—Kansas City, Lela M. Rahe, President
St. Louis, Lucy Hoblitzelle, President

Special committees: Committee on State Board Problems
Committee on Mental Hygiene and Psychiatric Nursing

Activities: Continuation of group study of the Curriculum Guide; concentration on the work of the Committee on State Board Problems and formulation of plans for a questionnaire to be submitted to all members aspiring to state board membership before their names are sent to the Governor. The questionnaire was accepted by the state nurses' association. The league also assisted in forming a committee for the study of the Nurse Practice Act in Missouri, which work is under way at the present time. A Committee on Mental Hygiene and Psychiatric Nursing was organized.

NEBRASKA

Members: 49
New members in 1937: Not reported
Local leagues: Two—Omaha, Alma Folda, President
Lincoln, Geraldine Scully, President

Special committees: Committee on Mental Hygiene and Psychiatric Nursing

Activities: Institute for all nurses in the spring; one-day convention preceding convention of state nurses' association; meeting of Curriculum Committee to discuss use of the Curriculum Guide in Nebraska schools of nursing; league members attended meetings held by State Department to study use of Curriculum Guide; members also attended meeting of State Department to study new rules and regulations before adoption; study of available resources for psychiatric experience in Nebraska schools with the idea of establishing an adequate service for affiliation; monthly meetings of the local leagues were held with interesting programs both cultural and professional.

NEW HAMPSHIRE—No report

NEW JERSEY

Members: 249
New members in 1937: 95
Special committees: Committee on State Board Problems
Committee on Mental Hygiene and Psychiatric Nursing
Committee on the Care of the Child

Activities: Regular monthly meetings of the Board of Directors from September to May; four meetings of the league, one held with the state nurses' association and the
state organization for public health nursing; league has been active in sponsoring extra-mural courses in various parts of the state; planned program of annual meeting emphasizing the importance of various aspects of child care.

NEW YORK

Members: 619
New members in 1937: 116

Local leagues: Five—New York City, Helen Young, President
          Hudson Valley—Albany, Marcella Feinauer, President
          Central New York—Syracuse, Adele Stahl, President
          Genesee Valley—Rochester, Christine Stewart, President
          Western New York—Buffalo, A. Grace Scott, President

Special committees:
          Committee on State Board Problems
          Committee on Mental Hygiene and Psychiatric Nursing
          Committee on Lay Participation
          Committee on Nursing Information
          Committee on Subsidiary Workers
          Committee on Graduate Nurse Education
          Committee on Sisters' Problems

Activities: Annual meeting in Lake Placid; meeting of state league officers, chairmen of standing and special committees, and local league presidents to coordinate activities in New York State; committee at work on revision of New York State minimum curriculum; Committee on State Board Problems doing questionnaire study of comprehensive examinations; Committee on Sisters' Problems studying ways and means of improving faculty who are Sisters, studying merits and demerits of various types of examinations; Committee on Tuberculosis Nursing preparing outline of ten weeks' undergraduate course in tuberculosis; Committee on Psychiatric Nursing conducting state-wide institutes on psychiatry; membership drive; joint committees working with state nurses' association on the Nurse Practice Act, student forums, course of study and work of subsidiary worker; Committee on Graduate Nurse Education stimulating interest in graduate nurse education; planning annual meeting in fall of 1938 to consider constructive criticism of Curriculum Guide, clinical instruction for graduate nurses, and tuberculosis and psychiatric affiliations for students.

NORTH CAROLINA

Members: 59
New members in 1937: Not reported.

Activities: Met with state association in October, 1937; directors meeting in May.

NORTH DAKOTA:

Members: 11
New members in 1937: None

Activities: Activities are limited because there are only 11 members and they are scattered throughout the state.

OHIO

Members: 235
New members in 1937: 57

Local leagues: Two—Cincinnati

Cleveland, Edna S. Newman, President

Special committees: Committee on State Board Problems
          Committee on Mental Hygiene and Psychiatric Nursing

Activities: Emphasis on revised curriculum through state and district meetings and institutes; chairman of state section is member of all committees of the state nurses' association; letters sent to district sections on nursing education emphasizing member-
ship in the National League and suggesting appropriate programs for meetings of educational sections and encouraging group participation in programs; letters to principals of accredited schools in Ohio asking them to assist in increasing League membership among their faculty members; letters to principals of high schools enclosing Nursing and How to Prepare for It and giving them information and sources of further information for those wishing to enter nursing, as well as a list of books which would be of interest to prospective students in nursing; $500 Florence Nightingale Scholarship Loan issued to one nurse in 1937.

**Oklahoma**

*Members:* 36  
*New members in 1937:* 27  
*Activities:* Since the Oklahoma League was just reorganized in November, 1937, after a two-year period of inactivity, there has not been much opportunity to accomplish things. In May there will be an institute in Tulsa at which a program for future work will be organized. The Oklahoma nurses are interested in making their league an outstanding one and expect to put forth every effort during the coming year to accomplish this.

**Oregon**

*Members:* 58  
*New members in 1937:* 13  
*Local leagues:* One—Portland  
*Special committees:* Committee on State Board Problems  
Committee on the Care of the Child  
*Activities:* Panel discussions in cooperation with state nurses' association and state organization for public health nursing; department in state bulletin; twelve talks given in public high schools; three groups of high school pupils visited clinics of VNA and were given general talks on nursing.

**Pennsylvania**

*Members:* 389  
*New members in 1937:* 86  
*Local leagues:* Four and two league committees—  
Philadelphia, Emily Talbot, President  
District 2, Judith Saville, President  
District 3, Sister Mary Coyle, President  
Pittsburgh, Mildred Shellenberger, President  
League committee, District 5, Nettie Bealer, Chairman  
League committee, Districts 7 and 8, Lida Snellbaker, Chairman  
*Special committees:* Committee on State Board Problems  
Committee on Mental Hygiene and Psychiatric Nursing  
Committee on the Care of the Child  
Committee on Lay Participation  
Committee on Nursing Information  
Committee on Membership Campaign  
*Activities:* Membership Campaign Committee very active and producing fine results; Curriculum Committee sent representative to all local leagues to speak on new Curriculum Guide; a skit called New Curriculum Enters was sent to all local leagues, district, and alumni associations to be dramatized; study made of students' health, insurance, budget plans, etc., throughout the state; league as department of education of the state nurses' association sponsored institutes on tuberculosis and maternal welfare; Curriculum Committee recommending ways of bridging the gap between required curriculum and Curriculum Guide; members appeared on round table at Pennsylvania
Hospital Association meeting to discuss the selection of teaching personnel; study being made of postgraduate and "added experience" courses; study being made of certification for nurses with view toward making recommendations for setting up a certification bureau sponsored by league; league as department of education of state nurses' association now sponsoring cancer clinics and tuberculosis clinics; members appeared on program of the convention of the Pennsylvania Hospital Association.

Rhode Island

Members: 112
New members in 1937: 32
Special committees: Committee on Mental Hygiene and Psychiatric Nursing
Activities: Courses at Brown University on ward administration and history of nursing; two-day institute on mental hygiene and problem children; special meeting for senior students on post-graduation problems and activities; interschool visits by league members with special programs by the schools; instructors' section for discussion of curriculum problems.

South Dakota

Members: 28
New members in 1937: 17
Activities: Most of the activities of the past year have been those connected with the organization of the league, getting new members, forming constitution and by-laws, etc. Curriculum Committee has made a study of clinical facilities and faculty education in the 16 schools in the state.

Tennessee

Members: 42
New members in 1937: 3
Local leagues: Two—Memphis, Betty Gilmore, President
Nashville, Adele Rhodekohr, President
Special committees: Committee on State Board Problems
Committee on Mental Hygiene and Psychiatric Nursing
Committee on the Care of the Child
Committee on Lay Participation
Activities: Group study of the Curriculum Guide; a vocational guidance bulletin was published and sent to every high school in the state together with a copy of the Nursing Information Bureau pamphlet, Nursing and How to Prepare for It; another local league formed; Committee on Mental Hygiene prepared plan for the functioning of the Dorothea Lynde Dix Scholarship Fund of the state nurses' association and the league.

Texas

Members: 138
New members in 1937: 42
Local leagues: One—Dallas, Lena Koller, President
Special committees: Committee on State Board Problems
Committee on Mental Hygiene and Psychiatric Nursing
Activities: Annual state meeting; three-day joint institute with the state organization for public health nursing; a program leading to a B.S. degree in nursing education adopted by the University of Texas; extension courses in nursing education given by the University of Texas both semesters of the long session and a campus course
in the summer, the program and extension courses both sponsored by the league and
the state nurses' association.

UTAH

Members: 21
New members in 1937: 16
Local leagues: One—Salt Lake City, Louella Mahaney, President

VIRGINIA

Members: 59
New members in 1937: Not reported
Activities: Efforts during the year directed toward forming a league of the educa-
tional section; two-day institute held to discuss some of the outstanding factors in
relation to the adaptation of the Curriculum Guide; program for annual meeting in
May planned to include a round table discussion on the topic of stimulation of better
nursing through the use of the Curriculum Guide.

WASHINGTON

Members: 72
New members in 1937: 18
Local leagues: Two—Western, Harriet H. Smith, President
Eastern, Dorothy Daigle, President
Activities: Arrangement with the state nurses' association whereby league sponsored
one program during the winter in each district where numbers are too few for a
local league and distances too great for members to travel to branch meetings. Topics
discussed were: Methods of teaching, course planning, student rotations, etc. This
plan will be continued next year. Joint meeting of the two local leagues in Yakima
in September in addition to annual meeting in May in Port Angeles. Local leagues
have regular monthly meetings.

WISCONSIN

Members: 127
New members in 1937: 14
Local leagues: One—Milwaukee, Sister Felician Owens, President
Special committees: Committee on State Board Problems
Committee on Mental Hygiene and Psychiatric Nursing
Committee on the Care of the Child
Activities: Letter to every superintendent of nurses in the state asking for the
appointment of some one in their school to take charge of membership drive; two
splendid regional meetings, one at Wausau and the other at Madison; annual meeting
at Ashland; letters to every member in the state informing them of each regional
meeting.

REPORTS OF EDUCATIONAL SECTIONS OF STATE
NURSES' ASSOCIATIONS

ALABAMA

Members: 26
New members in 1937:
Activities: The chief work done by this section during the current year has been
that of the Committee on University Relationships. This Committee was sponsored
originally to foster the courses offered at the University of Alabama during the
past few years.
During the course of its experience there developed among the members and others who were engaged in the field of public health nursing a strong feeling of need for more adequate facilities within the state for preparation of nurses in the basic requirements as well as for public health nursing.

This Committee is comprised of superintendents of schools of nursing, teachers, and other nurses interested in education and has as its chairman, Miss Zoe La Forge of Birmingham.

To date the Committee has studied the requirements of collegiate schools of nursing, and at present it is studying budgets of schools of nursing in this and other localities.

A great deal of interest has been stimulated and the Committee will continue the work with the hope of elevating the standards of the schools of nursing in the state.

Sister Valeria of St. Margaret's School of Nursing, Montgomery, Alabama, is working for an increase of membership in the National League of Nursing Education, with the goal set at fifty.

**CONNECTICUT**

*Members*: 128  
*New members in 1937*: Not reported  
*Activities*: Revision of the by-laws of the section; institute held on maternity nursing and integration of the medical and surgical courses; fall meeting—round tables on ward teaching; reorganization of work of the Membership Committee; participation with the state nurses' association in publicity, scholarship and loan work; reorganizing the method of routing the history of nursing slides to the schools and increasing the number of slides; planning program for annual meeting in May with the following topics for discussion: value of membership in league to the nurses of Connecticut, libraries in schools of nursing, progress in the schools of nursing as found by the secretary of the state board.

**MONTANA**

*Members*: 27  
*New members in 1937*: Not reported  
*Activities*: One meeting annually at times of state convention; should be active in supporting university and state college pre-nursing courses and affiliations for psychiatric nursing and tuberculosis and communicable disease nursing at the two state institutions.

**NEW MEXICO**—No report

**WEST VIRGINIA**

*Members*: 13  
*New members in 1937*: 3  
*Special committees*: Committee on Mental Hygiene and Psychiatric Nursing  
*Activities*: Organized college affiliation on credit basis with Morris Harvey College and five Charleston schools of nursing for psychology, chemistry, and sociology; organization of instructors' section of Educational Section for Instructors in Southern West Virginia Schools of Nursing to discuss common problems at monthly meetings; institute for instructors at Richmond, Virginia, publication of pre-nursing course at West Virginia University in the bulletin and university catalogue; booklet prepared for high school libraries and an instruction sheet for all instructors of girls' groups in junior and senior high schools throughout the state.
Some Questions About the Use of Federal Funds for Nursing Education

Isabel M. Stewart, R.N., Professor of Nursing Education, Teachers College, Columbia University, New York, New York

The President has requested me to speak to this group on the two questions listed on the agenda. I shall not attempt to deal with these questions in any detail because I have not had opportunity to consult with other members of the League Board on all aspects of these problems. Some of the points presented have been discussed in the League Board, however, and the League has taken action. Others are expressions of my own opinion, which I submit as a basis for consideration and possible discussion.

I shall begin with the second question and try to review some of our previous inquiries and experiences with respect to the Smith-Hughes Act in relation to the education of nurses.

This Act was passed in 1917. I can’t take time to explain just what the provisions of that Act were, but I think you know it provided quite a large sum of money for vocational education, the money to be spent chiefly for training workers in industry, agriculture, and home economics. In the very beginning, it was definitely stated that the work of these students should be on a secondary level. The funds were appropriated by the federal government with the understanding the states would duplicate the amounts allotted to them, and that the administration of these funds should be under state departments of vocational education.

In 1918, during the War, a small committee composed Miss Crandall, Miss Jammé, and myself, was appointed by the Committee on Nursing of the Council of National Defense to look into the possibilities of securing aid from the Smith-Hughes fund for nursing schools that were finding it exceedingly hard to conduct good educational programs under emergency conditions. An interview was arranged with the officers of the Federal Board of Vocational Education in Washington, and an arrangement was worked out by which the teaching of certain basic services in the nursing school program was to be paid for through these federal and state funds. The League of Nursing Education appointed representatives in certain states to advise with the schools in those states that needed such help and to cooperate with the vocational education departments. Every effort was made to emphasize the fact that this was an experiment limited to schools that had not reached accepted professional standards.

The following is an extract from a letter written to these representatives at the time: “As you probably know, the Federal Board of Vocational Education has charge of the federal funds appropriated under the Smith-Hughes Act for the promotion of vocational education throughout the whole country. The Committee on Nursing has consulted with the Federal Board as to the possibility of securing some aid from these funds for educational work in nursing schools and has been assured that this is possible under
the following conditions: The subjects taught must be of secondary school grade; the students must be doing part-time work in the hospital during the period of instruction, the total number of hours instruction yearly must not be less than 144 hours, and all instruction must be under public supervision and control. Classes may be held either in the hospital or in an adjacent high school and should be conducted by properly qualified teachers, who may come from the regular high school staff or may be appointed quite independently. Equipment and teaching materials would be included in the cost of instruction.

"The committee does not consider it advisable for training schools with good average resources and standing to apply for such assistance, as their work is unquestionably of a higher educational standard than that of the secondary school and it is highly important, in order to maintain our professional status, that nursing instruction should be kept on as high a plane as possible. But in the smaller centers, where schools are struggling with very inadequate facilities for teaching, such a plan may be found helpful until better resources can be secured. It seems wise, therefore, to try it out in a few representative schools before making any general recommendation for its further extension."

The general results of this experiment were reported in the NLNE Annual Report of 1919. The NLNE representatives came to the conclusion that the better nursing schools would lose status by entering into such arrangements and that there were not sufficiently large financial inducements, in any case, to compensate for the adjustments required.

Ten years later, in 1929, as chairman of the Education Committee of the League I had some conferences with Dr. J. C. Wright, Director of the Federal Board for Vocational Education, in regard to the same subject and after a full discussion we came to much the same conclusion. We realized that schools working under special handicaps might find it advisable to make arrangements for some beginning courses, say, in chemistry and dietetics, on a high school level, but did not consider it advisable for nursing schools generally to accept the conditions under which such financial assistance is given. It was believed that they would lose more than they would gain by such an arrangement.

Recently the question has been raised again by the recommendations made in a publication entitled *Nursing Education in Minnesota*, which many of you have seen. It is recommended therein that nursing schools accept what is practically the status of trade schools in order to be eligible for financial help under the Smith-Hughes Act of 1917 and the George Deen Act of 1936. The conditions are not specified and many people are wondering why they have not been told before that there is a large fund of public money available to nursing schools for the asking.

It may be well to read some of the conditions. The following statements are quoted, in full or summarized, from the statement of policies for the administration of vocational education previously referred to:
(1) Federal funds for vocational education are available only to train
persons for useful employment in agriculture and industry, home economics,
or commercial occupations; (2) education given must be of less than col-
lege grade; (3) college entrance requirements are not to be made pre-
requisites for admission; (4) the training programs are not to lead to a
degree; (5) federal funds cannot be used for schools that train for pro-
fessional service (an explanatory clause states that nurses, laboratory as-
sistants, draftsmen, and some others are considered as semi-professional);
(6) federal funds can be used only for schools under public control; (7)
schools or classes receiving such funds will be administered, controlled, and
supervised in all details by officials on the staff of a state or local board
responsible for vocational education (this covers such matters as selection
of teachers, their salaries and so forth, qualifications and admission of pupils,
content and organization of all courses and curricula); (8) apprentices or
cooperative pupils are required to give at least half their time to practical
work on a useful or productive basis and receive a monetary wage at a rate
comparable to wages paid to other employees.

I have consulted with some representative educators who have been on
the President's Advisory Committee on Education. This committee which
has just issued its report * has made a number of recommendations covering
the whole question of federal expenditures for education, among them some
proposals for the revision of the Smith-Hughes and George Deen Acts.
There is a possibility that the provisions may be changed to allow for the
use of these funds for certain branches of professional education and for
other uses. We need to keep in touch with what is happening in Washington
and to get expert advice on the possibilities of nursing schools securing a
share of the financial appropriations available for education, if this can be
done without setting us back in our struggle for professional standards.

The time seems to be ripe for an active inquiry into all the possible sources
of financial support, public and private, for nursing education. The Social
Security Act and the extension of hospital and public health services in
the country at large would give strength to our claim that nurses are public
servants and that the public should assume greater responsibility for the
support of nursing schools.

In regard to the question of cooperating with state vocational education
departments in the training of attendants, practical nurses, or nursing aides,
or whatever we decide to call this type of worker, we all know that voca-
tional courses are being offered in many schools of secondary grade (and
in some cases, of junior college grade) and paid out of the Smith-Hughes
funds. These courses will undoubtedly continue whether we, as a pro-
fessional group, cooperate or not. Most of them have been under the
supervision of the home economics specialists in the state departments of
vocational education. We can be fairly sure that this group will welcome
our cooperation and will appreciate the need of professional guidance in

courses dealing specifically with nursing. There seems to be no question of our responsibility in this matter, and I would urge that we proceed as rapidly as possible in working out a plan and making the necessary arrangements, through our state headquarters, for active cooperation with state vocational education departments.

With the increasing recognition of subsidiary nursing groups in the care of the sick and the development of schools for the training of such workers, we need to give a good deal of thought to the best way of setting up such schools. If all kinds of hospitals are to set up courses of this type, we shall have the same old problems to meet that we have struggled with in our attempt to control nursing schools. My belief is that it would be much better to have the education of these workers developed on the plan that is now being followed in the training of industrial, agricultural, home economics, and other workers, where the theoretical work is centralized in a vocational school and the practice is carried on in cooperating institutions and agencies. The apprentices, as these students are called, are paid a normal wage and conditions of service, hours, and so forth, are under control of the state vocational education department. The funds for teachers and coordinators of the theoretical and practical work come from the state, half of the funds being supplied from federal sources. It would be impossible, under the present provisions of the Smith-Hughes Act, to have funds paid directly to private or non-public agencies. They can be made available only to public institutions.

Whatever changes may be made in the federal acts governing educational funds or in the disposition of these funds, there would seem to be no reason to doubt that the use of such funds will be available for practical nurses, and I believe that we shall be much safer in working out plans under public control and with public support than in allowing the old system of individual enterprise or rugged individualism to get too strong and then have all the trouble of checking and regulating the "wildcat" schools for practical nurses that will undoubtedly multiply under hospital and private auspices—not to mention correspondence courses and the like.

Needless to say, a clear distinction must be drawn between the professional school for nurses and the non-professional training of nursing aides or attendants. This should be a stimulus to the professional school to put its work on a sound basis. The only danger I see is that the non-professional courses with public support may be in a better position financially than the school working on a higher level.

Professional nurses must be prepared to develop, teach, and coordinate these courses for the non-professional group. Funds are available, under the acts referred to, for the training of such vocational teachers under certain conditions and in certain specified centers. Only non-degree programs are approved and they can be given only in institutions supported by public funds, but even under these conditions there are possibilities of definite help for graduate nurses who are interested in preparing themselves for this type of educational work.
THE IMPORTANCE OF FACULTY MEMBERSHIP IN THE LEAGUE

GRACE WARMAN, R.N., Director, School of Nursing,
Mount Sinai Hospital, New York, New York

Many of us who are principals of nursing schools, though for years ourselves members of the National League and accustomed to its benefits, have not always been able to give sufficient time to the problem of arousing the interest of our faculties in League membership. With all our responsibilities this is, of course, not unusual; yet I am sure we are all aware of the desirability of building as strong and effective a League of Nursing Education as we can possibly establish.

In this day of organized achievement, nurses who are doing any form of educational work are as dependent upon progress through group participation as are members of other professions. A professional nurse on the faculty of a school of nursing should consider it not only an obligation but also a privilege to belong to an organization which will contribute to making her a better person for her position.

In interesting new members it is necessary to appeal to the qualified individual nurse in terms of her own advantages. What, then, are some of these advantages?

First of all, let us consider the nurse after her graduation from the school. Up to that time she has been a member of a group, working with them and sharing their interests. After graduation the group disbands, and the young graduate, probably by now a staff nurse, is promoted to a faculty position. Even though her new work may take up most of her time she undoubtedly will, back of everything, feel a certain sense of emptiness, a "let-down" feeling. She feels that, even though basically well prepared, she is not keeping in the fore of her profession—she is, in a sense, definitely dropping behind. While a graduate course or two will materially add to her background, the essential give-and-take of mutual professional contact may be wholly lacking.

Here is where League membership comes in, because it fills the professional needs which the young graduate is experiencing. After attending several local league meetings she begins to feel again the stimulation of group participation that she felt while in the school. There is also the personal gratification that she has achieved a definite professional advancement in being eligible for membership.

Through timely, well-planned programs, she not only is informed of the newer trends and developments in nursing education, she is also able to discuss them with other members of the group, and when she comes away from the meetings she will find that she has gained new suggestions, a fresh point of view, and confidence for carrying on her own work.

Membership in the League, as you know, entitles the nurse to the Annual Report of the League. This report, alone, is well worth the money expended for membership dues, because it helps to keep the faculty member up to date, and also provides her with valuable reference material.
Amazingly enough, this is not all that the League offers its members. In addition to informative programs and discussions, the members may, through committee work, actually help to shape the League’s policies, and learn to conduct meetings. Experience like this is invaluable in promoting and maintaining self-confidence and leadership.

Finally, we come to the importance of League membership in securing a position. I believe that all principals of our schools, in their interviews with applicants for faculty positions, make inquiry concerning membership in professional organizations. The applicant’s affiliation with the League usually means that she has, in addition to her other qualifications, a desirable professional awareness.

Now that we have examined the importance and advantages of League membership, I should like to indicate a few ways in which the principal of a school can aid in the important work of attracting eligible applicants into the League:

1. Through contact with faculty members at their conferences, the principal can stimulate interest in League membership by speaking about new projects and accomplishments of our National League.

2. In planning the faculty preparation record, a space can be provided for organization membership, thereby bringing to the consciousness of the faculty member the importance of League membership.

3. The principal may, as a part of the staff education program, arrange for various faculty members to report at their conferences the current activities of League meetings attended.

4. And finally, a principal can arrange to appoint a small committee of senior faculty members to take charge of application forms and interest those of the personnel eligible for membership.

If we can gain interest in promoting membership, we will, in addition to strengthening our organization, be enriching the possibilities for future progress in nursing education.

**Increasing League Membership in Illinois in 1937**

**Dorothy Rogers, R.N., Instructor, Department of Nursing Education, The University of Chicago, Chicago, Illinois**

On January 14, 1937, letters were sent from the President of the National League to heads of all schools and nursing services in this state, as in all other states, acquainting them with the fact that barely one seventh of the potential membership of the country were on the roster of the League. Enclosed was a form asking for a list of faculty members not in the League, which was to be returned to National Headquarters.

Following the receipt of these lists each member of the faculty thus reported received a personal letter urging her to join.

The Illinois League sent out on March 24, a follow-up letter over the signature of the state president, asking the directors of schools of nursing and of nursing services what progress had been made in enrolling their
faculty members in the League, and reminding them of the honor of the 100 per cent certificate which might be earned.

The organization of a Sisters' Committee early in the year stimulated membership in their group. Their group was responsible for arranging a mass and breakfast for the Catholic nurses and sisters at the state annual convention. Without doubt, through such efforts we have been able to draw in many of the sister-instructors of the state.

Bills for membership dues have been sent out to delinquent members several times during the year as lists of delinquent members were available.

The results for 1937 are as follows:

<table>
<thead>
<tr>
<th>Membership</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>October 1, 1937</td>
<td>..............</td>
</tr>
<tr>
<td></td>
<td>October 1, 1936</td>
<td>..............</td>
</tr>
<tr>
<td></td>
<td>Total new members in 1937</td>
<td>..............</td>
</tr>
</tbody>
</table>

1937 Membership

<table>
<thead>
<tr>
<th>Membership</th>
<th>Renewal</th>
<th>New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>279</td>
<td>47</td>
</tr>
<tr>
<td>Junior Active</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>Sustaining</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>314</td>
<td>75</td>
</tr>
</tbody>
</table>

The largest increase in new members is among the Junior Active group. Obviously these need to be followed to assure full standing as active members later.

Potential membership for 1937, according to the accredited schools' list of faculty, is 765 exclusive of possible members from nursing services. This reveals the fact that we should display an 85 per cent increase over our 1937 total at the close of 1938. With the first half of the organization's year gone, our present progress in the march toward this goal gives the following data:

<table>
<thead>
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<th>October 16, 1938</th>
<th>..............</th>
<th>372</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Renewals</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>257</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Junior Active</td>
<td>19</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Sustaining</td>
<td>27</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

The list of members delinquent in their dues on that same date is 8 per cent.

**General Session**

**Tuesday, April 26, 2:30 p.m.**

Presiding: Nellie X. Hawkinson, R.N., Chairman, Joint Committee on the Costs of Nursing Service and Nursing Education.

**A NEW EXCURSION IN COSTS**

BLANCHE PFEFFERKORN, R.N., Director of the Cost Study

The title of this paper is a statement of fact. In support of it I submit the following points:
1. This Cost Study is sponsored by the three national organizations: the American Hospital Association, the National League of Nursing Education, and the American Nurses' Association.

2. It is guided by a specially appointed committee, the Joint Committee on the Costs of Nursing Service and Nursing Education, of these three organizations.

3. It considers various "cost" concepts and their special application to nursing cost analyses.

4. It is based upon the principle that, to be meaningful, costs must be related to practice.

5. It has been approached as a long-term research problem in the gathering of facts and the testing out of methods.

6. It proposes to develop techniques and measures in order that
   a. Costs may be analyzed in an institution not only upon the basis of its present practices, but also upon the basis of administrative policies adopted by the Committee
   b. Valid comparisons may be made of the costs in one institution with the costs in another.

You will, I think, want to know the names of the Committee members. Representing the American Hospital Association are E. Muriel Anscombe, Dr. Claude W. Munger, Robert E. Neff, and C. Rufus Rorem; representing the National League of Nursing Education are Nellie X. Hawkinson, who is chairman of the Committee, Marian R. Fleming, Stella Goostray, Elizabeth Melby, Effie J. Taylor, and Claribel A. Wheeler; representing the American Nurses' Association are Susan C. Francis and Alma H. Scott. The Director of the Study is Blanche Pfefferkorn; the Associate Director, Charles A. Rovetta.

The Cost Study may properly be considered as having two stages. The first stage, now in process, divides itself into two types of endeavor, for convenience here classified as nursing and accounting. The nursing classification has to do with nursing service and nursing education measures which lend themselves to quantitative treatment and are significant in costs; the accounting classification is concerned with the application of cost concepts appropriate to the problem, and the working out of an accounting system which will facilitate cost analyses of nursing service and nursing education as separate activities. The work on the nursing classification phase is the especial function of the Director of the Study; the work on the accounting classification, of the Associate Director. For the most satisfactory prosecution of the study, the efforts of these two workers should be closely coordinated.

In the remainder of this paper, I shall report on the progress of that part of the study for which I am especially responsible—the evolving of nursing measures. As the major portion of my time has been given to the Cost Study during the past year, this presentation becomes, in effect, my report to the membership since the last convention.

It can be safely asserted that the most significant cost item in the nursing service of a hospital is the provision for the bedside care of patients. Some data had already been gathered on this factor by the League but, because of the influence on the total cost picture, the Committee was of the opinion
that whatever measures were applied in cost analyses should be supported by substantial facts, widely gathered, and over a sufficient period of time to take into consideration staff and seasonal fluctuations. Other nursing service measures, which are also indices of the nursing education program, and which the Committee thought of sufficient importance to build upon a solid background of fact are (1) relationship of graduate bedside hours to student bedside hours, (2) provision of supervisors and head nurses in relation to patients, and (3) ward helpers and orderlies in relation to patients.

Looming large in nursing service expenditures is the item referring to graduate and student bedside hours. This expenditure is in direct proportion to the number of graduate staff nurses employed and the amount of bedside care they give as compared with the amount given by student nurses. Recently I was told by the superintendent of a hospital, held in high repute and employing a relatively large number of general staff nurses, that the cash salaries and rooms of its nursing service personnel constituted one-sixth of the total hospital budget or about one third of the payroll.

In hospitals, particularly in the medium-sized and larger ones, where students mostly or entirely make up the bedside staff, the nursing service costs decrease and the value of the school increases. While this is a well-known fact, we do not believe that, in analyzing or comparing nursing cost findings in the past, it has been clearly pointed out and sufficiently emphasized. It is one thing for a hospital to say that it would lose money if it gave up its school, but quite another to add that the loss would be found in the salaries paid out to the general staff nurses necessary to replace the students. As a matter of fact, this is not "loss" in the accountant’s definition of the term. What actually happens is that the hospital adds to its operating expenses by the replacement of student service by graduate service, or the substitution of a more expensive commodity for a cheaper one. Stated more accurately, it is a matter of alternate choices in policy.

About a year ago, we began the plans of a nursing service study that would provide the data for evolving the measures described above. Much thought was given to possible procedures which would reduce the time necessary for the development of this aspect of the study without affecting the reliability of the results and which would also simplify the work for the cooperating institutions. Fourteen hospitals located in the Middle Atlantic section, New England, the Middle West, and the South are participating in this aspect of the study. The major premise underlying their selection was the practice of good nursing, since criteria are to be evolved from the findings in these hospitals for the application of the "standard cost concept." The plan provides that data covering seven consecutive days will be collected every alternate month over a period of a year for the fourteen hospitals. The Director of the Study visited each hospital to obtain the data for the first sampling period. The hospitals were asked to record the information for the succeeding five periods and were given the necessary

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1 See page 113.
instruction and schedules. The cordial manner in which these institutions are cooperating in this study is most gratifying to the Committee. It indicates, we think, their interest in the project and their willingness to lend assistance to an undertaking which they believe merits it.

Another phase of the project to which we are now giving attention is the hour-for-hour service value of graduates and students. I do not think there is any problem in the whole list of problems involved in the Cost Study more controversial, more perplexing, or more conditioned by administrative and educational policies. For a time, I thought that its solving belonged in the realm of "things hoped for" but never attained. And yet there is straight and sound thinking on the side of a reasonably objective solution. Such a solution is fundamental in and indispensable to the satisfactory completion of the Cost Study.

Two methods of approach were presented to the Committee for consideration. One may be briefly described as a study to find out the relative amount of accomplishment of students and graduates within the same unit of time. Such a project is very costly and may require months or even years, and the conditions necessary to carry it on may involve a good many nursing service administrative difficulties. Mainly because of the cost, this method was rejected. The second method, the one being applied by the Committee, is to assemble information as to what is actually being done in practice in a selected group of hospitals when the replacement situation arises. Behind these replacements are principles and facts which it is our task to ferret out and to consolidate into a reliable working measure.

We know, for example, that particularly in a school where one class only is admitted each year, the number of students assigned to service in the hospital varies during different periods and that the variation will depend on the size of the class admitted. More graduate nurses must therefore be engaged at one time of the year than another in an institution whose policy it is to maintain an even level of nursing. If the administration replaces the outgoing students with graduate staff nurses (in a special hospital this replacement may be by affiliating students), it consciously or unconsciously engages in an arithmetical process to reach a decision as to whether five, six, seven, or more graduates are needed to replace ten students completing their course.

We also know that the rotation of students on services means that more students may be on the medical or surgical service at one time than at another. In this case, the same type of staffing problem is involved, except that there may be added to it the fact that students are in their first, second, or third year. Many institutions have either given up or reduced the size of their schools in the past ten years, and here again was a realistic situation which required replacement decisions.

You will see, therefore, that in proposing to find out how students are replaced in institutions where good nursing consistently prevails, the Committee is in the field of realism and not theory. But this fact does not
necessarily imply that the task is simple, because I believe you will agree with me that in schools of nursing we have traditionally been accustomed to do a thing without crystallizing the reasons as to why we do it.

My approach to the problem was something like this. In the Hospital Survey for New York sponsored by the United Hospital Fund, we had assembled the staffing set-up of the nursing service ward by ward in 50 hospitals. I looked up the data for one of these organizations and tried out the substitution procedure, replacing students with a hypothetical number of graduates, keeping in mind the hour schedule of each group, the department where the replacement occurred, and the time of day or night the nurses were on duty. The experiment worked out smoothly and nicely at my desk, —and I then went into the field to test out the method.

In the first two or three institutions I visited, it appeared as though the replacement plan by department would not be necessary. The directors of the nursing service either readily or fairly readily supplied a replacement figure for their student body, as a whole or according to particular class groups. These figures could be reduced with very little work to comparable form, and I began to think that we had exaggerated the difficulties of the problem. If we could secure information as to replacement policies, without going into the detail of departmental substitution, from a dozen or more institutions where a good nursing service was maintained, we had the answer to a fundamental question with comparatively little effort or work on our part.

But our hopes for an easy solution soon disappeared. Several directors of nursing stated categorically and with emphasis that they could not give one replacement figure for the nursing service of the hospital or the student body as a whole. Others provided it with hesitation and apparent reluctance. "Replacement," said they, "is one thing in the operating room and quite another in the diet kitchen and still different on the ward." By that time, I was again changing my thinking, and we returned to our original plan—that of departmental substitution.

As I have probed more deeply into the problem, it has seemed to me that accepting gross replacement figures on our part would have been open to challenge and would not have given us the essential supporting data. Replacement varies in different departments, and for intelligent interpretation we need to know and to present these variations as well as a composite figure for all services. As a matter of fact, no matter how we theorize, in practically all institutions that I have ever visited, students on night duty are replaced on a one to one basis. In certain departments of some hospitals, students have no service value because a stable graduate staff is maintained whether students are on the service or not. We believe that any figure we apply to translate practice into dollars in this study should be based not on theories or ideals but on conditions as they exist in good practice, securing the facts of these conditions as accurately as we can.
Not only is it the aim of the Committee to identify policies which represent good administration for the purpose of interpreting costs, but also to find out something about conditions which are, as it were, by-products of administration but which, nevertheless, have cost implications. In this latter group of investigations is the Illness Study. The primary question which this survey sought to answer was the amount of illness of students as compared with that of graduate staff nurses and the cost of each to the hospital. The Illness survey is now completed. It is ready for the printer and will represent the first report of a series which we expect to result from the Cost Study. To us at headquarters, the results are illuminating and in some respects unexpected.

Briefly, the study is based on monthly reports for twelve successive months of 223 schools representing some 17,000 students and 9,000 graduate staff nurses. So far as I know, it is the most comprehensive survey that has been undertaken of illness absence among students. Here are a few of the findings.

In the country as a whole,

1. Student nurses (preclinical and clinical) average 8.3 days of illness each year; graduate staff nurses average 6.6 days
2. Preclinical students have fewer days' illness than clinical students. The average for preclinical students is 5.2 days annually; for clinical students 9.2 days
3. The illness record of nurses, both student and graduate, is higher than those of college students, public school teachers, and workers in the clerical and industrial fields
4. If all sick student and graduate staff nurses were hospitalized every day they were ill at the per diem rate for ward accommodations in New York City, the cost of their hospitalization would be somewhat more than $4,000,000 each year. It is probable that the actual cost to the hospitals is somewhere between three and four million dollars
5. The cost of caring for preclinical students when ill is $375,000. Estimating that one-fourth of these students drop out, hospitals expend $94,000 a year on students who never get beyond the preliminary stage.

The Illness Study supplies medium for thought and has a very direct bearing on the costs to the hospital of nursing education and nursing service. In closing, I should like to return to the Cost Study as a whole. From the report which I have submitted to you, you will see that the cost project is not one study of one subject, but is made up of many single studies. I have described two or three of the single projects which are part of the nursing aspect. There are at least half a dozen more. Mr. Rovetta will tell you of the accounting aspects and problems. Eventually, all the studies, nursing and accounting, should be brought together so that we may be able to tell not only what nursing education and nursing service cost, but why their costs are what they are.
RATIONAL COST CONCEPTS IN NURSING

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In view of existing confusion between economists, accountants, hospital administrators, and members of the nursing profession in regard to costs, it might be well at the outset to defend two simple assumptions: that hospital institutions are distinct economic entities although operating as nonprofit enterprises; and that being distinct entities, they are subject to administrative guidance. If the first statement were not true, there would be no basis for separating from all facts those which pertain specifically to a given hospital; if the second statement were not true, there would be no pronounced need for cost data.

If it is agreed that hospital entities are subject to administrative guidance, then it follows that for purposes of control it is essential to know costs. Since hospitals have attempted cost studies in the past and have attempted in many instances to compare results, it is imperative that problems allied with the measurement of these costs be isolated, articulated, and classified. As I see it, difficulties of determining costs from the accounting aspect may be grouped into three major classifications: problems of determining the total value of all assets consumed during the entire life of the institution; problems of allocating portions of that total value consumed to the various fiscal periods; and finally, problems of allocating the expenses attributed to each fiscal period between the different functional activities performed during that time.

The problem of determining total value of assets consumed is complicated in turn by changing price levels, and by differences of opinion over including in “Cost” all assets which have been donated. The orthodox accountant has attempted to overlook the effect of changing price levels by insisting that the historical acquisition price be used. Yet, even though such a principle of valuation were universally used, final results are not comparable. If two hospitals, for example, are using identical equipment purchased at different prices, the identical service will cost more to that hospital which bought at higher prices. Yet the two costs computed on the historical acquisition price would not be comparable in evaluating current operations. Assume also that in an attempt to establish comparable cost results, it was agreed that all donated assets would be excluded in determining costs. Final results would still not be comparable because of the varying proportions of donated assets to total assets among the different institutions. Hence, comparability in this respect can be attained only by including in total cost all donated assets. Such costs of course can and should be kept separate.

The accountant does not assume full responsibility for solving this first group of problems outlined. Generally they are assigned to other professions for solution. In evading responsibility for the determination of total value, but in assuming responsibility for the fiscal allocation of por-
tions of that total, three authorities within the past eighteen months have commented as follows in stating principles of guidance:

"Accounting is essentially the allocation of historical costs and revenues to the current and succeeding fiscal periods."

"Accounting is not essentially a process of valuation, but the allocating of historical costs and revenues to the current and succeeding fiscal periods."

"The division of the life of a business enterprise into fiscal periods has created the problem of determining the income of the enterprise for each fiscal period. This determination is a most important task of accounting. . . . All income and all expenses should be correctly allocated to the periods to which they apply."

In two of the three statements a definite commitment is made for the use of actual historical price as against replacement or reproduction price. In none of the statements of principle has there been established criteria to eliminate doubt concerning the identification of certain portions of expense with the current period. The amount of expense involved in the area of doubt is relatively small in commercial enterprises of quick turnover and small fixed investments; but in hospitals with slow turnover, large fixed investments, and rapid obsolescence, the amounts are large. The method of attacking the difficulties lies in the use and acceptance of double entry accrual accounting. However, accountants are forced to admit that measurement of the accrual of certain items of expense is so difficult that they are overlooked and the inexactitude excused on the basis that the items will balance out after the first year.

Briefly two groups of problems have been presented: those of determining total value and those of distributing this value as consumed to fiscal periods. There still remains the third group of difficulties: those of allocating the expense of the fiscal period to the different functions performed by the hospital during that period. Nursing costs will be more closely related to this last group of problems than to the first two groups discussed. However, the first two, in deciding the total cost which must be distributed, have just as important an influence in deciding nursing costs as have the problems of dividing the total expense between the many activities of the hospital. Yet time does not permit more adequate treatment of the ramifications involved in the first two groups of problems discussed. The remainder of this paper will be devoted to problems associated with allocating total hospital expense of a fiscal period between all the activities performed.

Objectives

Most previous cost studies of nursing service and nursing education have overlooked the significance of the problems associated with total cost and fiscal expense determination. Moreover, these former studies of nursing service and nursing education may be classified into two categories: those

which attempted to measure unit performance in terms of financial cost, and those which measure unit performance in quantitative statistical terms. In the latter instance, only a partial answer is provided for hospital and nursing administrators, for the relative performance in terms of financial efficiency cannot be ascertained as between periods of time, or as between institutions. In other words, such procedure does not recognize the fact that different hospitals may provide the same quantitative and qualitative service at different cost; or that the same hospital may provide the same service at different costs; or inferior service at the same or higher cost, as at different periods of time. In the former case, financial "cost" is ascertained, but it is in no way related to service provided. Furthermore, in many of the financial cost studies to date, procedures of calculation and component elements of cost are undefined, thus complicating the task of interpretation even more.

**Cost Concepts**

It is true that writers in the field of hospital and nursing accounting have taken great care to present in detail the various technical procedures necessary to secure proper classification and allocation of expenses. But the explanation of the nature of cost as a concept has been omitted, even in books just released. The reasons for this omission are difficult to explain, especially when the concept of "cost" changes in kaleidoscopic fashion.

"Cost" is a word circumscribing a group of ideas, or a "concept" of complex nature. Arbitrarily defining such a word is a useless procedure. What is needed is a development of a "thought-image."

Four closely associated terms, "expense," "loss," "cost," and "profit" should be differentiated. The central idea in the cost concept is that of giving up or parting with something of value to acquire some other thing, service, or value. When the term "cost" is used, it usually refers to the total outlay incurred for goods or services. The term "expense" should refer to that portion of such outlay allocated to a certain fiscal period. Thus the essential problem of expense determination is one of "timing." A "loss" as differentiated from a cost represents outlays for which no corresponding returns were received. In contrast, it is to be noted that cost is incurred for the purpose of, and is accompanied by, the securing of some other value. When the value received is greater than that which was given out, the excess is "profit." Profit, like expense, is measured in terms of accounting periods.

In cost accounting there is distinction between "expense" and "cost" in that cost figures are calculated by reclassifying and assigning expenses of a fiscal period to "cost units." Cost, as used technically, is that portion of the expense charge which has been assigned to a particular unit of production, service, or administrative "cost unit" of a fiscal period. The sum of the individual expense items allocated to each cost unit is the cost of that unit. All such allocations of expense are made to cost units on some basis.

However, the process of allocating expense to cost units is not a singular or a fixed and stereotyped routine. The process varies greatly, and it is this
important fact about cost procedure that calls for further consideration. By varying these processes of allocation, one may compute different costs. In order to know which procedure to use, it is essential to know the conditions under which costs are being measured and the purpose for which they are intended. This is as it should be, for there is no one cost which can be used for all purposes, any more than there is one wheel which fits all watches, automobiles, or wheel-chairs. Thus it is apparent that the purpose determines the cost concept, which in turn determines the cost procedure.

From the many types of cost concepts recognized by accountants and economists, four types are of particular significance in a study of nursing service and nursing education. These are: average costs, avoidable costs, alternative costs, and standard costs. Each type will be examined before the final selection is suggested.

**Average Costs**

Nursing cost studies in the past have employed average cost techniques almost exclusively, with, in some cases, misinterpretation of results in terms of avoidable costs. Average cost is the total expense divided by units of service output. Such a cost assumes that an equal amount of cost is incurred in the production of each of a given lot of similar units. Let us suppose, for example, that a hospital serves 1,000 meal units per day at a total “cost” of $320 per day. Two hundred of these meals are served to student nurses who constitute the entire bedside nursing staff. The “average cost” of the meal or unit of service output is the total cost of $320 divided by 1,000 meal units, which gives 32 cents.

Most hospital administrators rely entirely upon data developed by average cost techniques. In fact, a recent book on hospital cost procedures, although failing to develop a specific concept of cost, presents average cost procedure exclusively. The advantage of average cost procedure is its apparent simplicity. Its serious limitations may best be developed in terms of the other types of costs mentioned.

**Avoidable Costs**

As distinguished from average cost, avoidable cost is the additional cost involved in producing an additional lot of output assuming that the previous lot would be produced. As related to nursing education, avoidable costs would be those costs which would be eliminated if nursing education were abolished by a given hospital.

Let us suppose that the hypothetical hospital in the average cost illustration given above plans to give up its nursing school and replace the 200 students by 100 graduates. On the basis of average costs one could conclude that the meals served to 200 student nurses cost $64 and the meals served to 100 graduates cost $32, so that by abolishing the school the hospital saved the amount of $32 daily on meals. However, the replacement of student by graduate nurses would not produce the saving stated for the following reasons:
An analysis of expenses in the above situation should have disclosed that some costs were constant and did not fluctuate in proportion to production, that some were partly fixed and partly variable, and that some expenses varied directly with production. Examples of fixed charges connected with meal service are depreciation of equipment, telephone service, and, in all probability in the instance cited, the wages and other expenses for cooks would remain unchanged and, therefore, should be included in the “fixed charges” classification. Examples of variable costs are the waitress item since fewer of these workers would be necessary to serve 100 than 200 nurses; replacement costs of raw food. Actually, the only items which should have been included in the cost of the 100 meals eliminated when the school was closed are the variable costs associated with their service. In general, the smaller the units of output, the smaller the number of items of expense that can be eliminated. In the above instance only 10% of the meals were to be eliminated. Hence an analysis accurately made would have resulted in retaining in the “constant” expense classification many items that might become variable when larger percentages of output were to be eliminated.

**ALTERNATIVE COST**

The concept of alternative cost as applied to hospitals tends to emphasize the alternative means available for providing a given service. Thus, for the maintenance department of a hospital, the concept has usefulness in deciding whether it is more economical to generate rather than to purchase electricity from public service companies. In nursing, the concept finds application in deciding whether to provide bedside nursing care by employing graduate nurses as against providing the service by utilizing student nurses in training. It is to be noted that this concept indicates a means of comparing the cost of alternatives. It presupposes that both costs are known, but in no way indicates the content of the two costs. Thus it is possible to use “average” or “avoidable” techniques in computing the cost of service as rendered by student nurses for comparison with some arbitrary cost imputed to a similar service rendered by graduates.

**STANDARD COSTS**

The fourth concept—standard costs—has received marked attention in industrial accounting but has been relatively neglected in hospital accounting. The precise definition of standard costs varies, but in general it includes the idea of a continuous basis of comparison. Another aspect of standard costs is that they are prepared in advance; in this respect standard costs are closely related to the fiscal budget although not necessarily identical with it. Standard costs offer the advantages of requiring that the operating plans of the institution be carefully considered in advance, and that proposed expenses be reviewed. When the program is in operation the standards established will subsequently serve as a mark at which to aim, will stimulate criticism, and will call attention especially to unsatisfactory performance.
A hospital may evaluate performance by using data of the hospital itself; it may study the performance and positions in terms of another hospital; or finally it may establish definite standards and evaluate actual performance with planned performance.

It is interesting to note that in the industrial field standard costs have had a parallel development with time and motion studies. The recognition of the significance of time and motion studies has created a realization of the need for standards which might be applied to performance and which would provide a basis for comparing, evaluating, and relating the results of cost analyses with quantitative output. The lack of such standards in hospitals is probably the reason why standard costs have not been more extensively developed in these institutions. Indeed, standards underlying nursing costs have either been entirely absent or so woefully haphazard that they may have actually jeopardized the nursing care given to patients. Dependence upon historical comparison within the same institution or upon comparison with other hospitals has been widely practiced. In the former instance, the result was often a comparison of inefficiency with inefficiency; in the latter instance, a comparison of unlike conditions and services. To an analytically minded administrator, such comparisons would immediately raise the question of the cause of any differences. The development of standards for administrative control would avoid both consequences, and cost comparisons would consequently assume significance.

**Avoidable Cost Suggested as a Base**

From the point of view of hospital and nursing administration the most significant information can be developed by costs based on an “avoidable” concept. If it is assumed that a hospital is operating with a nursing school, then the cost to that hospital for nursing education is the cost which could be eliminated if the school were abolished. Likewise, if the hospital were operating without a school, the cost of the school to that hospital would be the additional costs incurred with the incident of the nursing school.

From the point of view of internal administration the avoidable cost concept places emphasis on the costs which tend to fluctuate more widely with current operations. By eliminating from emphatic consideration those costs which are more constant and less sensitive to administrative control, one can more equitably evaluate managerial ability. All too frequently expense analyses emphasize consideration of fixed charges over which administration has relatively little control. Thus, by the avoidable cost concept, costs are placed into two categories; those which tend to be subject to administrative control and those which are apt to be more rigid under fairly narrow ranges of operating capacities.

Another advantage is that the “avoidable” cost concept develops costs which are accurate for use in policy formulation in terms of alternative possibilities such as the substitution of graduate for student service, the abolishment of meal privileges for graduates, the elimination of living ac-
commodations for graduates, and contrariwise, the addition of any of these services or items. It is worth repeating with emphasis that average costs for policy formulation are apt to lead to erroneous conclusions in terms of eventual cost behavior.

Any study of nursing costs should give full recognition to all variables which affect nursing costs. The factors must be measured both in financial terms and on a basis of quantitative and qualitative nursing service rendered. The detailed procedures of accomplishing this are inappropriate to discuss at the present time. Suffice it to say that the technique used must give recognition to all the problems of the specific concept of cost selected. If this is successfully accomplished, the results will be intelligently useful costs for:

a. Evaluating management, because emphasis is placed on those costs which tend to vary and which are within the control of the nursing and hospital administrators.

b. Deciding how much of the funds of a hospital are actually being used to finance a nursing training school or how much of the funds of a nursing school are being used to finance a hospital. The best evidence that a cost is being incurred for a nursing school is the proof that the cost would be eliminated if the school were abolished. Likewise, it cannot be argued that a hospital is incurring a nursing education cost if that cost were to persist or increase even though the school were abolished.

c. Reaching decisions by the public as to the institutions most capable of effectively providing for nursing education.

To me personally, no concept of cost should imply that "cost" is the sole basis for deciding policies of nursing service and nursing education. Neither should emphasis on the necessity for accurate costs indicate that effort should be entirely one of reducing those particular "costs." In fact, accurate costs computed on the basis of an avoidable concept may show the provision of funds for such an important activity to be lower than necessary to maintain current standards. Exceedingly low and inadequate nursing costs thus might well become a source of serious concern and a warning for intelligent hospital investigation.

In the field of nursing education, the order of the day is a shifting emphasis. More and more that emphasis is placing nursing education in a category apart from the hospital. If the hospital wishes to carry on nursing education, it should recognize it as a joint activity, co-equal in importance with that of caring for the sick. As joint activities, every attempt should be made to safeguard the standards of both. Coordination is essential of course, but that coordination should take place at the level of the board of trustees in the management hierarchy. Such an organization will encourage the further development of a philosophy of nursing education along a fuller, broader curriculum of study rather than along narrow lines of vocational training. Nursing education will then be accepted not only as training for a profession, but more important, as a way of life. And what other fields of education can offer so much for the individual and for the welfare of society?

In conclusion may I summarize by outlining the steps to be taken in the
determination of costs acceptable for use. Chronologically, it is necessary to accomplish the following:

Develop possible concepts of cost applicable to nursing education and nursing service
Select the concept of cost most useful for present purposes
Suggest procedures and methods for determining the financial cost as evolved by the accepted concept in a simple, inexpensive, and understandable manner
Relate financial costs so determined to standards of performance and variables so that reliable interpretations of results may be made.

This discussion has dealt briefly with only the first of these objectives. In developing the concept of cost, recognition was given problems associated with:

1. Determination of total value of all assets consumed
2. Distribution of portions of that total to each accounting period
3. Allocation of the expense of each accounting period among all the activities performed during that period
4. The intelligent use of costs so determined.

The problems are grave but not insurmountable. Concerted thinking and work by both hospital administrators and members of the nursing profession will shortly evolve a cost—acceptable, accurate, helpful.

EVALUATION OF THE COST STUDY

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The focus of attention on nursing education and nursing service, particularly during recent years, has been such as to stimulate extensive studies in hospital nursing problems and to enlarge plans for nursing education. Hospital executives have observed these developments with unabated interest. No one appreciates more than the hospital administrator the importance of a sound and satisfactory educational program for nurses. Good nursing is a prime requisite of a good hospital and good nurses must be properly trained. All will grant that the general level of nursing education should be raised and more satisfactory relationships established between nursing service and nursing education. To what extent and by what means are the important considerations which need the combined attention of hospitals and organized nursing groups.

The hospital administrator who fails to heed and to become concerned in this problem is grossly negligent in his job. His negligence in assuming a share of responsibility in the problem cannot be excused in these momentous times. The far-reaching significance of nursing education with its direct relationships to good nursing service and the economic elements of supply and demand of qualified nurses compels a participation in the discussions, studies, and surveys of this important problem.

It is gratifying to note that nursing leaders recognize the importance of the hospital administrator as a participant in these explorations. The economic
questions involved are of such fundamental importance that no appropriate solution can be developed without assistance of those responsible for hospital government. Nursing education has always been an activity requiring the cooperation and joint endeavor of both nursing and administrative groups and it shall continue to be so. Nurses cannot be educated without hospitals, and the economic factors particularly must be regarded primarily as administrative considerations, at least for such time as the hospital assumes the chief financial responsibility for nursing education.

The needs of the nursing service in the hospital, instead of how many students may be properly educated, have been the basis upon which most of our training schools have been operated. Inasmuch as the cost of nursing education has been borne by the hospital, the economic factors involved have forced the hospitals and training schools to this plan, and according to custom, they have carried on a joint program of nursing education and patient nursing service. Only rather recently have hospitals awakened to the fact that the school of nursing conducted under a joint program of nursing education and patient nursing service can be a financial liability. Some of our hospitals, during the past few years, have made cost studies which have shown that the nursing service in the hospital can be operated at less cost with graduate nurses than with the plan of almost total dependence upon student nursing service. These determinations are most pertinent to the modern hospital, and upon these economic considerations will be largely based the extent to which hospitals are willing to contribute to a program of advancing standards in nursing education. The hospital should not exploit the student nurse, nor should the student expect to gain an education for a profession without cost to herself—either by her services, by the payment of fees, or a portion of each.

If the hospital assumes the financial responsibility of educating the nurse, then the patient must pay for it. The patient does not care to make a contribution to nursing education through his hospital bill. Student nurses' fees, endowment for training schools, and credit allowance to the training school by the hospital for nursing services performed by students can be adjusted to meet this important economic element. Too many of our hospitals today expect the nurse to pay for education with her services and compel her to spend more time in ward practice than the educational content justifies. Numerous are the procedures that the student continues to carry out long after the educational content has been exhausted, just for the reason that the hospital depends to a large extent upon the services of the student nurse. Whatever surplus financial returns may be gained by the hospital through the services rendered by student nurses should be returned to the benefit of nursing education. On the other hand, the hospital should not be expected to bear the financial burden incidental to educating the nurse, with a corresponding obligation on the patient's purse.

The day has passed when the hospital can depend entirely upon student nursing service and at the same time provide the student with anything like
the proper and adequate educational advantages. Nursing education should be considered as a separate and distinct problem, and be placed under educational auspices with hospital affiliations sufficient to provide the required ward practice. Schools of nursing should function on a strictly academic basis, the same as schools for other professional groups. Under this plan, ward practice would be limited to the period of time necessary for educational purposes, and the academic requirements would receive paramount consideration with a lesser emphasis on the obligation of the school toward the nursing service of the hospital.

The advancement of educational standards has brought about a very marked reduction in the number of schools. State boards of nurse examiners are gradually imposing requirements in an effort to produce better standards, with the result that many of the smaller hospitals are now finding it impossible to operate training schools. Some of these institutions feel that the state boards are doing them a grave injustice. It is likely that such an attitude on the part of the hospital is an indication that it has been exploiting the student nurse and objects to dispensing with its training school for economic reasons, and has, for the most part, lost sight of its obligation toward the education of the nurse. The need of the hospital for cheap labor is no legitimate reason for maintaining a school.

Any considerable increase in the cost to the student nurse is likely to bring about a decrease in enrollments and a corresponding reduction in the output of nurses. The hospital is already uneasy and seriously concerned with a scarcity of well-qualified nurses, and anything which might magnify this problem will add to the financial insecurity of the already perplexed hospital governing board.

Two forces, particularly, are working toward an inadequate supply of nurses—the reduction in the output following the discontinuance of schools and the replacement of students with graduate nurses in those hospitals which have discontinued schools. Impending government projects contemplate widespread demands for nursing service and the liberal compensation paid for government work will increase the difficulties of the civilian hospital in its efforts to meet the conditions. These conditions may not be displeasing to the nursing profession but they are disconcerting to the hospital administrator.

It is generally recognized that the evolution and development in nursing have been circumscribed by economic limits which have determined and controlled very largely the advancement in nursing, and further that the economic factors are vital and basic in the consideration of our problem. These considerations have brought about a more serious interest as well as a determined effort on the part of those interested to establish better relationships between hospital nursing service and nursing education through a study of costs which may involve these elements. We may therefore expect that the conception of cost will have a great influence on hospitals in shaping the policies toward the further development of nursing education. Not only in the interest of
nursing education but also in that of a sound financial operating policy does it become necessary on the part of hospitals to consider the elements of cost. Cost determination in any important project prior to its inception has proved its value over and over again. We cannot afford to enter into the planning of anything as important as nursing education without a reasonable degree of assurance that financial means for carrying out plans will be available or forthcoming from rather substantial sources.

We venture the opinion that the majority of hospitals today not only are unaware of the cost of operating their schools of nursing, but are uncertain of the proper methods for determining such costs. Organized hospitals are just as much interested in aiding this situation as are nursing organizations. Therefore, it becomes a matter of mutual interest, and one in which both groups have combined their efforts, to place before the field a study which it is hoped will be sound in its principles, clear in its methods, and simple in its application, so that it may serve as a guide for the many institutions perplexed with the problems of elevating standards in nursing education and without knowledge as to the costs under the present varying conditions and the relationships. Cost methods and determinations contribute to the economic stability of hospitals just as they do to industrial and commercial concerns. It is needless to emphasize the fact that stable business enterprises in the commercial world give early and basic consideration to the matter of cost before launching any project or other schemes for the development of business or the raising of standards.

We believe, therefore, that the cost study now under way and directed by the Joint Committee of the National League of Nursing Education and the American Hospital Association should be recognized as an important and basic approach to the problem of nursing educational standards and should become not only a guide for determining costs but should serve as an aid in clarifying the numerous complexities now involved in the relationships of nursing service and nursing education. This study must be predicated on present facts and practices, keeping in mind the changing era in which we find ourselves today. Progress and change are rapid and what may be considered practical and sound today may be discarded or modified by tomorrow. The temptation to visualize the future in terms of present conditions is one which confronts us all. For example, to establish standards and requirements with such light as we have at present may seem a rational and socially desirable step. However, what wisdom have we today to determine that the future, in these economically disturbed times, will hold with any degree of permanence those principles and guesses whose validity may be unquestioned today.

There are many in our generation who hold the old and established practices sacred and would have everything remain as it is. They forget that improvement and progress are possible only through change. We are today witnessing some of the most stirring spectacles of a century, involving changes in our social and business structure, and our hospitals and their related ac-
tivities, as well as all branches of our present system of society, are in a period of transition. So the technique of the plan of study must be applied not alone on the basis of previous facts and studies but also by a plan that will contemplate criteria under a system of rapid and progressive change.

The cost study, to serve its intended purpose, must be based on extensive facts and information so gathered and analyzed that criteria may be developed which can be used in analyzing cost findings in various individual hospitals. The information collected must be accurate and uniform among all the individual institutions included in the study. Naturally the collection of the information involves considerable work on the part of the hospitals under survey, at least until the formulae for the collection of data have become well established. The data desired are no more than a well-organized hospital should have available for daily or monthly reports, and the study should stimulate better current record keeping on the part of hospitals in general. Daily reports of census by various units of patient occupancy, number of personnel, hours of duty by various classes of personnel, and other items of information needed for the study will indicate the present practices in the institutions, and such information will serve not only as a basis for analyzing the cost according to those practices but for fundamental measures or criteria adopted by the study committee.

The accounting classification necessary in the study is another phase which requires major consideration. A cost accounting system must be devised that will facilitate cost analyses of nursing service and nursing education as separate activities, and the accounting classification and system must be closely coordinated with the nursing classification phase of the study. While the information desired for the study is available in many hospitals, nevertheless the task of reconstructing it for satisfying the purposes of the study requires considerable effort on the part of the hospitals. The selection of the hospitals to participate in the study was based on their practice of good nursing service, since the findings derived from these hospitals will become a large factor in the criteria to be applied to the standard cost concept to be used in the study. Other conditions imposed are the segregation of patients on at least the major clinical services and the separation of the physical units of private patients from semi-private and ward patients.

These conditions and premises which become necessary for the study are such as to stimulate better usage as well as more standard methods of statistical record keeping in hospitals and the establishment of these practices will benefit the general record system for all purposes in appraising institutional performance. The study will encourage better quantitative statistical information in measured units of performance which every hospital should aim to practice not only from the standpoint of better records but for having such information constantly available as a basis for more efficient operation. Similar benefits will result as will make for better accounting methods in hospitals as well as for more accurate and better records of quantitative statistical information. Anything that will encourage or put into practice
better accounting methods will prove to be extremely helpful to hospital administration. Uniformity in accounting methods is a great need in the hospital field. At the present time, the American Hospital Association is making a study through its committee activities with the hope of promoting and prescribing better methods and more uniform accounting classifications for hospitals. It is needless to recount the benefits of such a condition but suffice it to say that sound cost finding methods will contribute to the economic stability of hospitals as they have to industry, and that the need and value of costs are readily recognized by progressive administrators and related groups.

So as the cost study progresses, we find that procedures and methods are developed for determining the financial cost in what we believe will be accepted as a simple, sound, and understandable plan. These costs will then be correlated with the standards of performance so that reliable interpretation of the results may be made. The results expected will prove useful to hospitals in determining what amount of hospital funds are actually being used to finance the nursing school or how much of the funds of the nursing school are being used to aid in the financial operation of the hospital. Without this vital bit of information we cannot expect to satisfactorily solve the problems of nursing education and its relationship to nursing service. Hospitals are eager to know this fact and this study should help them to determine whether the hospital operating with a nursing school would be relieved of the school cost if the school were abolished. Likewise, if the hospital were operating without a school, would the cost of a school to that hospital be the additional costs incurred with the establishment of a nursing school. Such determinations by the application of the principles and methods contemplated in the cost study give concrete evidence of its value to hospital and nursing authorities in dealing with this very important problem of costs.

Those actively engaged in the cost study are enthusiastic in their expectation that the study when finished will represent the most comprehensive and satisfactory effort yet completed in the field of cost accounting for hospitals.

The study, therefore, as Miss Pfefferkorn has outlined to the Joint Committee, in early stages of planning divides itself into two types of endeavor, for convenience here classified as nursing and accounting. The nursing classification has to do with the evolving of nursing service and nursing education measures which lend themselves to quantitative treatment and are significant in costs; the accounting classification is concerned with the working out of a cost accounting system which will facilitate cost analyses of nursing service and nursing education as separate activities. The work on the nursing classification phase is the especial function of the Director of the Study; the work on the accounting classification, that of the Associate Director. For the most satisfactory prosecution of the study, it is believed that the efforts of these two workers should be closely coordinated.
Joint Session

American Nurses' Association

National League of Nursing Education

National Organization for Public Health Nursing

Wednesday, April 27, 9:00 a.m.


PROBLEMS RELATING TO THE MERIT SYSTEM

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Progress in the social field is marked by a continuous refinement of its principles and technics with a resulting increase in efficiency and personal security, both of which are essential in a well-ordered society. Principles develop slowly and methods evolve through study and experimentation in real situations. The merit system is the application of scientific principles to personnel administration in public service.

Today, as never before in the history of our country, government positions are offering opportunities for service to interested and qualified men and women. Organizations, bureaus, and departments under city, county, state, or federal control are springing up over night. Government activities are touching people in all walks of life regardless of personal interest, profession, or business. They are affecting and controlling, to a certain extent, the income, the conduct, and the standard of living of every citizen in the United States. These activities are supported by taxes; the legislative bodies of the country formulate the policies governing them; and the personnel performing some of this public service is from our own ranks. Regardless of whether we like it or not, government control is expanding and entering into our private lives in a way not dreamed of years ago. Therefore, it behooves all thinking people to become interested in, and to give careful attention to, the selection of the personnel which is performing these important functions.

In a democratic form of government, the people at large, by popular vote, select their leaders for many of the positions. These chosen leaders head organizations where large numbers of people are employed. In the early days of our democracy all government personnel was appointed by the executives in office. This method was quite satisfactory when the area of our country was limited to a few colonies or states, and when the total population was less than that of one of our present medium-sized states. Now, however, when the government is the world's largest employer and is using about 40 per cent of all taxes collected to pay the salaries of civil service employees, it is necessary that a sound system of recruitment, appointment, promotion, and retirement be adopted, in order that service may be of the very best. Modern methods are essential in dealing with modern problems
if our government—national, state, and local—is to meet adequately the strained situations, at home and abroad, which are demanding constant attention.

During the first forty years of national life, when the duties of the government were few and relatively simple and when the number of people seeking positions was limited and political patronage less active, the personnel of the government, except the members of the Cabinet, remained in office as long as their behavior was satisfactory. This practice was changed in 1820 by the enactment of a four-year-tenure-of-office law, because it was thought that the selection of employees for public service should be more democratic. The motive underlying this change was a worthy one. The early practice of the law was not entirely detrimental, but unfortunately such a system could not continue to be satisfactory for any length of time. With each new administration there was a wholesale dismissal of personnel, even employees of the same political party were often released without cause except that the incoming officer failed to reappoint them. This method was adopted by all political parties and met with very few obstacles, but as time went on it became more vicious and far-reaching.

In 1832, Senator William L. Marcy of New York made a stirring speech in which he denounced the practice in the most vehement terms, and at that time the phrase originated which became a national slogan, "To the victors belong the spoils." In our early political history the "spoils policy" was so universally adopted and became so widespread that President Lincoln, greatly alarmed at the effects it was producing in all government offices, declared that it was a national evil and that unless something was done to check its influence, the government itself was in danger of disintegration and our democracy would be democracy in name only. In spite of this warning, the pernicious custom held sway for almost twenty years longer and sweeping changes continued to prevail every time newly elected officers took charge of government affairs. Such a procedure was wasteful, undermining the very structure of our democracy and being most demoralizing to individuals. Finally public opinion was aroused and concerted efforts were made to correct the practice. After much difficulty with both political parties, Congress, in 1883, passed the Pendleton Act, a civil service law, aimed to establish the merit system in federal government service. Since then there have been periods of progression and periods of regression, but in spite of losses here and there the tendency has been toward using more scientific methods in the management of government personnel, rather than toward continuing the method of political patronage which had become such a menace in our democratic government.

Two factors emphasized the evils of the spoils system and tended to direct the attention of the public to better methods of personnel administration: First, the normal increase in the number of employees; second, the expansion of the classified service to include many positions not included in the early days.
At the present time over one-half of the federal employees have civil service status and the remaining number are recruited and selected according to some predetermined standards of fitness.

*Civil Service Agencies in the United States*, a pamphlet recently published by the Civil Service Assembly of the United States and Canada, gives the following:

Approximately three million, six hundred thousand persons in this country are now regularly employed in government service of one kind or another. They represent a sizable proportion of the gainfully employed population, and their annual payroll of more than four billion dollars is a further indication of the importance of public service in the national economy.\(^1\)

It has been said that the last twenty years has been the darkest period in state personnel management, but the prospects for reform appear more promising today than at any time since the enactment of the Pendleton Law. The fact that more and more states, counties, and cities are applying the principles of the merit system to many of their civil service positions, is one of the most important and promising trends of our time. According to the Civil Service Assembly pamphlet, fourteen states now use the merit system for the selection and management of their administrative employees. These states, in the order of the adoption of the law, beginning with 1883, are as follows: New York, Massachusetts, Wisconsin, Illinois, Colorado, New Jersey, Ohio, California, Maryland, Arkansas, Tennessee, Connecticut, Maine, and Michigan.

Only one state has ever repealed the law after having tried it. The Connecticut legislature in 1921 repealed a civil service statute which had been enacted in 1913, but in 1937 the state passed a much more extensive and far-reaching merit system act which is in effect today. In 1915 the legislature of Kansas enacted a law setting up a civil service system, but after four years it was forced to give up the service because no money was available for its administration.

Counties have lagged behind in adopting civil service measures. Out of 3,053 counties there are only eight which maintain their own civil service commissions, namely: Cook County, Illinois; Los Angeles County, California; Milwaukee County, Wisconsin; Alameda County, California; Multnomah County, Oregon; Jefferson County, Alabama; and San Diego and Sacramento Counties, California.

It is interesting to note that the majority of these counties are in the far West, four out of the eight are in the State of California. The counties of four states, Maryland, New Jersey, New York, and Ohio have a form of merit system administered by their state civil service commissions. The other counties have a form of centralized personnel organization but they do not come up to all the requirements of a true merit system. The political machines of the counties are responsible and some leaders of all parties do

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\(^1\) Pamphlet 11. Published January 1938, by the Civil Service Assembly of the United States and Canada, 1313 East 60th St., Chicago.
everything in their power to prevent the establishment of a system which might interfere with the mechanism of their organized voting groups.

The cities of our country have been much more progressive in that almost every large city now has some type of civil service and the spoils system is rapidly being replaced by a form of personnel management which is based upon personal fitness rather than on political affiliations. The first groups to be placed under civil service were those charged with the protection of life and property. Today the practice is extended to almost all workers employed by the municipal government.

The prospect for better systems in civil service are encouraging because organizations devoted to public welfare are doing research on the subject and people at large are becoming better informed. Many societies and leagues are contributing money for study and civil service commissions are making every effort to bring their activities up to the highest standards. All this indicates a deep and intelligent interest in securing better public service.

The service of a government is classified into two main groups, military and civil service. The latter is usually referred to as civil service, a phrase which is often considered a synonym for merit system. This is not correct because the civil service is concerned with all government positions except those in the military department, regardless of method of administration. The merit system in its broadest sense may be defined as a system of personnel management for the civilian employees of the government, federal, state, county, or city, based upon fitness and merit. Its concern is personnel management involving recruitment, selection, promotion, demotion or discharge, and retirement. It is also interested in compensation of employees and in the setting of standards of service.

The need for the elimination of political favoritism from all government positions in the United States is greater at the present time than ever before, since government activities are extending into new fields every year. Many people deplore this extension of the government, but there is no indication that it will abate; on the contrary, there is every evidence that it will not only continue but will expand. This trend has existed since the beginning of our national life, and history shows that the same is true of every other civilized nation.

The government should have the very best people to do its work because the results affect the public at large. Since the personnel is paid by public money and the people are contributors directly or indirectly, it is important that this money be not wasted on incompetent workers. Incompetency and financial waste sooner or later will destroy any organization.

The Commission of Inquiry on Public Service Personnel, in its report of 1935, recommended the adoption of a merit system by the American government as the next forward step in the promotion of standards in government personnel. This would offer unusual opportunities to our young men and women. Increased interest in the advancement of the merit system and the

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abolishment of the spoils system is generally approved today. The majority of political leaders prefer it, government personnel find security in it, and society in general wants it as was manifested by the result of a poll taken a few years ago by the American Institute of Public Opinion of which Dr. George Gallup, Director of the Institute, said:

Frankly, the size of this majority surprised the Institute and was not anticipated by even the most ardent advocate of the merit system. The voting was done by all classes of people and represents all political parties.

The merit system in civil service is not new and a careful study shows that it is not perfect even in the best-organized commissions. There are many problems but, when carefully planned and properly executed, it is a superior method of personnel management. The united efforts of the public consisting of all political parties, special groups interested in public welfare, and civil service commissions will bring about an improvement in personnel administration that all good government is seeking for its people—both for those who are served and for those who are serving. Qualified personnel in government positions should be the aim of a democracy. A career service in our government—federal, state, county and city—should be possible and available to any man or woman seeking it. Someone has defined the term "career," as follows:

By a career is meant lifework, an honorable occupation which one normally takes up in youth with expectation of advancement, and pursues until retirement. A career service in government is thus a public service which is so organized and conducted as to encourage careers.

Such an ideal would direct to government positions individuals with ambition, fitness, and integrity, and would offer the opportunity for devoted service of the highest type.

A career service demands a broad comprehensive program built upon scientific principles evolved through research and study of actual situations and permeated with a philosophy based on the highest ideals for public service. Such a program would involve the following:

1. A centralized personnel agency staffed with men and women imbued with high ideals of service, educated for the positions, and experienced in personnel activities.
2. Adequate funds to execute the plans outlined by the agency.
3. Adequate funds to pay salaries comparable to those paid to personnel occupying similar positions in private institutions. This is necessary in order to secure the best-prepared individuals and to keep them in the service.
4. A recruitment system which would reach qualified persons and would direct those best fitted by personality, education, and experience to government service.
5. A grading system for specialized services which would be comparable to the systems adopted in private institutions of similar nature.
6. A method of selection and appointment which would be based upon fitness and worth. Competitive examinations for entrance should be given to all candidates to determine educational capacity, general and professional preparation, and personal fitness. The latter should be given very careful consideration because personal success and satisfactory service in the organization depends, to a very large extent, upon this attribute of the worker. Research in methods of examination should be of vital concern to civil service. One of the most difficult functions of the commission is the
examination of applicants, and it cannot be administered intelligently, fairly, and satisfactorily without much study and experimentation. An efficient method of examination is one of the greatest assets of civil service and its most effective tool.

7. In some instances it may be advantageous to give instruction preparatory to the appointment. A preliminary program will help the individual to adjust more quickly in his position. His functions in the early days of assignment will be performed more completely and accurately.

8. A probationary period for all newly appointed personnel is an excellent supplement to the preentrance examinations. This affords an excellent opportunity for both employer and employee to test and to be tested in the actual situation. Such a procedure might end in a change to another department or division for which the applicant is better fitted or, on the other hand, it might manifest abilities or dispositions which would indicate withdrawal from the service. Early recognition of personality difficulties, general unfitness, or deficiency in preparation would be beneficial to both personnel and organization.

9. Assignment in service should always be based upon personal fitness and the initial position should be considered a basis from which later positions emanate. An assignment should lead on to a higher one when interest, suitability, and preparation for advancement are manifested.

10. Courses for professional development, which would be preparatory for promotional examination, should be planned for those in service. In a career service an educational program is a necessity and the entire staff should be encouraged to prepare for advanced positions. Professional fitness requires constant study. In addition to this there should be courses for general intellectual and cultural advancement. Without an educational program of some type the personnel of an institution sooner or later becomes inexact, uninterested, and easy going. With such characteristics the service is likely to fall to a very low standard and the department becomes cluttered with dead timber.

11. A system of ratings to determine degrees of achievement in the performance of duties should be adopted. Ratings should be made as objective as possible and not left to the opinion of the rating officer. Methods of rating personality and character should be a subject for constant research. These aspects of employees should be given careful consideration and be used as part of the information in determining promotion and transfers.

12. A method of supervision should be adopted which would be educational rather than disciplinary. It should be dominated by ideals of coöperation, scientific research, and high standards of service. Supervisors should be specially fitted and trained for their duties and conversant with the underlying principles of good supervision. They should be interested in promoting the professional growth of the supervised.

13. There should be a system of dismissal by which an organization could speedily eliminate the dishonest, inefficient, and undesirable. The efficiency of the service should not be hampered by the misfit, incompetent, or disturber.

14. Provision should be made for retirement on an adequate pension after a stated period of faithful service. Such a measure will encourage efficiency and create a personnel movement in the service which will be very beneficial to the institution. The older employees, many of whom may be disabled, will retire, thus making way for the younger group.

15. Vacations with pay should be planned for all, as is done in private organizations. A limited period each year, with pay, should be allowed for sickness. In institutions where such service is available a yearly physical examination should be given to everyone, and where this is not possible definite regulations should be made regarding it. Everything should be done to encourage employees to give attention to their health because the healthy individual is an asset to the community and the organization he is serving.

16. There should be a method of granting leaves of absence, with and without pay, based upon the type of service rendered, years in the service, and the reason for requesting the leave.
17. Absence with pay for the purpose of professional study should be available for all the deserving. Anything that is done for the worker to enrich professional knowledge and to extend experience is returned to the organization through more faithful and better service.

18. A system of exchange of selected personnel with institutions within and without civil service is beneficial to both the individual and the organization, and should be part of the educational program of the merit system.

19. Political activity within a government organization should be discouraged and assessments for political reasons should be prohibited. Party affiliations are not the concern of civil service and a policy of non-interference in politics should dominate the attitudes and activities of government employees.

20. Research programs should be carried on in all types of organization. The government should be a leader in active research and have a definite program in practice. Sufficient funds should be set aside for that purpose. A splendid illustration of what can be done along this line is the work now being carried on by the Personnel Research Division of the United States Civil Service Commission.

The program outlined constitutes the articles of a sound merit system and should be the foundation for a true career. A career service in our government is a worthy ideal and should be promoted by all public-minded citizens. It is a system which should bring efficiency into our institutions, should assure individual security, and should guarantee economical expenditure of public money. Many may consider this too idealistic to be practical and too difficult to be attained. It is not impossible if its promoters can secure the support of the voters of our country and this support should be forthcoming when the public becomes informed of the benefits of such a system. Information can be disseminated through high schools and colleges, young peoples' clubs, and through current events discussions. Vocational guidance counselors should be informed and should direct youth to the civil service. Schools should be interested in setting up definite programs for the training of young people for civil service positions, thus aiding the government in securing better-qualified people for public service.

Many organizations and societies interested in public welfare are doing research along this line and are giving publicity to the results of their studies, which show very definitely the benefits accruing from a merit system in government positions.

Some of the problems which might be encountered in the establishment and administration of a merit system along the lines indicated in this paper are as follows:

1. The lack of accurate information regarding government positions has resulted in poor legislation which has retarded the development of a merit system in many instances. There is yet too much of the spoils system policy dominating our state, county, and city work. Citizens should be informed so that they may give the necessary support for the enactment of proper civil service laws. Much of the difficulty is due to prejudice, ignorance, and short-sightedness in our people. Because of this lack of knowledge, they have not insisted on the adoption of the necessary measures to secure a better system of organization and management in government affairs. The united efforts of organizations, reform leagues, and societies interested in better government can bring about the necessary legislative assistance to promote more satisfactory policies governing the activities of civil service commissions.
2. The residence requirement prevailing in most civil service commissions is a great obstacle in the merit system. It means that a candidate for a position must be a resident of the state, county, or city in which he is seeking the position. Or it may mean, as in the federal government, that a certain number of positions are allotted according to the population of the state concerned. How detrimental such a ruling might be, is obvious. A perfectly capable applicant could be ruled out because he happened to live in another locality or because the quota assigned to the state in question had been allotted, with the result that the position might be filled by someone not nearly as well qualified. Here again is an instance which affects efficiency.

3. Certain discriminations due to family status retard and interfere with good service. A very competent person may be prohibited from obtaining a position because one member of the family is already serving the public. By this unreasonable rule the government may be deprived of a valuable servant.

4. Preference given to veterans is another burden in the administration of the merit principle. Anyone who has served in a war is given priority in appointments and in some instances is promoted before others. When reductions are necessary, the veteran is retained and another is dismissed although the latter may be rendering much better service.

5. The budget provided for in most civil service commissions is often inadequate and, as a consequence, activities are limited, research is impossible, and standards are lowered. If the public could be made to realize that better financial support will eventually result in large savings in time, energy, and money, it would insist upon larger appropriations for civil service.

6. The spoils system is not entirely gone from government service, due to faulty laws or to poor administration. Public opinion and public demands will help to eliminate this fault. An interested and enlightened public can assist in the establishment and administration of a merit system by insisting that appointments be made by non-political officers, and that the merit system be adopted and executed without political interference.

7. There are weaknesses in the administration of the merit system, manifested in the techniques of the civil service commissions and in the management of personnel in their respective positions. The publicity and methods of recruiting are limited; officials are seeking advice on this matter and it should be a concern of the public to give assistance. Methods of appointment are, in some instances, not as effective as they should be; there are loopholes which permit practices not conducive to the efficient execution of a career service. Rating systems for promotions or dismissals are poor and not on a sound basis. The method of classification may be inadequate and therefore unsatisfactory in many cases. Often retirement is not a part of the system or, when it is, the regulations are such that it is almost impossible to get the benefits of it.

The problems in establishing a merit system are many and complicated. They will require careful attention and concentrated effort for solution. There is every indication, however, that they will be solved because the public is interested, larger numbers of qualified men and women are entering the government service, civil service commissions are searching for the best methods, and institutions are adopting scientific principles in personnel management. It is evident that the public is aroused, and improvement in personnel administration in our country is on the way, for is not the quality of government service in the hands of its people?

BIBLIOGRAPHY


PROBLEMS RELATING TO THE MERIT SYSTEM

Discussion of Miss Kennedy’s address


In common usage, the term "civil service" has been thought of as relating only to those persons under a merit system of government employment. However, as Miss Kennedy has pointed out in her address, any person employed by government (whether city, county, state or federal) not in the military service, is in the civil service. Appointments under the merit system are made from among those who have demonstrated their ability by some type of competitive examination. Although the merit system still presents many problems, it is becoming an indispensable feature of efficient public personnel administration. Five states adopted merit systems during 1937—as many as had taken similar action in the past quarter of a century. My part of this discussion is to deal especially with the merit system in relation to public health nursing.

The essentials of a true merit system are: (1) A broad, positive program covering recruitment which is concerned with the selection of personnel; (2) modern methods of personnel administration for those within the service which are concerned with policies relating to conditions of work such as sick leave, vacations, hours of work, promotions based on merit, and the like; (3) removal of those who do not meet the standards set; and (4) a retirement or pension plan. It is the application of these policies within the civil service of government that interests us today.

In the 1937 Census of Civil Service Agencies in the United States, eligibility for inclusion in the count requires that the organization must be estab-

lished by formal legal provisions as the central personnel agency of a governmental jurisdiction and must, in addition to other functions, administer a merit system of appointments based upon open competitive examinations. The dictionary defines civil service as "the departments of the public service that are neither military nor naval." In actual practice it also excludes elective positions. In the popular sense, however, the terms "civil service" and "merit system" are used interchangeably.

HOW DO MERIT SYSTEMS AFFECT PUBLIC HEALTH NURSES?

The most recent information concerning personnel policies in public health nursing is contained in a book of that name prepared by Marian Randall ² last year. Miss Randall's study of current practice in a sample of official health agencies in the United States was made at the request of the Committee on Personnel Policies in Official Agencies of the National Organization for Public Health Nursing.

Fifty-nine representative health agencies in the United States were studied, comprising over two thousand public health nurses. In twenty-five of these agencies the nurses were under civil service rulings.

It does not follow that public health nurses are under civil service policies in all communities where there are civil service commissions. A canvass of all cities and counties known to have civil service commissions revealed that in approximately half of them, civil service rulings did not apply to public health nurses. Some states, for example Massachusetts and New York, have more than thirty city departments of health where the nurses are employed under civil service. Likewise, in about a dozen county departments of health the nurses are under civil service rulings of either a county commission or, in the absence of that, a state civil service organization.

WHAT ARE SOME OF THE ADVANTAGES OF A MERIT SYSTEM?

The advantages of a merit system are found to be these:

1. Public service as a career attracts more well-qualified and competent people if the standards are high enough.
2. There is an opportunity for free competition without interference of political pressure or favoritism in making appointments.
3. There is assurance of tenure of office as long as the work is satisfactory.
4. Retirement provisions and sick benefits are included.
5. Recognition for achievement through promotions and salary scales commensurate with the duties involved have been devised.

WHAT MAY BE SOME OF THE DISADVANTAGES?

On the other hand, there may be disadvantages, such as the following:

1. Standards may be too low if they are established before a sufficient number of qualified people are available.
2. If high enough standards are not established the positions are apt to become filled with poorly qualified persons content to remain on a certain level.

3. Inability of existing tests to measure personal qualities and special skills which are essential for the job.
4. It may be difficult to get rid of unsatisfactory persons and raise the requirements for new appointees.

EFFICIENCY RATING PROVISIONS

Some plan of efficiency rating is fundamental to the organization and carrying out of a merit system. Miss Randall discusses the use of efficiency rating schemes as a basis for promotion and states that only nine agencies in her sample reported experimental use of objective rating methods. Ratings based upon the efficiency of the worker may serve as a justification for promotion, for reduction in personnel in emergent situations, and for guidance in dealing with various personnel problems. Today there are few efficiency rating plans which are wholly satisfactory. However, efforts are going forward to create objective rating scales which should be equally fair to the interests of the individual and to the work to be done.

SELECTION OF PERSONNEL

Regarding the selection of personnel, the Federal Classification Act of 1923 provided for the grouping of all types of positions into broad classifications with various grades indicated under each. Applicants for positions within a certain grade may be required to take an assembled general information test and, in addition, submit notarized proof of previous experience and education. To develop efficient methods of personnel selection there are two essentials that should be kept clearly in mind. First, the type of work to be done and, second, the kind of worker needed for that type of work. The first necessitates defining the job; the second listing the qualifications of the worker needed.

As some of you probably remember, Robert T. Lansdale in speaking on "Professional Organizations and Public Personnel" at the Biennial in Washington in 1934, emphasized the necessity for administrators to know quite specifically what they want:

That sounds so simple (he said) that you may think it ridiculous of me to mention it, but as a matter of fact, I find a common weakness of public administrators is that they cannot define their personnel requirements. The worst personnel job I ever had to handle was an eighteen months’ search to fill a job where the administrator above me could not say specifically what he wanted. I trotted out candidate after candidate, guessing at the requirements, but it was a wasteful procedure. I could not find satisfactory candidates because the administrator could not sit down and say, “This is the kind of man I want.” One’s requirements for personnel must be objective and specific. They must be set up in terms of a specified type of training, clearly defined experience, and precisely stated aptitudes.

One way to safeguard standards and to avoid problems which may arise is to have a civil service advisory committee composed of professional and technical experts in the field involved whose responsibility it may be: (1)

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4 Public Health Nursing, August 1934, pp. 404 and 405.
to advise in the formation of suitable examination questions; (2) to review qualifications; (3) to assist in the evaluation of credentials. Such a committee can give invaluable service to the civil service authorities, but the committee must realize that the final responsibility always rests with the civil service agency.

THE INDIVIDUAL NURSE'S RESPONSIBILITY FOR HER OWN SECURITY

JULIA C. STIMSON, R.N., Major, United States Army Nurse Corps, Retired

Many of us remember the days when, in addition to our alumnae dues, we were asked or obliged to make contributions to the Relief Fund, which, we were told, would be sent to Headquarters of the American Nurses' Association. This Fund was for the assistance of disabled members of the Association.

The plan had existed for many years. Although the funds on hand at Headquarters were large, the income, only, was available for beneficiaries and the number of applicants for relief was increasingly out of all proportion to the increase of the money available. Such a situation, of course, meant ultimate financial disaster. The actual case work for beneficiaries was entirely unsatisfactory. Even the state relief committees were unable to make the personal contacts and give the social treatment necessary. The impossibility of doing social case work by correspondence became more and more evident.

When the problems of relief-giving on a national basis were first seriously studied,¹ there were 175 beneficiaries, half of them with tuberculosis, more than half of them thirty-five or younger. The average amount received by beneficiaries was fifteen dollars a month. More than a quarter of the time of the Headquarters staff was required to care for the affairs of the Fund. The membership of the American Nurses' Association at that time was 88,000.

So many questions had been presenting themselves regarding this inadequate relief—eligibility, qualifications, duration, supervision and control, administration at Headquarters, and the unsatisfactory long-range value of the help given, that finally after many conferences and much advice, it was voted in 1932 to discontinue relief-giving on a national basis, and the return to the states of the funds on hand was commenced.

The discussion of relief led logically to that of insurance and pension—in other words, to making provision for oneself. Times and thinking have been changing and relief as far as members of professional groups is concerned has become a term that has been transformed into self-help, long-time planning, thrift.

This new concept has developed as new opportunities and constructive plans have evolved. No longer do self-respecting business women—and all

¹ Digest of the Minutes of the Meetings of the Advisory Council of the American Nurses' Association held at Atlantic City, June 21-22, 1929.
women who earn their living are business women whether it is in professional work or not—think in terms of possible relief when they can no longer care for themselves. It is true that in the old days of the Relief Fund few young nurses consciously thought of the Fund as a possible refuge in time of need, for few young nurses give thought at all to the chance of sickness or unemployment. Their minds are full of the new joy of earning, and the possibility of marriage; retirement and old age seem very remote contingencies. Nowadays, however, wise instructors in high schools, colleges, and professional institutions are urging the attention of young people to definite programs which, whether married or unmarried, sick or well, will give a measure of safety and security as the years come on.

With the increasing number of women in industry and the professions the old fantasy that women work for pin money and not because they have to, is disappearing, and studies show how large a proportion of working women are supporting others besides themselves. The business woman nowadays is taken for granted. However, a grave menace to the success of both men and women who work is looming larger and larger and is receiving more and more attention.

This menace is age, inexorable, uncontrollable, like the tides of the sea, the change of the seasons. A recent article in the New York Times says:

Middle age is economic old age. . . Even if we had no depression, the general conviction that age, next to occupation, is the most important factor in a worker's life is reinforced by the findings of official investigations made in New York, Massachusetts, California, and Maryland, and by studies of special industries.  

While many of these studies are about men, I can give you some statements about women that will probably amaze you. They have a bearing on our own problems and should be a hammer to help drive home our own individual responsibility for our future security.

The New York Commissioner of Labor Statistics in 1900 set the dead line for women at forty-five and men at fifty. This limit for general unemployability was made thirty-eight years ago, but what about now? Recent reports of eleven public and eleven private agencies in twenty widely scattered cities in the United States indicate that applicants of forty are usually classified as "older women." The dividing line is sometimes even less. Others say that women reach the so-called "older" status at about thirty-five years. Moreover, since it is becoming increasingly hard to place applicants over thirty, it has been said that that age, thirty, might be called the dividing line between "older" and "younger" women.

Are nurses different from other women in the factors that sometimes all-too-rapidly do more than the mere passing of years to bring on old age? Everyone knows that old age is a relative matter, a state of mind, and it is

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3 Ibid.
4 Placing the Older Woman. International Altrusian, December 1937.
significant to note that employment bureau directors say that in an enormous number of cases the older woman is not hampered so much by her age as by her attitude and the fact that she is inflexible. Lack of alertness, loss of an aggressive youthful spirit and enthusiasm, poor health, carelessness in dress and appearance, touchiness and other emotional attitudes, lack of a sense of humor, sad looks, carrying grousers and jealousies, all these and similar sins, employers say are the causes of putting women into the "older woman" group. These are depressing statements, but they are useful. I could, I am sure, thrust you into a deep gloom if I presented to you even a portion of the facts I have been reading recently about the problems of the older woman. Since I have had the subject of this paper in mind, statements having bearing on it have jumped to my eyes from nearly every paper or magazine or report that has come to my attention.

There are, however, hopeful aspects and it is those that I want to put before you next, as well as to make you believe with me if I can, that all these facts about women in the business life in general are equally applicable to nurses.

There is much unemployment among nurses. There are employed nurses who are discouraged and dissatisfied. Promotions have not come along as fast as they think they should. They are growing unhappy and slowly a spirit of unrest moves in. It is said that few people fail because of poor intelligence or lack of ability to perform a given task successfully, but they fail because of their inability to use properly such aptitudes and abilities as they possess. Mental attitude is the most outstanding cause of work failure, psychiatrists say. They also say that the crucial time for a single woman is the period approaching thirty. Probably she is unconsciously disturbed that she is still unmarried. She becomes impatient of progress and dissatisfied, not always facing the issue that she may not be mentally and emotionally capable of holding better positions. In the group of women between forty and fifty are many who are emotionally unprepared to accept the changes that come with age and feel that in that period they have a right to act a little queerly. In the next group the psychiatrists say are old employees who have given their lives to one organization. Many are highly successful, splendidly adjusted women. But there are pretty apt to be others in the group who have no hesitancy in airing their real or imaginary grievances at changes in the organization. They become trouble makers and one cannot help wondering if too much security in a position is not unhealthy.

For all these, mental hygienists say there is something that can be done to help place the individual in tune with her surroundings so that she may be given a greater understanding of herself, may be content, may do satisfactory work, have a harmonious social life, and at the same time opportunity for the development and use of her maximum ability. Second skills and diversi-

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5 Ibid.
fied interests are also being urged, for it has been found that the woman who has had a variety of jobs is more adaptable and easier to place than the woman who has been in one kind of work over a period of years. There is help from mental hygiene then and that is hopeful.

Another cheering aspect is the fact that many studies show that the great discouragement among women that has been so prevalent is changing to a new attitude. An intelligent interest in all of the economic problems that caused the depression and in the reasons for the age discriminations has developed. There is a new sense of activity, planned activity and an increased interest in the kinds of jobs that women can do. Many women who have had to change their positions are now doing what they had always wanted to do and are much happier than before. Vocational and counseling bureaus are being set up in many lines of work including nursing, where older workers may talk over their problems frankly. All this is hopeful.

To meet the personal responsibility for her own security, a nurse must not only consider these factors in her own character and mentality and age which make for insecurity in employment, but she must also own her own life, as Mr. Henry Bruère said in the American Journal of Nursing last June:

If one does not save, it is more than likely that one will develop the habit of relying on good fortune to surmount difficulties and to avoid them, with the result that life will sooner or later get out of hand. A backlog breeds self-confidence and ability to act directly. It gives one balanced judgment because one need not so much improvise decisions or face the occasion for calling attention aggressively to one's merits. Compensation should be based on the recognition of the need of a margin between income and living costs. But that margin should be represented in large part by savings which keep the recipient in a position to meet the daily job mentally, as well as physically, fit.

The Study of Incomes, Salaries and Employment Conditions which has just been published by the American Nurses' Association contains (page 507) the following recommendations and suggestions for financial security for private duty nurses, so applicable to all nurses that they are being quoted verbatim with the omission of the words "private duty" when they occur:

REGARDING INSURANCE

It is recommended:

1. That attention be given by nurses to the matter of providing for insurance.
2. That inasmuch as the three national nursing organizations are sponsoring the Plans outlined by the Harmon Association for the Advancement of Nursing, nurses give attention to the types of insurance which are offered by that Association and which it is believed will assist in promoting financial security for the nurse. The two types of insurance offered by the Harmon Association for the Advancement of Nursing are:
   (a) Protected Retirement Income for Nurses (Harmon Plan).
   (b) Group Accident and Sickness Insurance for Nurses (Harmon Plan Supplementary).

7 Panel Considers Older Worker. International Altrusian, December 1937.
8 Own Your Own Life! American Journal of Nursing, June 1937, pp. 599-601.
3. Further, that nurses become fully informed about other types of insurance which may be beneficial to them and which are recognized as having a desirable status in the insurance world.

4. If a plan for hospital insurance has been adopted in the community and is recognized as offering acceptable hospitalization insurance, it is suggested that where the . . . nurse does not have access to hospital service through the use of rooms endowed by her alumnæ association, she make plans for participation in the accepted group hospitalization plan in her community.

Incidentally, the necessity for providing insurance, in so far as private duty nurses are concerned, is emphasized by the lack of provision for private duty nurses in the Federal Social Security Act. There is a new leaflet recently prepared by the Harmon Association for the Advancement of Nursing called, Individual Security for Registered Nurses Through Cooperative Group Plans which is available without cost from the office of the Association, 140 Nassau Street, New York City. The pamphlet tells about payments beginning at five dollars monthly; the fact that the amount of annuity income obtainable through the Harmon Plan is greater than can be secured at the same cost through any comparable individual contract; the normal retirement date being sixty or sixty-five; the surrender cash value at any time before cash payments begin is the total amount of payments made by the member up to date; about payments to beneficiaries and what happens if a member stops making payments. It also tells about the Group Sickness and Accident Insurance Plan, showing that unusually broad coverage is provided without physical examination for all injuries and illnesses, with very few exceptions, no matter what the cause or when the condition began, for a premium of two dollars and fifty cents per month; the lump sum benefits for losses of limbs or sight, and weekly indemnity of eighteen dollars during disability up to fifty-two consecutive weeks. The leaflet also tells about service annuity plans whereby institutions and organizations may provide retirement incomes for registered nurses. Such service annuities like the individual member's annuities are purchased from the Metropolitan Life Insurance Company and are guaranteed by it.

Participation in such plans as these is evidence of thrift and shows that a nurse is taking seriously her responsibility for her future financial security; but there are other ways to keep the wolf from the door. A woman investment broker has summarized them as follows:

1. Live within your means.
2. Save patiently and systematically even though the amount set aside at regular times may be small.
3. Be satisfied with a moderate or even a small rate of interest on your money.
4. Do not play tips.
5. Diversify your investments.
6. Do not take the advice of every Tom, Dick and Harry for the investing of your money. Seek the guidance of persons qualified by education and experience to give investment counsel.9

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The same writer also has said,

The most dangerous age for women is that dark interlude between the time when she may find herself the unemployed, unplaceable "older woman" and the attainment of the age when insurance annuities start or when she shall be eligible for the old-age pension for indigent persons, or for admission to a home for the aged poor. A well-balanced thrift program should give to any woman the security, materially and spiritually, that she dreams of for her sunset years. With some capital of her own, the problem of readjustment of the older woman to a new line of endeavor is greatly diminished. Because of her economic security she can take the time to consider the opportunities that are hers and to retrain if necessary. Furthermore, she is able to keep up her appearance and her standard of living and to maintain a healthy attitude.\(^{10}\)

In a pamphlet written for the National Federation of Business and Professional Women's Clubs the following suggestions about the "Over Forty" question are given. They apply as much to nurses as to women in business:

Don't be constantly on the defensive.
Don't feel sorry for yourself.
Don't be critical to the young person with or for whom you work.
Don't let success make you smug.\(^{11}\)

And I would add, "Don't be bossy if you are an executive."

In a recent article, the following advice was given:

Capitalize on your maturity rather than attempt to camouflage it.

It will not hurt you to be frankly forty provided you are alert, vigorous, well preserved and smartly-dressed forty—a forty to which the years have given much more than they have taken away.

Steer as far away as possible from the more crowded and competitive fields and use all the ingenuity and enterprise you have to ferret out some existing need that is not being met in your community, and then find a way to meet it with working skills already in your possession.\(^{12}\)

The question naturally arises, how can one save and pay for annuities when work is so uncertain and salaries so low, and how can hospitals pay higher salaries or patients higher rates with things as they are? What's the use? Every nurse who reads Dr. Joseph K. Hart's article, "Economic Security for Nurses Through Trade Unionism or—?" in the April issue of the American Journal of Nursing cannot help but feel that there is ultimately a way out if we continue to work together with a definite program. She will have a lifting of the spirit because of his objective, impersonal interpretation of some of our problems and his observations about some of the values and trends in our own profession.

For sound planning for our profession, however, we must have sound planning for ourselves individually, and have our own personal programs for economic security. In such programs I submit that there are three important parts: (1) Watching all those factors in ourselves that tend to make us less employable; (2) practicing mental hygiene on ourselves so that we may recognize and control those personality changes that creep up on us as

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\(^{10}\) *Ibid.*

\(^{11}\) That Over Forty Job Question. *New York Sun*, February 10, 1938.

the years advance; and (3) beginning as young as possible to build up a backlog of savings, and dropping out an anchor to windward by putting as much as we possibly can into some recognized plan for a future retirement program. Planned security is our individual responsibility.

**General Session**

*Wednesday, April 27, 10:45 a.m.*

Presiding: Anna D. Wolf, R.N., *Chairman, Committee on Accrediting.*

Subject: **ACREDITATION OF SCHOOLS OF NURSING**

**ACREDITING—A COOPERATIVE VENTURE**

**CLARA QUEREAU, R.N., Secretary, Committee on Accrediting**

In order to present a clear picture of the principles and purposes underlying the plan of procedure of the Accrediting Committee, it seems necessary to refer to certain origins of the accrediting movement in this country and to draw two parallel lines of distinction. These lie between the purposes of accrediting in general education and professional education on the one hand and on the other hand between accreditation by a professional agency and by a state department.

The accrediting movement in this country began in 1868 by defining the term "college" and listing all educational institutions conforming to that description. By that means a criterion for measurement and recognition was established. It was noted soon after this that conditions detrimental to the accepted purposes of general education existed in some of these colleges. As a means of raising the level of all secondary and higher educational institutions, a more exact measuring device was inaugurated. This consisted of a list of characteristics which were set up as standards for accreditation of secondary schools, colleges, and universities. Institutions not meeting these requirements were sifted out.

Gradually these standards became more definitely fixed and serious dispute arose concerning the harmful effects of inflexible regulations. It is generally recognized, however, that these standards served a useful purpose at a time when schools were multiplying rapidly in the country. The greatest defect in the system was perhaps that it was not sufficiently dynamic nor built to progress with the changing needs of each period. Some leaders in education still question the necessity for an external control or direction of liberal arts colleges and universities but the inauguration of qualitative methods of evaluation, as well as freedom for research and experimentation, have won for accrediting agencies widespread recognition of their need. The purposes of the North Central Association, one of the most widely known agencies in the country are stated as follows:

An accrediting association, such as the North Central Association, is the cooperative venture of a large number of institutions who are earnestly seeking first to ascertain what are the best standards of college work, and second, effective
ways and means of bringing these standards to the attention of the institutions within its constituency.

To replace the fixed standards formerly used, a school now is "judged for accreditation upon the basis of the total pattern it presents" or, in other words, upon the excellence of the school as a whole. Recognition is given to the fact that there may be wide variations in attainment and that "superiority in some characteristics may be regarded as compensating, to some extent, for deficiencies in other respects." In evaluating the characteristics of a school, investigations proceed from the merits of stated objectives and extend to the competence and effectiveness of the school in fulfilling these objectives. The individuality of institutions is recognized and encouraged but minimal facilities for general education are demanded. By general education is meant "that type of education which acquaints a student with the facts and the modes of thought in the chief fields of knowledge." Individual development too is given major emphasis as shown by the following statement:

The educational aims of most institutions transcend the impartation of knowledge and the cultivation of the intellectual abilities of students, and include development of personal traits, broadening of esthetic interests, refinement of manners, discipline of conduct, and liberalizing of the mind—a group of aims frequently denoted by the inclusive term "character-building." ¹

The definiteness of emphasis placed upon this essential is clearly shown by the requirement that the college which lacks such objectives is expected to account for this fact and the college that sets forth such objectives must present evidences of achievement.

Attempts have been made also to measure achievements of a college by testing the graduates, but little has been accomplished beyond measuring the degree of mastery of traditional subject matter. Sound methods of testing individual development and ability to apply knowledge in life situations is still in a highly experimental stage. Effort in this direction will doubtless be continued as the real test of soundness of organization of any educational institution lies in the character of the product, judged in terms of the school's objectives. Such are the purposes in general education around which safeguards through accreditation have been built. These trends in general education are important to us since they provide patterns which we may use as guides, and they indicate some of the pitfalls to be avoided, particularly in the development of a plan which might prove to be inflexible. Perhaps the most important point for emphasis is that accrediting agencies have become recognized as necessary in the cooperative and progressive development of general education.

In turning from general education to professional education, there seems to be much supporting opinion that if accrediting agencies are necessary in the former field of education, they are more definitely needed in the latter. The following opinions may be quoted:

In stating objectives of education, one must always make a clear distinction between professional and vocational education on the one hand, and non-professional or general education on the other. Professional schools and colleges have a duty or responsibility to the public which is paramount to, but not necessarily in conflict with, their allegiance to the welfare of their students. This paramount duty is, briefly, to protect the public from incompetent physicians, from ignorant lawyers, and from illiterate teachers. For students in medical and other professional schools, prescribed curricula and absolute standards are not only defensible but necessary and should be rigorously enforced.2

Quoting again from another source:

Does it follow that social control should be equally restrictive in all forms of higher education? Is it not clear that there is more public necessity for certain restraints in connection with the several forms of professional and technical education than is necessary or wise in the wide field of liberal education. The practice of a profession is certainly society's affair. The practice of a liberal education is largely, though not exclusively, the individual's affair. A liberal education is practically for the satisfaction of individual wants and may be of little or no concern to society in general or to any other individual. On the other hand what is taught in the medical or dental curriculum affects the very lives of individuals.3

Three important principles are implicit in these statements: first that the members of a profession should be prepared according to their potentialities to fill useful places as citizens in the community; second that they should be prepared to meet acceptably the public demands of that profession; third that professional education has even greater need than general education of direction through cooperative action. For each school to attempt to function independently is unthinkable. Unified effort is of paramount importance to all concerned if professional education is to be directed toward worthy objectives, if low standards, confusion, and ill repute are to be avoided.

The experience of many other professions which has led to the organization of such national agencies might be cited. Many of these are known widely and it is generally recognized that they have been largely responsible for much needed reforms. Among these might be mentioned the Council on Medical Education and Hospitals of the American Medical Association and the American College of Surgeons, both of which have done much to advance medical practice in hospitals; also the National Organization for Public Health Nursing which has been largely responsible for improvement in public health nursing courses. Other professions, such as law, dentistry, and engineering have traveled the same road. Nursing organizations have been fully conscious of their responsibilities in this respect and have been working valiantly through group activities for half a century to improve the efficiency of nursing service to the public. Individual members of the profession, working through district, state, national, and international organizations have focused their efforts upon the obligations of nurses to patients and to health-promoting agencies.

The next step seems to be to unite the efforts of schools through an accrediting organization in working toward the ever advancing goal of education for changing needs. The foundations of this structure were laid years ago and the Grading Committee, the Committee on Standards, and the Curriculum Committee have given us definite building materials. They have formulated for us the duties and responsibilities which professional nurses should be qualified to undertake; they have prepared for us an outline of the essential elements of a good school of nursing; they have given us a curriculum to use as a guide in the future development of nursing courses. To the Accrediting Committee has been transmitted the task of setting standards for evaluation of nursing education, of publishing a list of schools of acceptable standard, and of rendering whatever assistance may be possible to those schools which voluntarily seek recognition and identification with this activity. These in brief, are the objectives of the Accrediting Committee.

Rapidity of growth of this project will depend in part upon normal processes of development, upon the values accruing from the service, and upon the education of the public to the useful place which this agency can fill. Attention will be focused upon goals which will advance as fast as public interests dictate.

Between this type of direction of professional education and control of professional practice by state boards there are several sharp lines of demarcation. First, educational standards of state departments can advance only as fast as legislatures can be convinced of public needs and desires. The second distinction that should be made is that accreditation in the professional organization is entirely voluntary on the part of the school seeking it, whereas accreditation or registration of the school under state authority is coercive. Third, the standards for recognition in a professional agency are formulated by specialists who are well grounded in their fields, while legislative enactments bearing on requirements for the registration of schools are often far below or even contrary to demands made upon the profession. It is not my intention to imply that members of the profession do not propose and assist in obtaining desirable legislation but because legislators are not always informed on such matters, the law that is written on the statute books may have little relation to the proposals of the profession.

It is true that the law can and does serve as a powerful weapon in forcing a community to do the bidding of a central authority. It may act as a buttress to a professional agency in maintaining at least a minimum level below which no schools may fall, but laws soon become obsolete or cease to serve the purpose intended and then the long struggle for better legislation must begin again. Unevenness in the progress of states in changing laws has also complicated matters for graduate nurses in moving from state to state, for state boards in dealing with applications for registration, and for hospitals in obtaining nurses eligible for professional practice within a state. Great confusion too has resulted from the wide range of competence of schools which have developed under state law. These are some of the conditions that the state boards, working independently, cannot adequately meet.
What has been accomplished by members of our profession in the past and what they are still doing to obtain laws based upon the best opinions of leaders in nursing education are most commendable and deserving of the highest praise. Their hands should be strengthened in every possible way by our national organizations.

We believe this can be done best by a national accrediting agency which will serve as a guide in state activities. There should be no confusion of thought, however, concerning the functions of each. There is no overlapping; each serves independently of the other. Professional organizations study current needs and suggest plans which are usually considerably above state legal requirements. State boards, if they accept the professional leadership, encourage progressive schools to adopt the recommended pattern, and at the same time start the slow process of obtaining legal enactment which will raise the minimum level of all schools.

In summarizing up to this point it may be assumed that we have ample reason for believing that accrediting agencies serve a useful purpose to society through cooperative planning of standards in higher education and especially in professional education where safety to the public is of paramount importance. The distinction between a professional accrediting agency and a state board is that the former is organized and administered by the profession, the latter by statutory enactment. Membership of schools in the former is entirely voluntary, while in the latter it is mandatory.

In developing a national agency for the accrediting of schools of nursing, therefore, the NLNE is fulfilling an obligation to the public and exercising a leadership which should give added strength to state boards in their effort to obtain desirable legislation. Permeating and conditioning all our activities will be the dominating purpose of obtaining better nursing care for the patient through better education of the nurse. The detailed purposes which have been formulated by the Committee and published in the American Journal of Nursing are included here and are as follows:

1. To stimulate through accrediting practices the general improvement of nursing education and nursing practice in the United States
2. To help those responsible for administration of schools of nursing to improve their schools
3. To give public recognition to schools that voluntarily seek and are deemed worthy of professional accreditation
4. To publish a list of accredited schools for the purpose of guidance of prospective students in their choice of schools of nursing and to aid secondary schools and colleges in their guidance programs
5. To serve as a guide to state accrediting agencies in further defining their standards for recognition of schools and to promote interstate relationships in professional registration of nurses
6. To make available to institutions admitting students or graduate nurses to advanced standing, information that will help in evaluating credentials
7. To provide information which may be made available to lay and professional groups for the purpose of developing an understanding of the ideals, objectives, and needs of nursing education.4

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The committee which was chosen to serve in the development of this work includes League members from various geographical sections of the country. Consultants to represent the American College of Surgeons, the American Hospital Association, the Council on Medical Education and Hospitals of the American Medical Association, the American Nurses’ Association, and the National Organization for Public Health Nursing were also asked to aid the Committee in its deliberations. Other representatives from general education who have been closely associated with accrediting procedures were invited to give the Committee the benefit of their experiences. All of those who have been asked to help with this project have given devoted service and invaluable advice.

In the fall of 1937 the work was started by formulating, as a basis for procedure, a tentative statement of policy concerning the general characteristics the Committee would expect to find in the school which seeks accreditation. This was built upon the purposes which have been stated and upon the principles which have been set forth by our various NLNE committees.

The essential feature of the Committee’s plan is that each school will be judged upon the basis of the character and general excellence of the school as a whole and in terms of its stated purposes. Superiority in certain areas may be considered as offsetting to some extent limitations or defects in others, provided the general character of the work is found to be on an acceptable level. After discussion and consultation, this statement of policy was approved for temporary use.

At the same time it was also decided by the Committee that the ensuing year should be spent in studying costs of the accrediting procedure, in formulating criteria to be used in accrediting schools, and in testing the application of these in a limited number of schools which would be invited by the Committee to participate. A sampling of schools of representative types was prepared and invitations extended to these schools to share in this preliminary step of the Committee’s work. The announcement to the schools explained that the expense of this project would be borne by the Accrediting Committee of the National League of Nursing Education and that it was the expectation of the Committee that two representatives of the headquarters’ staff would visit each school some time during the coming year. It is possible that a smaller number of schools may be sufficient for this study or that finances may limit this work. Schools were assured that sufficient time, in observation of school activities and discussion with members of the faculty and executive staff, would be expended by these visitors in order to obtain a comprehensive picture of the work which is being done in each school, and that facts obtained during the survey would be considered strictly confidential. With a very few exceptions a prompt response was received from each school extending a cordial invitation to the League’s representatives to visit them.

Further explanation is necessary concerning the manner in which the schools were selected. The total number of schools was determined, to some
extent by the opinion of the consultants, the estimate being that forty to fifty should give a representative sampling. It was believed also that one year would be an adequate period for this experimental part of our program. The geographical divisions as set up by the Grading Committee were used and effort made to distribute the schools selected for study so that each section would have representation in proportion to its total number of registered schools. Some of the points which were considered in preparing this list of schools were as follows:

Organization of the school in general and special, municipal and private, large and small hospitals, also those controlled by religious groups.

The general content of the course offered and whether or not a degree is granted for all or some of their students. The type of students admitted, including male and colored students. The kind of affiliations offered or maintained with other schools. The general recognition of the school as a "good school."

While this list of schools was being prepared, the work of constructing questionnaires and schedules for the surveys was carried on at headquarters. Conferences and group meetings with Committee members and specialists in the various clinical fields were held for review of this material. The opinion of consultants was also solicited.

The schedules have been designed to show the main objective of the school and the organization which has been built as a means of carrying out this objective. Effort has been made to make these outlines so inclusive that they will be applicable to any type of school. Some of the chief areas of study are organization, administration, faculty competence, student selection and promotion, curricula, instruction, physical and clinical facilities for teaching, housing, health and recreational programs, and other matters of importance. Further explanation of the outlines is probably unnecessary as copies have been sent to all state leagues and educational sections and are available from headquarters at a minimum price.

After receiving responses from the schools which were invited to participate in this study, an itinerary was planned for the two visitors. In order to avoid retracing any territory, to minimize travel costs, and also in order to cover the southern states before hot weather, the schedule of visits was started in North Carolina, proceeding south and west in order to arrive in Kansas City in time for the Biennial and submit to the members of the League the first results of the field work. Your two visitors left New York on March 6 and in the six weeks up to the Biennial, eleven schools were visited in the following states: North Carolina, Georgia, Florida, Alabama, Louisiana, Texas, Oklahoma, and Kansas. The cordial reception which has been extended by all the schools and the hopes that have been expressed of the values which they see in accreditation are most heartening to the Committee.

The time spent in these schools has averaged between two and three days, each school being visited by two representatives. In addition to the routine work of accumulating facts in relation to organization and administration it has been possible to meet school committees, faculty and student groups,
and such influential representatives as medical superintendents, and other executives such as presidents of universities, deans of medical schools, and lay persons who are interested in the schools. These contacts have been exceedingly stimulating and helpful as they have given your visitors an opportunity to observe the attitudes and interest in nursing education which play such an important part in the progressive development of a school.

Following the sessions of this convention the survey work will be continued in Missouri, Colorado, Utah, California, Oregon, Washington, Montana, Iowa, and Minnesota. This schedule will be completed about July 1. After a vacation interval, the visits will be continued in the North Central, Middle Atlantic, and New England states.

On the basis of our findings in all schools visited, we shall attempt then to set up the criteria which will be used in the actual accrediting procedure which will follow. State leagues have been invited to examine the questions asked to determine if, through the use of these schedules, information which is pertinent in judging the character of a school can be obtained. Committees on state board problems have been invited to study the outlines to determine the value of such material in guiding the development of schools in their states. Where committees on state board problems do not exist state leagues may refer the material to their boards of examiners. It should be emphasized however, that definite criteria have not been formulated and that the work of this year is entirely experimental. We hope for the fullest cooperation of many league groups in studying the schedules and in giving the Committee the benefit of their opinions and criticism. By so doing this project will become a real cooperative venture in which all who are interested in nursing education may share and through which all may enjoy the stimulation and profit which should be concomitants of such a project.

Special Luncheon Meeting for Nursing School Board and Committee Members

Wednesday, April 27, 1:00 p.m.

Presiding: Nellie X. Hawkinson, R.N., President

A Plan for Lay Participation and What a School Committee Has Meant to Me

Grace A. Warman, R.N., Chairman, Committee on Lay Participation

Today, as never before in the history of our country, a word, old in usage but new in meaning, has been gaining in popularity and significance. The farmer mentions it when he works for good roads and markets, the industrialist uses it when he seeks to raise the standards of business, President Roosevelt has referred to it in many of his talks to the nation. That word is cooperation.

Until a few years ago cooperation, to most of us, meant working together on a purely local project. We were asked to cooperate with the citizens
of our community to build a new swimming pool, or our church group asked us to cooperate with them in raising money for a new building. Life, however, as lived by members of our community, went on pretty much as always; each man worked for his own interests and each group kept to itself without much consideration of the aims or importance of other groups.

Recently, though, surrounded by the effects of the longest depression in history, we have realized that if the American way of life is to survive, the work of all groups in the professions, in industry, and in labor must be integrated into one large pattern through cooperation between the groups themselves. In other words, the range of our life has broadened to such an extent that it is not enough to be a specialist in one profession—we must know enough about the activities in other fields to be able to work jointly with the people in them for a common goal. Cooperation, then, seems to be the keynote of our present civilization.

We in the field of nursing have long been aware, implicitly at least, of the value of cooperation within our own profession. For many years we expected little more. We served the public as best we could, but the public, with the exception of personally interested individuals or small groups, was not especially concerned with our problems. With the development of outside or lay interest in the work of the professional nurse, great strides have been made in nursing education. Besides acquiring specialized preparation for her profession, the nurse of today is encouraged to become an integral part of the community in which she finds herself.

Even with the new public interest in nursing and the resultant advance- ment in nursing education, we members of the National League feel that our task of building lay interest has just begun. For several years now, as all of you know, the National League has been considering ways and means of developing a more active understanding and cooperation between interested lay groups and the League. This year the Committee on Lay Participation was asked to present a plan whereby lay groups can work with the League. The plan, in brief, suggests that:

1. The National League of Nursing Education recommend to the state and local leagues the organization of committees on lay participation similar to that now existing in the National League. Although this point does not, of course, represent a new set-up, our Committee urges that more consideration be given to the establishment of these state and local committees as nuclei for later work to be done.

2. And as second step, it is suggested that the state and local committees on lay participation encourage the development of organized lay conference groups. Members of these groups, chosen by the state and local committees, will be expected to present their specific problems and suggestions to the state and local committees and later, through them, to the League officers. This will prevent rushing into impractical and unconsidered projects.

It seems to me that the committees and conference groups might work with the following purposes:

1. To interpret to the public the place of the professional nurse in the community
2. To stimulate interest in the promotion of sound programs in nursing education
3. To arrange for programs in connection with state and local league meetings, and for the attendance of lay groups at some of the regular sessions of the state and local leagues. It is suggested that these programs include features important in building up a background of understanding for lay associates.

4. To assist lay groups to become familiar with the publications, *Essentials of a Good School of Nursing*, the *Manual of the Essentials of Good Hospital Nursing Service*, and the new *Curriculum Guide for Schools of Nursing*. (The most formidable problem in this suggestion is to get each person to do it.)

5. To aid in the development of nursing school councils and committees, in accordance with the duties and functions of these councils and committees as outlined in the *Essentials of a Good School of Nursing*.

6. To help secure financial support for nursing schools as a part of public education.

The outline of this plan, general though it must necessarily be at this time, may nevertheless serve as the groundwork for later specific development of lay participation in nursing education.

In emphasizing the advantages of the intelligent cooperation of outside groups, I should like to tell you briefly what a school committee has meant to me.

The aim of the school of nursing with which I am associated, in common with many other nursing schools, is to accept well-selected applicants and then to provide them with an educational program which will direct and stimulate their growth as individuals as well as to prepare them to become professional nurses. We know that it is easy to create an aim for an institution; the problem is to carry it out. We all realize that a principal of a school, even with the aid of a loyal and interested faculty, cannot accomplish this alone. Just here, therefore, is where the active interest of the school lay committee comes in.

The first step toward realizing the aim of a school like ours is to have adequate resources to work with. In order to attract the most desirable type of student, a school should also have the personnel necessary to insure her receiving a superior preparation. There must be a well-qualified faculty, a planned budget, an effective health program, adequate clinical and teaching facilities, special funds for the school library, funds for recreation, and finally, a provision for financial assistance in the form of scholarships and loan funds for graduates and students.

The School of Nursing Board, which is the incorporates name of our committee, has been most willing to aid in solving basic problems of the school. The members of this board, who are business men and members of various professions, have always worked to interest their friends in the importance of the school program so that cooperation and support might be provided.

Actually running a school includes too many problems to be mentioned at this time, but it is in carrying forward this work that a principal needs encouragement and guidance. When I am called upon to deal with the specific problems of administration I feel confident in asking for the attention and counsel of the board, and each member has, by contributing his own
particular point of view, aided in the formulation of a more balanced decision than might otherwise have been reached.

At the time we considered the ever-important problem of faculty leaves of absence, we were assisted by our board members in working out a plan enabling those of the faculty who were granted leaves to be assured of their positions upon their return.

In mentioning the school faculty I might cite, also, another example of cooperation between our faculty and board members. When, after study and careful consideration of the new Curriculum Guide, the faculty recommended certain revisions in our curriculum, our board members took the time to study the proposed changes, to discuss them with faculty members, and finally, with an understanding of the situation, to accept and support the recommendations.

My examples of what lay interest has meant to me are examples of what the students, the faculty, and the principal of a school of nursing can work to achieve if they have the conscious support and the interest of an active lay committee. If this same spirit could be aroused in community and state groups, the possibilities for their mutual benefit are almost undreamed of in their range and significance.

May I, in closing, return to the point with which these remarks were prefaced? Cooperation is the keystone of the arch of modern democratic life. Whether we like it or not, the patterns of civilization are rapidly shifting from the old self-sufficiency of individual, isolated activity to complex yet efficient interdependence. If I may borrow a phrase from a science with which we are all familiar, it may be appropriate to say that modern society is no longer a mass of independent cells. It is a functioning organism. And because it is just that, the need for the mutual give and take between the layman and the professional nurse is vastly greater than ever before.

ADVANTAGES OF LAY PARTICIPATION IN NURSING EDUCATION

MRS. ARTHUR SPIEGEL, First Vice Chairman, Central Council for Nursing Education, Chicago, Illinois

It is a pleasure to meet with you today to discuss a subject which has interested many of us for some years. It has been our belief that professional groups and lay persons can successfully work together for the improvement of nursing standards and that the field of service for both groups, thereby, may be greatly enlarged. This cooperative relationship can be accomplished by:

a. A program of education for lay groups which will help them to become aware of the problems and needs of the hospital, school of nursing, and community
b. Interpreting nursing programs to hospital boards
c. Cooperative planning and, when necessary, supplying material aid for the expansion of nursing education.
The problem is not altogether a simple one, and, as I see it, the responsibility for either its success or failure rests in large measure in the hands of the professionals who have lived too long in cloistered halls and who have been too reticent about voicing their needs. I am sure that it is not necessary to point out to this group that nursing as a profession has struggled through the years against great odds and that the nursing group itself has been too reluctant about sharing its problems and confidences with other interested groups. This was probably a protective measure. Adequate leadership is within your own group, but to supplement this, a sympathetic and cooperative attitude must be developed and fostered outside of your profession. This may be achieved by helping the public to become aware of your educational aims and the various problems involved in making these aims effective. It is important to have the understanding of all community groups interested or affected by nursing, if the nursing profession is to succeed in achieving the high standard and ideals it has set for itself. Some one has said

No occupation or profession is independent, as far as its progress and development are concerned, of the people for whom it is exercised and because of whom it exists. Consequently there must always be an interrelation between the persons who supply a need and the persons who feel this need, and it is certainly in a measure true that in proportion to the general intelligence on the subject will the level of the standard rise.

Community education, as it applies to nursing education, can only be carried on simply and intelligently through the education of boards of directors or, stating it more definitely, by having well-informed nursing committees which will function within boards of hospitals in the capacity of interpreters of the problems of the school to the board of directors, and through the board to the general community. The development of nursing is so bound up with the development of the hospital that boards of directors cannot but recognize this fact and consequently will feel it incumbent upon themselves to become thoroughly familiar with the problems and development of the school. How can this be possible without the complete cooperation and whole-hearted support of the director of the school? In theory I am quite sure that you will agree with me, but in practice, probably because of the time involved and possibly because of past experience, you may hesitate to do so. However, the support of your school, financial and otherwise, is directly dependent upon the board of trustees. Therefore, any effort expended in securing its interest cannot help but bring results.

One of your own professional organizations has been a pioneer in this respect and has not only shown nursing groups the ideal way to function, but other groups as well. In the first paragraph of the introduction to the *Board Members' Manual of the National Organization for Public Health Nursing*, the careful thinking and aims of the public health nursing group in reference to their lay boards are most adequately stated. Their suggested plan could be used as an example by all other groups interested in nursing. They made provision for participation of lay groups many years
ago, while other nursing groups have only recently begun to recognize this need. The National League of Nursing Education in December, 1934 appointed a committee to study lay participation in League activities and more recently lay members were appointed to the Joint Committee on Community Nursing Service. But before lay participation in these larger programs can be made most effective, it is of the greatest importance that every director of a school of nursing should stimulate the interest of her nursing school committee to the fullest degree in the problems related to nursing and nursing education in her own school of nursing.

Directors of schools of nursing can and should stimulate and develop the interest of nursing school committee members, first by bringing to their attention matters of practical and immediate interest and usefulness; then, when they are sure of the committee’s interest, a carefully worked-out schedule of the school and its function, stressing both its weaknesses and its strengths, can be presented.

This can be followed by a plan which would more nearly meet the ideal standard. If it is hoped to achieve such a plan, budgetary support will, of course, be necessary, and the success of this achievement will again depend upon the sympathetic understanding of the lay members. This cannot be done quickly, but should follow a very carefully thought-out plan, in which the director of the school must use to the fullest her knowledge of the psychology of human nature. In order to get a comprehensive understanding of the educational aims of the school, the committee must of necessity be given careful instruction along these lines. The director must be careful in her method of procedure for if there are men on the committee they are apt to resent the term education, as applied to themselves. There are, however, fundamental principles involved in teaching which may easily be applied in presenting facts to the committee. Is it not true that teaching is not just a mechanical telling of facts? It is a contact made between a group of personalities in which the teacher gives to the facts his or her attitude and interest in the subject. Accordingly, within the hands of the director of the school lies the success or failure of her school of nursing committee.

This committee should be made up of individuals whose equipment is such that they can assume the responsibility of becoming well informed on the background of present developments and possibilities of the nursing profession. With all that is involved in a community program, they must be flexible in their point of view and must be ever ready to study the changing needs which such a situation demands. The selection of this committee is, as a rule, not within the power of the director of the school, but it would seem wise if she were conferred with in regard to her committee.

Members of hospital boards, I am reasonably sure, are most often motivated by interest in their particular institution. Otherwise they would not be serving on these boards. There is an incentive to work only where there are problems which challenge interest. As educators, nurses must take advantage of this fact.
If the school of nursing committee is woefully ignorant of the program of the school, how can one hope to have an intelligent interpretation presented at board meetings? The committee must have a reasonably good knowledge of the activities of the school in order to cooperate effectively. One must recognize an interdependence between the school and the school of nursing committee, and work out a partnership accordingly which can be made both stimulating and productive.

Obviously, the education of lay boards is quite as necessary in its way as is education of the staff nurses in your hospitals. The objectives and principles of staff education, as stated in *The Manual of the Essentials of a Good Hospital Nursing Service*, can be applied to the education of lay boards, or more specifically to school of nursing committees. As stated in the Manual, staff education should develop a better understanding of the problems of the hospital by giving, may I say board members instead of nurses, a clearer concept and more comprehensive information regarding changes and progress, responsibilities, obligations, etc.

"Since it is anticipated that the efficiency of the lay member (instead of the nurse)," I continue to quote from the Manual, "will increase somewhat in proportion to the value of the instruction given, the attitude and skill of the leader or instructor are of utmost importance." This point cannot be overemphasized, whether it be in reference to your own group or to lay groups. Upon the skill of leadership will the effectiveness and value of the committee depend.

You know better than I the ideal set-up of a school of nursing committee. But the point I wish to stress is that, given this committee, whether ideal or not, you should make the most of your opportunity, because it is through such committees that the nursing profession can hope to secure public interest in the problems of nursing education.

Your material is at hand. Make the most of it. Utilize all school of nursing committees to the fullest as a part of a publicity campaign to create interest in the education of the nurse and the development of schools of nursing.

Is there any reason why lay people should not be as interested in nursing education as they are in many other forms of education? More and more are our secondary schools bringing parents into closer contact with the educational problems of the schools through parent-teacher associations. Women's colleges are meeting the problem from another angle by inviting members of the alumnæ to become members of boards of trustees, as well as by giving them membership on committees of their colleges. The University of Chicago has made every effort to keep the so-called New Plan before the lay public and to interpret it simply and intelligently. The lay public is interested in other types of education, so why should they not be interested in nursing education?

I feel that it is of utmost importance, as part of your larger program of lay participation, to recognize the fact that the hospital and school of nursing
CONVENTION PROCEEDINGS

committees are sources from which may be drawn intelligent and well-informed members to foster larger community enterprises. Two-thirds of our hospitals have schools of nursing. Use the lay members of their nursing committees to the fullest advantage.

Another opportunity for lay participation is in community nursing councils. Here members of nursing school committees should be brought together for cooperative thinking. The Joint Committee on Community Service is stressing the importance of the community nursing council as a helpful agent in meeting community nursing needs. One plan which has worked out with some degree of success is that of the Central Council for Nursing Education in Chicago. It provides a common meeting ground for school of nursing committees, as well as other committees on nursing. The main objective of this organization has been to interpret nursing to the community by the dissemination of information regarding nursing education. Emphasis has been placed on the importance of the careful selection of students and a sound educational program as essential factors in providing adequate nursing service to the community. The Council has been in existence since December 1921, and has achieved a definite place in the community. This has been accomplished in part by holding luncheon meetings to which all those interested in hospital and nursing problems have been invited. These meetings have been scheduled at times when the medical profession were holding national meetings in Chicago and so its members were available to attend and participate in the programs.

The program of this organization for the past year has concerned itself primarily with discussions regarding the essentials of good schools of nursing. Joint discussions by lay members of nursing school committees and representatives of the professional staffs of membership schools have proved stimulating and instructive, if for no other reason than that lay members who participated were obliged to devote some time and thought to a study of the educational programs of their own schools.

Through the years lay groups have shown an interest in schools of nursing in various ways, one being the awarding of scholarships to nurses interested in securing additional educational preparation. In one school of nursing, through the interest and support of lay groups it has also been demonstrated that it is possible to strengthen the nursing curriculum by augmenting it with material in line with progressive trends in modern education. This school of nursing has recently incorporated in its curriculum a course of study in child development. The suggestion of the need for such a course came from the women's board of that hospital, and representatives from this board have cooperated with faculty representatives in planning for this special instruction. They provided a scholarship for additional training of an instructor who teaches this course and also the physical equipment needed for such a program.

Another way in which lay women can give valuable help to the director of the school of nursing is in the development of health programs and
better social conditions for the student nurse. A small proportion of the large schools of nursing have adequate and pleasant residences for their nurses, but these are exceptions. Whether or not there is an adequate residence for student nurses, the lay committee can find many opportunities for service in helping to create a desirable home environment for the students.

With a complete understanding of the school curriculum and an adequate appreciation of the general educational problems, interested and thoughtful lay members can and should prove of exceedingly great value to the nursing group. In the changes that are bound to come in the whole set-up of nursing education, as it affects the student and the graduates and therefore the hospital and the community at large, the nursing profession will need the support of intelligent, well-informed lay individuals.

LAY PARTICIPATION FROM THE POINT OF VIEW OF A MEMBER OF A SCHOOL OF NURSING COMMITTEE

MRS. JOHN A. HASKELL, Member, Administrative Board, Washington University School of Nursing, St. Louis, Missouri

As a lay member of a school of nursing committee, I feel that the plan of more general lay participation in the League program will be valuable.

In my few years of service on a school committee, I have seen possibilities of usefulness that I believe apply equally well to the proposed League committees. These possibilities are based on two major premises: first, that the professional point of view, its phraseology, its idealism, and its necessarily uncompromising adherence to the ideal, need interpretation to the public mind; second, that the lay member can usefully contribute, only in so far as he or she is used by the professional.

All schools of nursing are under some control other than their own committee, such as a hospital board, or a university board, or whatever. These boards, as a rule, are made up of non-professional people, the majority of whom are not particularly interested in education per se.

My first point is that in dealing with these controlling bodies a lay group can be of especial value, because their point of view cannot be challenged on the ground of self-interest or exaggerated professionalism—two lines of defence of the hard-headed business man in his resistance to a new idea. Also, such a body forms a proving ground, so to speak, for new ideas, new methods, and policies proposed by the professional group. When the questions and objections of the lay group have been answered, convincing them of the value of a project, the lines of approach to the controlling body have been pretty well defined and all reasonable objections thrashed out. Trying it on the dog is a very good plan in spite of the antivivisectionists.

In this connection I see a second use for the lay member. It may be taken for granted that at the present time the general public has been taught

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1 Since Mrs. Haskell was unable to be present at the luncheon meeting her paper was read by Miss Ruth Ingram, Director of the Washington University School of Nursing, St. Louis, Missouri.
to know and to expect good nursing, both in the private duty and in the public health fields, but I do think that we have not yet taught the same general public what it takes to equip a nurse to give good nursing.

In that term, general public, I classify not only those we usually so designate, but great numbers of these same hospital boards, university boards, city fathers and alasks, doctors, themselves. The tradition that a nurse is only a pair of hands and probably a heart, or she wouldn’t be a nurse, is still with us. Her most important asset, her head and what it holds, is not of such general interest. I believe that the lay member is a channel of publicity that can be used effectively in convincing the general public of what it takes educationally to make a good nurse.

A third usefulness of the lay member is that he is that impartial third person on the school committee, who is not so close to the job, and consequently not personally involved, who can at times break a deadlock over a matter, small in itself, but one which may lead to further friction.

As we all know, doctors and nurses do not always see eye to eye. When a school committee is made up of only these two groups, as is sometimes the case, I can imagine moments when those eyes snap dangerously. But if the eyes are drawn to the innocent bystanding lay member, the sparks probably die out and the problem is solved.

The fourth possibility of usefulness is in the financial role. Lay members represent an informed avenue through which interest can be aroused in the needs of the school. To raise money successfully, the solicitor must be an enthusiast, and have at least a working knowledge of the project. The lay member of a board is such a person.

To sum it up, I think of the lay members as the compromisers. They stand between the clear, cool, precise, professional point of view, and the muddled, resistant, and generalized thinking of the great mass of people. I know many individuals feel scorn of the compromiser, but in this far from perfect world, compromise is the way of progress, after all. The ideal is before us always, but by compromising from the best to the good, we have made great strides away from the bad or worst. The lay group can surely help in this compromise—toward the best.

Lay Participation from the Point of View of a Principal’s Responsibility to the School of Nursing Committee

June A. Ramsey, R.N., Principal, Harper Hospital School of Nursing, Detroit, Michigan

According to the latest recommendations of the National League of Nursing Education, the ideal “school of nursing council is composed of representatives from the trustees of the hospital, the community, the field of general education, the public health field, the profession of nursing (or alumnae), the profession of medicine (or medical staff), and the superintendent of the hospital and the principal of the school as ex officio members with vote.”
Fortunate, indeed, is the principal of a school of nursing who has been permitted to work with an advisory committee composed of such representatives. I am happy to say I am one of those who have the privilege of working with a carefully selected representative committee. As time goes on, I appreciate more and more the influence and support of a group of people who are not so engrossed with the finances of the hospital that they cannot see the school as an educational institution instead of a service department of the hospital. Whenever there are more mature students and a better prepared faculty, a committee so organized is quite ready to leave minor problems of administration to the faculty of the school and the director of the hospital, and to turn its attention to the broader questions of school policy and administration. The trustee members of the committee listen with greater understanding to the comments and recommendations of the other members of the committee and are often persuaded to change their point of view after the problem has been presented and discussed impartially. The great obstacle to the complete effectiveness of a committee of this kind in the average school of nursing connected with a hospital is its lack of authority to control the administration of the school. This is due to the committee's inability at the present time to provide adequate financial support without depending on the hospital trustees for at least a portion of the budgetary requirement. An important point to stress at this time, and one that should be emphasized frequently to lay people, is the necessity of separate support and control for every school of nursing, whether it is established in a university or in a hospital.

If the committee were influential enough and powerful enough to secure an endowment for the school, it is beyond question that the board of trustees would gladly surrender the responsibility and authority that goes with it. Conscientious hospital trustees who are conducting schools in good faith are just as anxious to share the responsibility and to secure financial support as we are. It is fear of financial embarrassment that limits their willingness to delegate authority.

Members of the National League of Nursing Education who have worked with committees of lay people, who have made every effort to meet their responsibilities to their committees, and who have seen the committee members develop interest and responsibility in turn are convinced of the timeliness of the plans submitted by the Committee on Lay Participation of the National League of Nursing Education. Organized groups of lay people in each locality of each state meeting regularly and holding institutes and semi-annual or annual conferences would surely help to stimulate in the minds of many more people the importance of a sound educational policy for every school of nursing. If state support of nursing education is what we are hoping for, these organized groups of lay people would be a strong political influence on the state machinery.

One of the important responsibilities of the principal of the school to her committee or council is to keep it informed of the progress and require-
ments of the school. The budget for the coming year, proposed changes in
the curriculum or faculty, changes of policy in the nursing service which
may in any way promote the progress of nursing education or retard the
development of the school, the latest trends in demand for nursing service,
presentation for which should, perhaps, be included in the undergraduate
curriculum, are examples of subjects which she must be able to interpret
fully. Surely it would strengthen her hand if her committee were a part
of a larger group, all of whom were studying similar problems in other in-
stitutions. The very fact that the problems of one school are identical with
those of every other school of nursing correspondingly organized would in
time be recognized. Thus a large enough group might become stirred to
effective action, and so relieve the harassed director of the hospital of this
extra burden, giving it back to the public to whom it rightly belongs.

Strong organizations of lay people who are interested in community health
programs can assist the hospital in several ways. They can support the
hospital materially by contributions of money. They also can give it under-
standing and moral support by accurately interpreting hospital functions.
Trustees, physicians, executive directors, and principals of schools of nurs-
ing become so overwhelmed, especially in time of business depression, by the
enormous difficulties of their tasks that they lose sight of the necessity of
public support and seem reluctant to take the public into their confidence.
Instead of soliciting the necessary financial help, they reduce salaries or break
down a principle for which they themselves have toiled earnestly for many
years. In years of prosperity they should be helped to prepare an adequate
financial defense for such crises as business recessions. Hospitals which serve
the public should be depositories for great public wealth. Nursing is a
great public service. It should be recognized as such, and education for
nursing—a specialized kind of education—should have a large share of
that wealth. I have confidence enough in the generosity of people of financial
means to believe in their desire to accomplish the most good with their
money. They must be shown the worth-whileness of the project they are
asked to support. Hospital people are probably the least vocal of any pro-
fessional group. The failure to talk about their problems is the direct
heritage of long centuries of repression. Until they become as vociferous in
making known their needs as is every other group, they shall continue to
be in the humiliating position of beggars. Perhaps well-organized groups
outside the hospital can help them find their voices and inspire them to seek
what they need. Lay people are taking an active and important part in
public health nursing organizations and in councils on community nursing.
They are bringing a thoughtful interest to many vexing questions and are
helping to find the answers to them. Certainly there is no more troublesome
question, nor one that concerns the public more directly, than the under-
graduate preparation of the nurse. It is a problem which begins with the
selection of the student, the kind of person she is, and her aptitude for
nursing. So much emphasis has been placed on the technical preparation of
the nurse that we have quite lost sight of her as an individual. We now realize that the development of her personality is of equal importance. That the whole subject of undergraduate nursing education has assumed far greater significance as the scope of nursing has widened, is well known to nursing leaders everywhere. The fact that this steadily growing responsibility for a greater variety of nursing service has been placed upon the nurse by the medical profession and the public, and not by the nursing profession itself, is less well understood by lay people generally. Therefore, it is increasingly apparent that the League of Nursing Education needs the interest and support of a greater number of people to spread knowledge and understanding of the nature of nursing as a profession, the part nurses have in any community program and the financial support which is required to prepare them to meet their obligation to society.

LAY PARTICIPATION FROM THE POINT OF VIEW OF A PUBLIC HEALTH AGENCY BOARD MEMBER

EVELYN K. DAVIS, B.A., Assistant Director, National Organization for Public Health Nursing

The National Organization for Public Health Nursing believes that the program of lay participation in the field of public health nursing is one of partnership. Neither group can do the job alone, and only as the board of directors and committees and public health nurses are all working together to develop the program can it be most effective.

We agree so definitely with all that has been said by the previous speakers. The fundamental principles of lay and professional relationships are the same whether we are talking about boards of public health nursing agencies, hospital trustees, or school of nursing committees. In order to adequately develop this partnership, both groups have a definite responsibility toward it.

Professional responsibilities are threefold:

1. Recognition of the value of the committees and use of volunteers. It is necessary to be thoroughly convinced that they are an integral part of the set-up and not begrudge the time needed to spend on development

2. Keeping the committee and committee members and volunteers closely in touch with the work. Making reports interesting and educational by the use of charts and demonstrations

3. Being willing to delegate things to the committee and to volunteers to do—in this way giving them a feeling of participation in the program, both by having an opportunity to do some actual interesting work and in participating in the thinking and planning of the program

The lay responsibilities are just as important, and are:

1. Recognition that serving on a committee is an important task
2. Being able and willing to attend meetings with regularity
3. Carrying out any job given to them to do effectively
4. Being ready to grow and change as the program demands, being proud of a tradition but eager to improve it
5. Being anxious to become informed and willing to study material that is available in the field of nursing, nursing education, and public health nursing.

Many methods have been tried out in the field of public health nursing to develop this joint responsibility. I should like to just mention two that have been very helpful. First, discussion meetings for committee members of like-size organizations and near enough to be able to come together for a day’s discussion on the problems of their committee organization. A series of ten meetings was held recently in one state, gathering together some 96 agencies where informal discussions of our mutual problems took place.

Second, as Mrs. Spiegel said so well, the importance of being informed about the problems is a very vital factor to the committee member in order to have her interpret correctly. This is one of the things we have been working on continuously. Many board members have welcomed the suggestion that a small handbook of information be prepared for each committee member, especially for the new member who is elected to the organization, but also for the member who has served for several years, because of the value of having available in this concise form the pertinent facts about the budget, the organization, the services, etc.

An outline was prepared to guide board members in preparing these handbooks, and it has proved very helpful.

This whole program of developing lay participation should be based on a partnership relationship and it is my personal feeling that no program, either health or social work, either supported by public monies or private contributions, will reach its full effectiveness without this partnership between the committee member and the professional worker. It must be one of mutual respect, recognizing each other’s abilities and each other’s limitations. Neither group can do it alone. The layman cannot organize a program today and carry it out without the employment of qualified professional workers. The professional worker cannot carry on a program without the backing and support of a committee to see that that program receives adequate monies for its continuance. Neither group should dominate. We must have group thinking and group participation. In my mind it is a partnership of equals—equal in the fact that both the lay committee member and the professional worker are interested and working for the very best type of service to meet the community needs.
Joint Session

American Nurses' Association

National League of Nursing Education

National Organization for Public Health Nursing

Thursday, April 28, 9:00 a.m.


ORGANIZING FOR BETTER COMMUNITY NURSING SERVICE

C.-E. A. Winslow, Dr.P.H., School of Medicine,
Yale University, New Haven, Connecticut

In discussing this subject, I am reminded of the gentleman who returned from a too exuberant party somewhat the worse for wear. His wife met him at the door and proceeded at some length to tell him just what she thought about it. As he supported himself against the doorpost, he slumbered for a time and awaking cocked one eye at his spouse and asked, "M'dear, are you talking yet, or again?" It would be natural for you to stir in your slumbers and say, "Professor Winslow, are you talking about organizing for community nursing yet or again?"

At your biennial convention in Louisville ten years ago, I pointed out that the problem of community nursing is one which urgently calls for solution and one which can be solved. I suggested that:

The development of group nursing for the patient of moderate means in the hospital is one step. The development of hourly nursing service in the home is another. The organization of registries on a constructively cooperative basis is a third. By these means, and others which will be worked out in the future, we may hope to attain for every patient the amount and kind of nursing care which he really needs and for the nurse those four essentials of reasonable hours, adequate income, constructive leadership, and opportunity for growth which are so vital to the very existence of your profession.

Such solutions are by no means simple or easy to apply. Hourly nursing, for example, can only be developed to full advantage when conducted by a . . . nursing group which can furnish expert supervision. . . . For the maximum of results, we must go still further and visualize a coordination of all community resources both intra- and extra-mural, under which nurses in the hospital and in the public health nursing organization and in the home can be used where and when they are most needed.

In all this, it must be remembered that there are two distinct types of questions involved—the problem of service and the problem of payment. We must first devise means for supplying to each patient the amount and kind of service needed (from the care of chronic or convalescent cases by a nursing attendant, to home nursing on the visiting nurse or hourly basis, and to continuous nursing of acute illness in the home or the hospital). We must develop machinery for facilitating payment for the service rendered through some form of insurance program, since many a family quite unable to meet the sudden financial emergencies of illness could bear the cost involved if it were distributed in time and over a whole social group.

These are problems which constitute a direct challenge to your profession; for they are, after all, primarily problems in nursing and can only be solved wisely with
the active cooperation of leaders in the nursing field. I can foresee in the future that in every well-ordered community there will be a joint council on community nursing which will include representatives of hospitals and training schools, of official and voluntary public health nursing organizations, and of the registries which will make continuing studies of these problems and will strive to solve them through joint effort for the common good.1

In 1934, I pointed out four major problems which cried out most urgently for solution: the development by public health nursing associations of part-pay and full-pay services on a really effective basis so as to replace the concept of our nursing associations as eleemosynary institutions by the realization that they should furnish a necessary health service for all economic classes which need such service; a closing of the gap between hourly service and eight-hour private duty so that any type of nursing care needed in the home could be obtained from a single central agency, under a supervisory leadership which would assure reasonable standards of quality; a coordination of nursing service in home and hospital; and the evolution of a plan for group payment for nursing service through which families of the middle economic level could pay for their home nursing service on a fixed annual basis.2

At your biennial convention in Washington in 1934, I again pointed out that:

In material compensation, in the opportunity for continued regular performance of function, in facilities for reasonable rest, recreation, and self-development, in security, and in progressive advancement in both achievement and reward, the nurse in a hospital or public health nursing staff enjoys advantages unattainable by her colleague in private duty. From the standpoint of the patient, which is, after all, the essential one, the superiority of organized nursing seems equally clear. Organization makes nursing service better and cheaper and more widely available than could possibly be the case under any individualistic program.3

Last winter in an address at Detroit, I elaborated the possible work of a council on community nursing in greater detail and pointed out in particular that

the evolution of such a program should be of great assistance in the development and stabilization of industrial nursing. On the whole, standards are perhaps lower in industrial nursing than in any other area of public health nursing. It would be of incalculable advantage, even to large industrial organizations, if their nursing work could be affiliated with a community nursing association and small factories which cannot obtain such service by themselves could obtain it from such an organization.4

At that time, too, I reviewed the actual progress made since the first pioneer Central Committee on Nursing was organized at Cleveland in 1914.

Detroit's Central Bureau on Nursing in 1917 (which became the Joint Council on Community Nursing in 1931) was the second organization of this type, followed by the Nursing Council of Cincinnati in 1918 and the Central Council for Nursing Education of Chicago in 1920. After long delay, New Haven formed a Joint Council of Community Nursing in 1929 and Alameda County, California, did the same in 1932.

In 1934 a step of the first significance was taken by the creation of the Joint Committee on Community Nursing Service of the three national nursing organizations, Lulu St. Clair becoming its executive secretary in 1936. In 1936 Rochester joined the group of cities with community nursing councils. In 1937, Boston, Essex County, New Jersey, and Saginaw, Michigan, followed suit. Recently definite steps for the formation of councils have been under way at Albany, New York; Battle Creek, Flint, and Kalamazoo, Michigan; Los Angeles, California; Rhinebeck, New York; South Bend, Indiana; and Washington, D. C.

The Joint Committee has prepared a guide to assist in the formation of a council of community nursing which appeared simultaneously in the January issues of the *American Journal of Nursing* and *Public Health Nursing*. This admirable document outlines a program for a comprehensive analysis of the problem based on a survey of local needs and local facilities, formulates the broad objectives of a nursing council, and develops detailed plans of organization. The Joint Committee has also prepared a valuable reference reading list on the subject.

Among the older councils, Detroit has perhaps most nearly approached the ideal of such an organization. Among the communities which are now developing councils, Rhinebeck, New York, and Battle Creek and Flint, Michigan, have broad and constructive programs in view. At Rhinebeck, there was actually organized on March 28, the Northern Dutchess County Community Nursing Service with a nursing committee already appointed and with consultant service from the Joint Committee on Community Nursing Service in New York. The headquarters of this organization will be in the community hospital at Rhinebeck and all types of nursing service, with the exception of institutional care, will be distributed through this one office. The Thomas Thompson Trust is subsidizing the program over an experimental period.

In spite of the slow progress of the past ten years, there seem no insuperable obstacles which need bar the way to the development of an organized community nursing service which would be adequate and complete. If we could start with a clean slate, free from the prepossessions of the past, what could be more natural than to organize all the nurses working in the homes of a community under a single community nursing bureau? Such a bureau should not be conceived as an employment office or as a union for the furtherance of professional income and prestige, but as a public service agency. It should have as its chief function the provision of qualified nurses for all

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*Reid, Grace L.: Councils on Community Nursing.*
forms of bedside care in the home, whether intermittent or continuous. It could also play an important rôle in providing special nursing in hospitals, whether intermittent or continuous. Its organization should provide for the supervision which is essential to adequate service; and its nurses should, preferably, be on salary, with due opportunity for that progressive advancement which is so desirable for professional morale and so sadly lacking in private duty nursing today.

The relation of the community nursing bureau to existing voluntary public health nursing associations may be worked out in various ways in different communities. In some places, the visiting nurse association might expand its field to include all forms of bedside care. In others, it might be fused with a newly-formed nursing bureau. In still others, two separate organizations might perhaps operate on an intimate coöperative basis.

In any case, the Joint Council on Community Nursing should continue to function as a center of coördination between the nursing bureau, rendering bedside care in the home, and the educational nursing service of health departments on one side and the institutional nursing of the hospital on the other. This Council should provide for joint thinking in respect to needs for nursing service and evaluation of results. It should be in a position to supply both hospitals and health departments with aid in the securing of adequate personnel and to furnish opportunities for continuing education for all the members of the group it represents. It should be able to insist on such remuneration and conditions of work as will make the highest grade of professional service possible.

Finally, such an organization should have as one of its major functions the interpretation of the local nursing program to the community. It could bring to bear effective evidence in favor of those substantial increases in allotment of funds for public health nursing which are urgently needed to meet the demands of a modern health program and to secure an adequate income for the nurse. Taking a longer view, it should concern itself with the even more fundamental question of obtaining adequate financial support for basic nursing education—without which all of its program will be built on shifting sand.

The problems of medical care are twofold in nature. There is, first of all, the organization of particular professional services so that the personnel concerned can function most effectively for the common good. This end can only be attained by some form of group practice; and it should be the first function of the council to develop such group practice in the nursing field. The second problem is the development of a sound basis of payment for the services rendered. This can only be attained by contributions from tax levy or voluntary agencies for the lowest economic group and by a system of group payment for families on the middle economic level. The basic problem of medical economics is obviously the unpredictable distribution of the burden of illness. As I pointed out at Detroit:
The Committee on the Costs of Medical Care showed very clearly that the total economic burden of medical costs is by no means excessive; and that the crux of the whole problem is the unequal incidence of illness. It is this chance distribution which, under present conditions, brings it about that one family in a hundred in a given year must pay out a quarter or more of its annual income for medical care. The obvious way to meet such a situation is through some application of the insurance principle, that is by the accumulation, through fixed annual contributions from a group, of a reserve to pay for the emergencies of illness. The very poor cannot even contribute to a sickness-insurance fund and the very rich may not need to do so. In between is a large section of the population which could bear the average cost of medical and hospital and nursing care on an annual payment basis but cannot meet the expense of an emergency illness when it comes without previous provision.\(^6\)

The idea of paying for home nursing service on an annual payment basis has been tried out in New York and elsewhere without great success; and I confess I am doubtful whether such a plan can be developed by itself. The public is perhaps not yet sufficiently conscious of the need for home nursing to support such a program. It would, however, I believe, be relatively simple to develop nursing insurance as an adjunct to hospital insurance. The hospital insurance plan is now an assured success and offers an adequate solution of the financial problem of the middle economic group so far as hospital charges are concerned. It would be relatively simple to expand the hospital insurance plan to cover nursing in the home by a very moderate increase in the annual fee; and such a plan would be of great advantage to the hospital since it would make possible the care in the home of certain cases which must otherwise be hospitalized, with corresponding decrease in institutional costs.

One of the things which most attracts me in any plan based on group payment is that it opens the door to the development of the principles of consumer coöperation; and to me consumer coöperation is the most promising of all approaches to a better social order. Maurice William\(^7\) has analyzed this subject in a notable work which is far too little known among his compatriots, although it was powerful enough to change the entire philosophy of Dr. Sun Yat Sen and to exert a profound influence on the social evolution of a great nation on the other side of the globe. In this book William points out that the major fault of Marxian socialism, as of traditional capitalism, is primary emphasis on man as a producer. If one thinks of oneself as a member of a group providing a particular service (professional, manual, or economic), all the defensive impulses of class solidarity are at once called into play; social evolution becomes—or remains—a conflict between competing selfish interests. When one thinks of oneself and of others as consumers, as human beings with human needs, the whole picture changes. The need for coöperation is obvious. The concept of "service" becomes a reality and not a catchword. It is easier to realize

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that we work to live rather than that we live to work. The ultimate aim of the good life for all emerges into the center of consciousness.

In buying groceries, consumer cooperation can be directly initiated by a group of consumers sufficiently intelligent and public spirited; but in the case of a professional service like nursing, the profession itself must take the lead. Its program must be formulated with the interest of the public in mind and with the intent and desire of recognizing consumer interest and encouraging consumer cooperation in management. It must be worked out in coordination with the two other major agencies now organized for community health service—the health department and the hospital. Yet primary leadership must come from the profession itself. Only nurses can provide an ideal organization of nursing to meet community needs just as only physicians can provide an ideal organization of medicine for a similar purpose.

This is merely one small phase of a fundamental social problem which faces our whole modern world today. Four years ago I said at the biennial convention, that we, in the United States, accept the necessity for national planning, for an organized and purposeful program which will ensure a richer and fuller life for the individual citizen. We hope, however, to realize that program within the framework of the existing political and economic order and without a sacrifice of the precious values gained through three centuries of democratic ideals. It is an evolution, not a revolution, at which we aim. It depends on leadership and not on mastership. If it fails, there is no recourse but to follow the alternative road.

"This, then, is the challenge of today—to the world as a whole, to the nation, and to each professional or business or industrial group within the nation. Social planning we must have. The activities of each group must be so ordered as to yield the fullest results to the whole society in which that group functions. The wider good must rule, and not the selfish interest of any trade or business or profession. This we may take as established.

"The question is whether such social planning can be accomplished by the group itself under democratic leadership or whether it shall be forced by dictatorship. There is no other ultimate choice but chaos.

"No one desires dictatorship, except dictators. The sacrifice of liberalism is always a forced capitulation, a confession of failure. The fate of liberalism for centuries perhaps depends on our success." \(^8\)

Essentially the same problem confronts each professional group within the nation itself. Can the banker, can the industrialist, can the labor union, can the doctor, can the nurse, meet the demands of a new social order without external force but by the processes of democratic cooperation?

In the case of nursing, I feel confident that the answer will be "Yes." Organization has, of course, always been characteristic of one field of nursing service—that which is carried on within the walls of the hospital. Even the

\(^8\) Op. cit.

physician enters into new forms of professional relationship when he joins
a hospital staff. The nursing staff, however, from pupil to superintendent,
is completely organized for professional service. Three-tenths of your pro-
ession is today engaged in such organized institutional nursing. Another
tenth is in another organized field, that of public health nursing; and the
phenomenon is of special significance since this type of organization has been
chiefly effected on the initiative of the nurses themselves.

The obstacles in the way of fully organized community nursing are not, I
am convinced, intrinsic in the technical or social situation. The job can be
done to the advantage of both the profession and the public. The real
difficulties are psychological and inhere in the fears and hesitation, the
suspicions and jealousies of the human beings concerned—nurses, doctors,
board members, hospital directors, health officers, chest executives, patients.
I do not underestimate these psychological difficulties. They are very great;
but they can be overcome.

The most significant contribution of the twentieth century is a recogni-
tion of those powerful emotional obstacles which must be dealt with in such
a situation. Freud—now an eighty-year-old invalid suffering persecution
from brutal Nazi bandits in Vienna—has taught us that the individual hu-
man being is generally motivated by subconscious urges rather than by logic.
Pareto has shown us that the same principles operate in the field of sociology.
James Joyce in literature, T. S. Eliot, C. Day Lewis, Auden, and Spender
in poetry have cut below the world of acts and words to the stream of
emotional revere which so largely determines our daily conduct.

It is through the understanding of such processes that we can learn to con-
trol our own reactions and those of others. Human nature is a complex
thing. Each one of us can be roused by appropriate emotional stimuli to
defensive anger; but each one of us can also respond to a different appeal.
We can press the stop which liberates a harmony of service as easily as that
which releases discords of self-interest.

Above all, however, the study of mental hygiene should lead us to replace
in some measure purely emotional appeals, both good and bad, by the proc-
esses of reason. It teaches us to ignore slogans and to seek facts, to hold
our subconscious urges in leash, and to face a world of reality.

The Book of Proverbs tell us that "Where there is no vision, the people
perish." What I would plead for today is vision, vision which sees through
all the veils of habit and tradition by which we are walled in to the real
needs of the human beings in our communities; and the courage to follow
that vision and to meet those needs.

The ancestors of the Maoris are supposed to have voyaged in tiny boats
from the Society Islands, a distance of two thousand miles to New Zealand;
and a good Maori can tell you which craft his own tenth-century ancestor
traveled in just as a New Englander boasts of the Mayflower. The head of
the party was a great leader named Ru. Many perils did they encounter, but
Ru calmed their fears, and surmounted every obstacle. When there was a
storm, or a whirlpool, all he said was, "Have no fear, I am Ru, who knows the sun and the stars. Take up your paddles." At last, however, there was a time when the heavens were so overcast that the stars themselves were veiled. Then Ru was forced to pray for help. And his prayer was in these words, "O God, clear away the clouds that Ru may see the stars to steer by to the land of his desires." Not a prayer to be miraculously transported to that land, to be saved by some force to which he would surrender all his problems. Just a prayer for light to be enabled to do his own work competently and well. That is the prayer which we may all make today.

ORGANIZING FOR BETTER COMMUNITY NURSING SERVICE

Discussion of Dr. Winslow's address

GRACE L. REID, R.N., Strong Memorial Hospital, University of Rochester, Rochester, New York

The people of Israel were warned long ago that "there is no new thing under the sun," and I am warning you that I have not one new idea to present as a solution to our problem of disorganization in community service, but there are a few firm convictions which may not be out of order in this discussion.

Professor Winslow has outlined, step by step in the preceding paper, the developments necessary to better service. Different communities over the country have tried some of these methods with more or less success, but up to the present time there has been no concerted effort in any locality to centralize all forms of nursing service under a so-called nursing bureau.

What has already been done to carry out the developments which have been suggested? Surveys have been made in different communities, nursing councils have been organized, registries have been examined more critically, advice and constructive plans have been offered by the Joint Committee on Community Nursing Service, and last—and possibly one of the most important of all steps—a curriculum has been evolved for schools of nursing which is designed to prepare our graduates to think of their place in the community rather than of their work as it affects individuals and small groups.

What is the value of a survey? "In order to get to where you want to go, you have to start from where you are." If a community does not know what it already has to work with, constructive planning, obviously, is difficult. Different motives have initiated surveys, but I believe I am safe in saying that when, in the beginning, the emphasis in making the study was, for example, on the facilities for educating nurses in that community, the tendency shifted as time went on toward recognizing that the problems of distribution of service were the most pressing of all needs.

Surveys, more or less comprehensive, have been made. Now what shall be done with them? When a faucet leaks, we report it to the maintenance department—but that doesn't mean that we can thereafter forget the faucet.
In the multiplicity of demands, the faucet may go on leaking for some time if there is no follow-up by the person who reported it. Just so with surveys. The survey itself is important and unquestionably informative, especially to the group of people who made it, but if the findings are not pretty generally publicized as a means of convincing the community where the trouble lies, then the conditions which might and should be corrected are at a standstill, if we are fortunate; but it is more likely that the conditions will grow worse as they grow older.

The tendency toward organization of nursing councils in many localities is a hopeful sign. Even this idea required a long time to percolate, for it is twenty-four years since the first group of this type was organized. Verily, the mills of the gods grind slowly, and the record which Professor Winslow has reviewed proves how many years it takes to make ideas really productive. Without a welding of community thinking, which is the expected or hoped-for outcome of a nursing council, there can be no acceptance of a desired or common goal, no unity of purpose, no continuity of planning, and no possibility for combining resources. Furthermore, nurses have been too prone to function under a policy of isolation, keeping their activities almost entirely within their own group instead of drawing in the non-professional but public-spirited citizens. For that reason, nursing councils should be a broadening influence for the nurses themselves as well as for the citizens.

The registry seems to be the significant and crucial area in community organization at present, as it has been for years past. It has become increasingly evident that many communities are groping for something to improve their nursing service, but no one seems to know just what that something should be. Undoubtedly it differs in some way in every city. A plan which might function in El Paso would need to be changed considerably for Chicago. Most sizable cities have some sort of nurses' registry which has functioned mostly as a center from which nursing service has been dispensed to homes and hospitals. In most instances these agencies have been in charge of nurses who have conscientiously struggled to fill the calls and please every one concerned, with indifferent success. Many of these registrars deserve some sort of decoration for carrying on at all when they have been expected to do the work of about three people. With such a tremendous amount of work to be done, how could they be expected to be aware of all of the trends in nursing and the changing demands, or to find the time to develop their registries to the highest point of efficiency?

The plan for a distributing center from which every type of nursing service might be dispensed seems ideal. With such a plan, there might be better knowledge of the whole situation, less duplication of effort, and more satisfactory results. It is a pleasant diversion to dream of a nursing bureau, comfortably housed, sufficiently staffed, where every person equipped to do nursing would be registered, and then assigned according to the type of work she might be especially qualified to do.
Dr. Winslow has said there are two distinct types of questions involved: the problem of service and the problem of payment. Another way of saying the same thing is that there are two sides to a nursing bureau: the human side and the business side.

If the human side dominates our thoughts and plans, we shall come nearer to establishing sympathetic coöperation with the public. From the standpoint of the patient, for whom this service exists, the advantages of organized nursing seem indubitable. We have the right to hope that the average member of our profession has sufficient social vision to picture an integrated service for her community, in which distribution is centralized, coöperation of all groups concerned is as perfect as possible, and the needs of the people are really met. We have heard about it for years at conventions and committee meetings, we have read about it in our nursing journals, and there seems to be no reason why every member of the profession should not have been informed, but it is too often apparent that the potentialities of the registry are only dimly realized, especially by the group for which registries were originated. There are of course many straight thinkers who are quite receptive to the idea of a bureau developed along the broadest lines.

Dr. Winslow encourages us in saying he can see no insuperable obstacles and we hope his vision is as true and clear in this instance as it has proved to be so many times. What obstacles can we see? Here are some: (1) Schools of nursing still exist in which careful selection of students is not considered of paramount importance; (2) even if students are selected with much consideration so far as their background and basic education are concerned, they are not always guided through their training to see themselves as a part of the whole community into which they should fit their contribution; and therefore (3) many of them graduate with too narrow a viewpoint and often with real resentments and antagonisms toward the milieu in which they find themselves. Until we can come nearer to eclipsing our personal desires and preferences by a sincere willingness to give up a little of our cherished independence and devote ourselves a little more unselfishly to real service to those who need us, we do not deserve to belong to a professional group. The fear of the nurses themselves that in this process of reorganization they will lose and not gain, has been one of the greatest obstacles to progress. As a matter of fact, many of their problems might very well be eliminated through better organization.

Sooner or later, usually sooner, we are confronted with the business side—with disturbing budgets, and with questions as to sources of income. Some time ago, a radio speaker delivered the following epigram: "Money never made an idea, but an idea has made money." Nurses have always raised money if they wanted it badly enough: for instance, to finance the Grading Committee, for the Delano Memorial, for the Bordeaux School. Why not for nursing bureaus? The insurance plan which would include nursing care as well as hospitalization seems perfectly feasible. If registries could be subsidized to the point of employing a few private duty nurses on salary
to supply hourly or appointment service until the value of such a service could be demonstrated, it seems certain that more rapid development would ensue. We might hope for substantial assistance from community chest funds and, if the local nursing program were properly interpreted to the community (proof of which interpretation is a satisfied public), we might also hope that appreciative citizens would contribute toward the support of such a worth-while project. It is consoling to remember that our profession does not stand alone in the need of funds; that is a constantly recurring problem in any field of endeavor.

A group of members of the Joint Committee on Community Nursing Service is working on a tentative plan which may be submitted to communities about to organize some form of centralized service. Knowing the pitfalls, the setting up of such a plan has been approached with much trepidation. No one knows the answer to the question, "How much nursing does a community need?" or, "How are we going to finance our program?" but we are working on the assumption that perhaps we shall be inspired to suggest a plan which can be adapted to various communities. It seems reasonable to suppose that a community can determine some minimum and add to that as development progresses and needs arise. Certainly community participation is a deciding factor in determining how much nursing will be used by a given locality and in furnishing the machinery to execute plans.

Although the organization of community service must begin with a plan, it sometimes seems as if the fundamentals of the plan are far beyond our reach. Financial problems loom large, but there is also the question of providing competent and qualified personnel. It has usually been left to the nurses to do the "pushing" and the leaders who would naturally take on this responsibility are already carrying such a heavy load that they haven't much energy left for pushing.

And now we come to the final and probably basic consideration, the education of the nurse. The curriculum published last year, if carried out as intended, should be instrumental in producing graduates with receptive and coöperative attitudes, graduates educated not only to care for all types of illness but to see the larger aspects of nursing as a social unit in community life. Some of our difficulties can doubtless be attributed to the fact that student nurses were not always given the broader viewpoint and therefore they did not understand, either as students or graduates, their function in coöperating in community activities. Successful service depends to a large extent upon the quality of students admitted to our schools of nursing, and then upon educating these students to think of patients as individuals who make up the community group. If this is emphasized throughout their school experience and in their instruction in the school, the hospital, and the outpatient department, and if this incorporated public health viewpoint is strengthened by at least two months of well-planned experience in the community, they will more easily fit into their rôles and adjust more favorably to
professional situations. With such teaching I venture to prophesy that a
good many of our problems will be liquidated.

Someone has said: "Administrative reforms come through finding out
what is wrong, getting groups of workers together, talking over possible
solutions, then trying them out one after the other, until some experiments
are found which work." That statement was made years ago; it is just as
true today.

**RELATION OF SUBSIDIARY WORKERS TO COMMUNITY
NURSING SERVICE**

**ELLA HASENJAEGER, R.N., Chairman, Joint Committee To Outline
Principles and Policies for the Control of Subsidiary
Workers in the Care of the Sick**

There has been so much discussion about the subsidiary worker in relation
to nursing service, and so much concern felt in regard to this problem, that
an analysis of the existing conditions and the needs for such workers is
timely and exceedingly important. If we, as a nursing organization, believe
it to be our responsibility to provide nursing to the community and to meet
the demand for nursing including all the levels of nursing service which
may be required, we have much to accomplish in order to prevent exploita-
tion of the public by any worker who, regardless of preparation, may decide
to nurse for hire.

In 1934, Alden B. Mills at a session of the National League of Nursing
Education discussed the need for subsidiary workers in nursing services from
the point of view of the Committee on the Costs of Medical Care. Subsidi-
ary workers, or nursing attendants, were defined by the Committee on the
Costs of Medical Care, as persons

Competent to furnish simple nursing service under the supervision of visiting
graduate nurses, who are willing to do housework when necessary, and who accept
somewhat lower rates of pay.¹

As reasons why such attendants are needed, Mr. Mills cited the following
needs as not usually filled by graduate nurses:

1. When the mother or homemaker is ill, nursing attendants will not only nurse her
but also do simple cooking, cleaning, light laundry, and the other activities necessary
to keep the household running. Often the smooth running of the household is almost
as essential as medical treatment in speeding the patient's recovery.

2. In the care of chronic or convalescent patients where the nursing needs are light
and do not constitute full-time employment, the attendant is willing to do other
duties so that her employment may not be too expensive for the family.

3. The nursing attendant should and will, if properly supervised and controlled,
work for smaller pay than the graduate nurse. In Brattleboro, graduate nurses in
1930 charged $49 a week while nursing attendants charged $21 to $30 a week
depending upon experience. This was an important consideration to a large pro-
portion of our families even in 1929.²

¹ MILLS, ALDEN B.: The Need for Subsidiary Workers in Nursing Services.
² Ibid., pp. 160-161.
In addition to the needs mentioned by Mr. Mills, I believe that the worker in the hospitals, both mental and general hospitals, who aids the nurse in making closed beds, in cleaning, in caring for the convalescent, and in many other duties makes for the successful administration of the ward or hospital.

It also seems to me that there is a need for subsidiary workers in the homes for the indigent and in welfare houses. In the study of homes for the indigent and in welfare houses made in 1937 in New Jersey, we found that 62 per cent of those which employ persons for nursing services utilize the services of subsidiary workers, because, as several stated, the average graduate nurse is not interested in that phase of nursing. In these situations, we found that the salary range was not much less for the subsidiary worker than for the graduate nurse.

It is also my belief that the care of patients with protracted illness in certain types of institutions could be facilitated by the use of these subsidiary workers.

In a study made of illness as it is related to nursing care in three visiting nurse services in New Jersey, in 1937, it was found that all those who answered the questionnaire used housekeepers, since the nursing and nursing supervision were performed by the visiting nurse services. This fact illustrates Mr. Mill's suggestion of a combined "nursing-housekeeper service."

The further development and growth of hourly appointment nursing services certainly seems to be a step in the right direction. This type of service might also be put into effect where visiting nurse associations are not in existence.

Most of us are not ready to accept on sight the viewpoints of others and discussions of subsidiary workers have so frequently centered around personal opinions rather than around factual data, that we as a group should put forth some effort to learn for ourselves, in each state, what the existing conditions actually are with respect to the need for, the use of, the extent of the need, the source of supply, and the public demand for subsidiary workers.

While we know from registry reports that "where the non-professional registrant is called for nursing service, the types of service for which they have been called are fairly evenly divided between acute and chronic illness," but we cannot do anything about it to protect the public unless we know actual conditions in our own state. No legislative body will pass a law based on the findings of some other state or states. It behooves all of us then to do something about it. Three principles of mental hygiene can here be applied, but first we must get the facts, "then face the facts, tell someone about it, then do something about it."

Now then, how can we get at the facts? The Joint Committee To Outline the Principles and Policies for the Control of the Subsidiary Workers in Nursing is ready to submit to you a plan for the study, and samples of

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4 Report of the Director of Headquarters, American Nurses' Association, to Board of Directors, January 1938, on file at ANA Headquarters.
questionnaires which were used in one state to get at the facts. The New Jersey State Nurses' Association appointed a Committee To Study the Need for Subsidiary Workers in Nursing in January 1937. Its first meeting was held in March 1937, at which time a tentative plan of study was discussed.

This Committee consisted of thirty-two members who represented the following organizations, groups and individuals: the Medical Society of New Jersey; the New Jersey Hospital Association; the New Jersey State Department of Institutions and Agencies; the New Jersey State League of Nursing Education; the New Jersey Board of Nurse Examiners; the New Jersey State Nurses' Association; directors of nursing services; public health nursing organizations; an attorney; the field of household economics; interested citizens.

The plan of study was adopted and immediately put into effect. Questionnaires, formulated with expert advice, were sent to: (1) medical men throughout the state representing different phases of medical service; (2) lay persons representing various income groups (some of the lay group were reached through the visiting nurse associations); (3) directors of homes for the indigent and the welfare houses throughout the state; (4) registries including nurses' professional registries, hospital registries, and those listed with the Department of Labor and Industry.

The New Jersey State Nurses' Association contributed $100 and the Medical Society of New Jersey $50, to carry on the project. The Board of Directors of the New Jersey State Nurses' Association has given permission to present any of these findings which may be of interest.

The final report of the Committee was exceedingly gratifying to all members present. The recommendations represented the unanimous opinion of the group and were based on the findings of the questionnaire. They are as follows:

1. That "nursing attendant" be used as a title for this type of worker.
2. That all persons, men or women, who nurse for hire be licenced by the State Board of Nurse Examiners and that established standards for the worker be set. A bill to be presented to the legislature as soon as possible.
3. That nurses' professional registries or community nursing bureaus be established throughout the state which will enrol registered nurses and licenced nursing attendants.
4. That further study be made of the types of institutions in which nursing attendants shall receive their technical experience. It is the recommendation of this Committee that: (a) nursing homes, (b) homes for the indigent, (c) homes for the aged, (d) institutions for the chronically ill be considered as suitable places for this experience.
5. That further publicity and further information be given to the physician and to the public regarding the services available by the visiting nurse services throughout the state.

The findings in New York State which finally resulted in the presentation of a bill to control by licensure all persons who nurse for hire demon-

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*S. Nurses' professional registries to meet the minimum standard of the American Nurses' Association.*
strate how very inadequate our protection of the public has been. We know that in New York there are more than 36,000 registered nurses and an estimated 41,000 unclassified workers who are engaged in nursing. These unclassified workers thrust themselves upon the public without any control and the public has no knowledge of their fitness or preparation for nursing. Since licencing is believed to be a means of protection of the public, these figures make us realize how little has actually been done to safeguard the health of the public in regard to nursing.

It is gratifying to know that the bill presented in New York which requires a license for all workers who nurse for hire became an act on April 6, 1938, when it was signed by the Governor.

Some may say, "But some states licence these attendants." That is right, a few states do licence trained attendants, but they are a classified group, not made up of those who have been dismissed from schools of nursing because of lack of fitness for nursing, or of those who have taken short courses or commercial courses set up by someone or some group whose motive is personal profit rather than public service. We must also bear in mind that New York is to date the only state which makes it necessary for all who nurse for hire to be licenced.

We are informed that a physician in a certain state charges $150 tuition for a few weeks' course in which set-up he provides the lectures, and his wife who is a nurse gives the practical instruction. Those who completed the course received certificates as graduates from Dr. X's course in practical nursing.

Another school in a certain state, so we have been told, conducts a commercial registry and graduates between fifty and sixty people every three months. These women are assured employment and are employed in homes during the time they are taking the course. They receive about one hundred hours of instruction; when they graduate they are given a pin in addition to a certificate. These so-called "nurses" usually receive $25 weekly, but may and do charge as high as $10 daily. The income to the founder of this school exceeds, from the school alone exclusive of registry income, $12,000 annually. Two graduate registered nurses conduct the school.

The Medical Society of New Jersey, although it does not approve commercial schools, has been instrumental in seeing that courses were established in connection with the three vocational schools in the state. Of the physicians in New Jersey who were sent the questionnaire regarding standardization with subsequent licensure and control of subsidiary workers, 90 per cent of those who answered the questionnaire believe this should be done.

Some hospitals which formerly conducted accredited schools of nursing have established courses for practical nurses. This we believe to be an exceedingly bad innovation, since hospital courses may become misleading.

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to the public. Experience in the past has shown clearly the inadvisability of this method of developing subsidiary workers.

One hospital administrator found, with one year's experience, that every graduate of a short course was in the field posing as a graduate nurse from the hospital and charging the graduate nurse's fee.

Also the establishment of such courses in hospitals is usually mainly to balance their budgets.

The article, "Angels in Blue Gingham," which appeared in Good Housekeeping magazine for November 1936, discusses the services given by graduates of the training school of the Household Nursing Association, Boston, which is under the direction of Katharine Shepard, R.N., Superintendent. This school was established in 1918.

While these attendants are expected to perform light household duties, the regulations regarding housework are as follows:

The attendant nurse expects to perform light duties around the house when she can be spared from the patient. These duties do not include sweeping or washing floors (except the patient's bathroom), washing and ironing the family laundry or waiting on table. The attendant nurse will always do an infant's washing. She will prepare all the patient's meals when necessary or do simple cooking for a small family, but cannot be expected to cook for a large household or for parties.

The attendant nurse is well prepared to take all the responsibility for well children, but this cannot be expected when she has also to care for a bed patient.

The office may be asked to make the decision when there is any doubt about the attendant's duties.7

According to the 1937 report of the Household Nursing Association, the salary for graduate attendants on the registry is $25 weekly for twelve-hour duty; $29 weekly for twenty-four-hour duty; while attendants under supervision receive $20 a week.8 The length of the course is two months' household training and twelve months' training in bedside nursing, with six months of follow-up supervision after the completion of the course.9

The registry report for the Household Nursing Association for 1936 indicates that during that year, the registry was unable to fill all calls:

One reason for this lack of attendants is that during the years when it was so difficult to find work for them after graduation, we limited the number taken in the school and are still feeling the effect of this policy. Another is that we are weeding out all the registrants who do not keep up to our standards in order to be assured of giving better service to the community.10

The publicity of this school is unusual. Besides the article in Good Housekeeping magazine entitled "Angels in Blue Gingham," which brought nine hundred letters to the school, a moving picture called "A Real Career" was

7 From "Information About Our Service." Household Nursing Association, Boston, Massachusetts (no date).
8 Review of the Year 1937. The Household Nursing Association, Boston, Massachusetts, p. 8.
9 Ibid., pp. 3-4.
10 Review of the Year 1936. The Household Nursing Association, Boston, Massachusetts, p. 4.
made showing the progress of a young woman through the school and her after work with a few typical patients.

All the implications in the problem of subsidiary workers in nursing are too numerous to mention in this brief space, however, I wish to quote from a communication received at national nursing Headquarters, from Richards M. Bradley of the Thomas Thompson Trust in Boston, this statement: "We shall never accomplish much of anything until leading nurses are willing to undertake the provision of needed service." He also says:

The attendant or household nurse, acting as the successor to the practical nurse and doing the work that the practical nurse once did, is now a recognized part of the American system of caring for the sick, and her use for the purpose for which she is fitted is destined to increase greatly in the near future. . . . She cannot be exterminated for she fills a recognized and legitimate need of the family for that kind of help. . . .

A better way out . . . is to be found through having the nurse take part in a better-organized, better-equipped, and more useful service for the people, in which the properly prepared graduate nurse will find a place where her position will be more satisfactory and her compensation more just and adequate.

We need to give attention to the community nursing and service bureau as a clearing house for all calls for help in sickness. . . . The numbers added yearly to the graduate ranks should be made to correspond more nearly to the actual demand for her services, and not to the exigencies of balancing hospital budgets. . . .

The nurse's education should be fitted more nearly to her potential field of action in the homes of the people, as well as in the hospital. . . .

The field for the graduate nurse can be made wider if she has the right training and can be intelligently placed and adequately financed. By this, I mean not only that there is a chance for increased use of the graduate nurse in the public health field, but that, by the development of nursing service insurance plans, the services of the graduate can be made available to a great number of people who need every bit of her skill and service in private nursing.

I have seen the demand for her services nearly treble when, in a small benefit group, the experiment was tried of reducing the graduate's cost (not her compensation) by two-thirds, at an expense of between three and four dollars a year in benefit payments.11

We cannot emphasize too much the value of the establishment of nurses' professional registries which meet the minimum standard as approved by the American Nurses' Association. It is well for every nurse to review this standard and see whether or not her registry complies with it and whether or not she is supporting a service office as a clearing house for all calls for help in sickness.

It appears that the service of the subsidiary worker will be utilized increasingly each year, therefore it behooves us to consider action toward the establishment of community nursing bureaus which will control and guide the distribution of nursing service. There is an apparent hesitancy about undertaking this, however, we are apt to fear what would seem to be an expensive venture for some communities and combined with this fear are certain misgivings as to the success of any such plan.

It is believed by some that only through studies similar to those which have been made in New York and New Jersey, can facts be secured upon which conclusions and recommendations can be based which will aid in the solution of this perplexing problem.

**RELATION OF SUBSIDIARY WORKERS TO COMMUNITY NURSING SERVICE**

**Discussion of Miss Hasenjaeger’s address**

**FRANK D. DICKSON, M.D., KANSAS CITY, MISSOURI**

Miss Hasenjaeger's discussion, as I understand it, states two premises: (1) That, according to the best information obtainable, subsidiary workers in the nursing field (nursing attendants) are being widely utilized in the care of the sick and that there is every prospect that such use will increase year by year; (2) that such being the case and in order that the interests of the public and the nursing profession may be safeguarded, such nursing attendants must be educated to an extent which enables them to perform their prescribed duties and must be licenced and enrolled in a proper category in an accredited local nurses' registry or bureau. There can be no question as to the truth of these two propositions and that a solution of the problems involved is important to the public and to your profession.

At all times even in this land where the vast majority of the people enjoy a reasonable economic security, there are thousands of families whose budgets are strained and even wrecked by the expense incident to illness; in times of economic stress the number of those unable to meet the demands placed upon them by sickness is tremendously increased. In the past decade there have been increasing and very vocal demands made upon hospitals and the medical profession to meet the problem of adequate medical care for those in the low-income bracket groups and that they develop plans to this end. You, the members of the nursing profession, are facing the same problem and these same demands and, I judge from Miss Hasenjaeger's report, are encountering the same difficulties as have the hospitals and the medical profession in working out a solution of the problem. The situation you are facing is quite clean cut: namely, accepting the responsibility, which your position as a professional group compels you to accept, of providing a set-up which will ensure adequate nursing care for all levels of our population. This responsibility will be discharged only by evolving a workable plan which can only be accomplished by careful study of the whole problem approached with a broad vision, and by displaying courage to do that thing which must be done to meet this situation even though it may seem to be striking at the very foundations of your association.

I am confident that so far as the nursing profession is concerned, there will always be ample opportunity for the skilled, intelligent, and industrious graduate of any accredited school of nursing to find adequate employment either in institutional, public health, or private duty nursing provided the
standards are maintained and in this way overcrowding of the ranks is
guarded against. I am equally sure that there is a broad field of opportunity
for the subsidiary worker or nursing attendant in institutions and private
homes where the budget does not permit the employment of a registered
nurse, not merely, however, as an assistant or "flunky" for the graduate
nurse, but as an adjunct and as an independent and self-respecting attendant
on the sick. In making this statement I am not referring to the elderly
and respectable but ignorant, or at least uneducated, and too often the
dangerously opinionated type of individual who in the past has made up
the group generally referred to as "practical nurses," but to an intelligent,
reasonably educated type of individual who has been adequately trained to
perform the semi-technical duties required of her.

Under just what aegis the training of such nursing attendants should
be carried out I am not prepared to say, but I am convinced that wherever
such training is given it should not be too long, too broad, nor too deep.
The time required should be designed to place the cost of training within
the financial reach of the type of person it should appeal to and it should
be as practical and free from academic deadwood as is consistent with the
attaining of sufficient knowledge to do the type of work that they should be
delegated to do. It is only in this way that the charges for their services
can be held to a reasonable amount which will make them available to those
who require their services.

As to the training of such subsidiary workers, while I can see reasons for
objecting to educating trained nurses and nursing attendants in the same
institution—the hospital, I am inclined to believe that in the final analysis
the proper place for training this group will be found to be the general
hospital. The fear that the public will be unable or disinclined to differ-
entiate between the graduate nurse and the nursing attendant who come
from the same training school has some basis, but the distinction could be
very clearly drawn through state licencing and state laws requiring registra-
tion in the proper category at a nurses' registry. I am sure that attempts
to establish schools or institutions for the exclusive training of the subsidi-
ary worker can only result in the widespread springing up of unqualified
and inadequate schools which will plague the nursing profession just as the
old "diploma mill" for years plagued the medical profession by issuing
diplomas which mean nothing so far as training and ability go but which
for one reason or another state licencing boards will be compelled to accept.
If the nursing profession is to accept the responsibility of providing sub-
sidiary workers it will serve them, the public, and itself best by maintaining
a careful supervision over their training, licencing, and registration.

In closing, may I say that I have a great sympathy for you in your present
dilemma and I am sure that the majority of the medical profession feels
the same. The devising of a workable plan for providing nursing care for
all classes of people is a difficult one. You have made a very satisfactory
beginning with your visiting nurse and hourly nursing plans, but you must
go farther. The decision which you arrive at finally as to your attitude toward the subsidiary worker in nursing service may perhaps be one of the most important your organization will be called upon to make both from the humanitarian and the economic point of view, and is worthy of thoughtful consideration on your part. I am sure, however, that if, in charting your course for arriving at your decision, you use for your beacons those unselfish and honorable precepts which are the heritage of your profession, whatever decision you arrive at will be right. If it is right, it will be a source of continuing satisfaction to you, yourselves, and to humanity which all professional groups must serve if they are to justify their existence.

RELATION OF SUBSIDIARY WORKERS TO COMMUNITY NURSING SERVICE

Discussion of Miss Hasenjaeger's address

EMMA COLLINS, R.N., Executive Director, the Nursing Bureau of Brooklyn, Inc., Brooklyn, New York

I heartily agree with Miss Hasenjaeger's statement that we should analyze existing conditions in the subsidiary nursing field, face facts, and decide upon our responsibility toward them. In discussing these points I will ask you to consider that large group of domestic nurses engaged in private practice in the home, whose service is undefined, uncontrolled, and largely unsupervised. If we believe that knowledge carries responsibility, professional nursing should consider its close relationship to this community problem.

However, we will find that we must get the understanding help of the physician and the lay citizens, who as employers of nurses must carry the major responsibility for the type of care given the patient.

Professional registries will not recommend the unskilled nurse for an acutely ill patient, but the economic urge sometimes directs the person calling toward what appears to be the less expensive service and the true diagnosis is not known until the practical nurse reports off the case. It is hard to believe that citizens in the middle- or upper-income brackets would save a few dollars at the expense of their comfort, safety, and prompt recovery, if made aware of the peril in uninformed nursing care. Advancement along the lines of nurse preparation in our schools should go hand in hand with increased public knowledge and availability of the finished product, not only in the hospital but in the home. Many people have the false impression that when in the hospital they must have a graduate nurse, but that any one can successfully nurse the patient in the home.

The practical nurse is in demand on all economic and cultural levels. This may be because there is a general feeling in the community that the professional nurse has been poured into the hospital mold rather than prepared to meet home situations. When ill, the citizen has learned to conform to the hospital's requirements. He fears that the hospital graduate will expect
the same type of conformity from him when she enters his home. It is gratifying to note the growing emphasis in our schools upon the development rather than the submergence of personality for it is our differences and not our uniformities that make us desirable to live with.

Our nursing knowledge and skills are badly needed in the home field so much of which we have lost through our inexperience and delay in organizing for community service. Although the professional registry offers continuous reeducation in the use of nursing, the "cold," for which the practical nurse may have been called, shortly becomes pneumonia; "tonsillitis" turns out to be a septic throat infection or diphtheria; and a mild "nervous" patient ends as active psychosis, perhaps all in the ordinary course of events.

Professional nursing is comparatively young in the medical field and the doctor has long been accustomed to explaining, to the nearest woman who would take the responsibility, the nursing procedures needed by the patient in the home. She has been more apt to be the mother, wife, other relative, or neighbor rather than a nurse—and a uniform and cap inspire great confidence. When the subsidiary worker can be persuaded to show her methods acquired in this hasty manner, or from less scientific sources, the gaps in her technic and their possible serious implications are appalling.

Education of the public along these lines is difficult because the privacy of the sickroom, the rights of the employer, and the authority of the physician surround the situation. When doctor, nurse, and the prospective patient sit down together around the council table to discuss the problem of subsidiary nursing, our communities will have better service.

What can we offer to such a conference?

We know what the practical nurse should be taught in order to give safe and modern care to the subacute case. We know how important it is to supervise practice after methods are taught. We know the hazards to the sick when the amateur nurse is charged with the responsibility for treatments which if clumsily, carelessly, or improperly given, may create new avenues of infection, spread disease in the family, and endanger life. I may add that there is a growing feeling in the registry that provision should be made for friendly and constructive supervision in home nursing, not only for the unskilled nurse but for the professional registrant who is new to the field. The objective would be to aid in the progressive development of the nurse, to help with adjustments, and to assist in safeguarding the helpless patient. It should not be too difficult a project in this age of scientific progress and high standards of living. The plan of the Boston Household Nursing Association and of the Toronto Visiting Homemakers Association, both of which I have observed in operation, are good examples of helpful relationships between professional and subsidiary nursing groups and the community. Among others, Detroit has organized home subsidiary nursing care sponsored by the professional nursing group, and Brooklyn has a small project now in its second year.
CONVENTION PROCEEDINGS

Where states have established licencing regulations for all who nurse for hire and have set up definite courses of suitable instruction for the subsidiary nurse, we should have a sound basis for control of practice and safe nursing care. Our growing interest in the problem of non-professional nursing is an encouraging sign of our advancing maturity as a professional group in the community family.

The discussion of the subsidiary worker was closed by Mrs. Loring G. Robbins of Pittsfield, Massachusetts, who, as a lay person, emphasized the need to provide necessary nursing care for all in the community.

General Session

*Thursday, April 28, 10:45 a.m.*

Presiding: Isabel M. Stewart, R.N., *Chairman, Committee on Curriculum.*

*Topic: How the Nursing School Faculty Functions in Curriculum Revision—(A Symposium)*

*What Part Should the Faculty Take in Curriculum Revision*

*Sister M. Berenice Beck, R.N., Dean of the College of Nursing, Marquette University, Milwaukee, Wisconsin*

Before going into the subject of faculty participation in curriculum revision, we should agree upon the meaning of the terms *faculty and curriculum.* The word *faculty* probably brings a dozen different pictures to mind. Those who come from small schools see a little group of persons, perhaps of varying ability and preparation, including the director, one or two full-time instructors, two or three head nurses or supervisors, a dietitian, perhaps a technician, and several physicians who "lecture" to the students. Those from larger schools may visualize several full-time instructors, ten or twenty head nurses and supervisors, two or three teaching dietitians and technicians and a number of physicians who teach students certain aspects of their specialties.

*What is the curriculum?* We tend to think of it as an aggregation of courses of study, but it is something more comprehensive than that. It is the sum total of the planned experiences that form the life of the student nurse in the school and the hospital, and from which she learns. Or, if you prefer Harold Rugg’s definition, “It is everything that the students and their teachers do.”

The following is an example of an experience in a student nurse’s life: Walking across the grounds from the hospital to the nurses’ residence, she encounters a visitor who has fallen on the icy ground and apparently injured himself severely. The student, seeing him lying there, immediately wonders whether he is conscious. She stoops to speak to him. She asks herself “How badly is he hurt? What shall I do first?” Obtaining assistance,

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she helps to transport the patient to the hospital and notifies the proper authorities. Later her mind, freed from the immediate needs of the situation, may continue to think about other angles—"How could the accident have been averted? Was the visitor careless, or was the hospital at fault? Is the hospital responsible for the accident and if so, to what extent? Will it become a court case, perhaps? Just how badly is the patient injured? Will he recover? Will he be crippled? Will he be able to work again? How would inability to work affect him and his family, financially and otherwise?"

In this single incident, the student has found an opportunity to apply to some extent the knowledge she possesses of anatomy and physiology, of fractures and other injuries, of first aid, of psychology (in her approach to the patient), of sociology (in her conjectures as to how this will affect the financial and social life of the patient), and of legal problems. Perhaps she may have to serve as a witness later, should the case go to court, and her experience will be still further extended.

Is this incident a part of the student’s curriculum, even though it was not planned in the formal program? It is an experience as valuable, perhaps, as most of the situations she will encounter in the wards or the classroom, the difference between the two being, mainly, the fact that there is no instructor present to assist her in extracting from this experience as much knowledge as possible, or utilizing the experience to test whether her knowledge suffices to meet the situation adequately. However I should scarcely say that this is part of the curriculum, though the student should profit from it because of her curriculum. To let the student stumble upon incidents and gain all her experience in accidental situations would be to make life and the curriculum identical. I prefer to think the curriculum should be superior to life’s experience for learning purposes in that it is an orderly section of life’s experiences, a series of planned situations, presented in the way best calculated to impart knowledge and increase wisdom. I believe this is the commonly accepted concept of curriculum.

The curriculum has an aim or aims, the outgrowth of a basic philosophy. This philosophy may be child-centered, God-centered, humanity-centered, self-centered, state-centered, or centered around something else. It may be spiritual, materialistic, idealistic, or realistic. It may be clear-cut and concise or confused and haphazard, but in every case it is a philosophy of some sort because only philosophy can determine aims. Science can teach how to repair broken bones, but it is our philosophy—theism, humanitarianism, Naziism, communism, or some other ism—which tells us whether we ought to repair these bones in any given instance and assist the individual back to health, or whether we shall ease him painlessly out of existence to save our valuable time, to get him out of our way, or to relieve his sufferings. Even the strictly professional curriculum does not fit into a vacuum emptied of the other aspects of life, but rather forms a part of life itself, and one’s philosophy of life permeates one’s professional life to a marked extent. Therefore, make your faculty realize that a philosophy dominates the ends
or aims of your curriculum; that their philosophy will inevitably color their presentation of material in and out of the classroom and hence, their philosophy is not a purely personal and private matter, but an influence, good or otherwise, over their pupils.

Just as aims are determined by philosophy, content is determined by aims. Content, however, must be presented in some fashion or other and as soon as we bring in presentation, we bring method into our concept of the curriculum. Shall we demonstrate our content, talk about it, make the student practice it, or ask questions about it? These are methods of presentation.

We are next interested in knowing whether our teaching program is producing the desired results, so we test to find out, by whatever ingenious methods we can best accomplish this end and thus we get into another aspect of the curriculum, the testing program. We desire a certain end, plan a way of attaining it, and test to find out whether it has been attained. This is the curriculum reduced to the simplest terms—a constellation of experiences, knit together by a unifying aim or aims, made concrete by a definite body of content, imparted to others by teaching methods and, finally, tested to determine the degree of learning.

This idea of the curriculum should become the property of the faculty by means of discussion, explanation, and examples. They should understand thoroughly that the curriculum is not a sheaf of papers or a book, divided into courses of study, but that it is the thing they are doing from day to day in classroom, ward, or in the social activities of the school; it is a dynamic something, greatly influenced for better or worse by every teacher participating in it and to some extent by the pupil herself, in her ability or inability to grasp its significant features. They will, doubtless, by the time they have grasped this, see not only the value but the necessity of frequent minor modifications and an occasional extensive revision, since the body of knowledge in our field is constantly being enriched by new scientific discoveries and experimentation. The following quotation from the Twenty-sixth Yearbook of the National Society for the Study of Education excellently expresses the need for a planned program supplemented by constant addition and modification as new and unforeseen needs arise:

In this process of curriculum-making, it is necessary that a teacher have at hand at any stage of his teaching an outline of the general attitudes, the finer appreciations, the important concepts and meanings, and the generalizations which he wishes to secure as part of the outcome of his instruction. Not only must he have this outline of attitudes, appreciations, meanings, et cetera, which he sets as the goals of instruction, but the activities of children (including all the kinds of work we do in the school) should be planned in outline form in advance.

Another way of stating the matter is that that part of the curriculum should be planned in advance which includes (1) a statement of objectives, (2) a sequence of experiences shown by analysis to be reasonably uniform in value in achieving the objectives, (3) the subject matter found to be reasonably uniform as the best means of engaging in the experiences, and (4) statements of immediate outcomes of achievements to be derived from the experience. That part of the curriculum from which selections of supplementary experiences and materials are to be used as conditions locally suggest, should be planned partly in advance.
and should be made partly as new materials become available. That part of the
curriculum which represents the daily life-situations and interests from which the
immediate specific needs of students arise, should be—can only be made from
day to day.2

Unless the director has an expert in her group better qualified than her-
self to guide the work of curriculum revision, she will probably be expected
to take the leading part. Before she can hope to enlist the intelligent co-
operation of her faculty, however, she herself must have an intelligent and
very clear idea of what the curriculum is and what she desires to accomplish.
She will have the Curriculum Guide to assist her and numerous books on
curriculum construction such as Harap’s Changing Curriculum,3 Caswell and
Campbell’s Curriculum Development4 and Readings in Curriculum Develop-
ment,5 also Norton and Norton’s Foundations of Curriculum Building.6
These are just a few of the latest books; there are others of value. As for
the nursing curriculum in particular, there are a number of articles in the
1935 issue of the American Journal of Nursing, most of them by Miss
Stewart, including planning of reconstruction, planning the program of study,
the educational philosophy underlying the curriculum, standards, and the
courses and technique to be accepted. A progress report appears in the
Journal of 1936.

The state has set down minimum requirements, leaving a great many
details, however, to be worked out by the director and her faculty in the
light of their particular situation and established policies. The faculty should
become familiar with the particular professional aims the institution sets
up for attainment, with the peculiarities of the situation or institution, and
also with the state and the national Guide, just mentioned. But the director
will probably not get very far if she expects them to gain this acquaintance
themselves, unless they are a very well-prepared and enthusiastic faculty,
not too busy about other things. This information should be placed before
them in a lively, interesting manner, with sufficient discussion to ensure a
comprehensive grasp of the major features involved.

For example, if yours is a Christian institution of learning, your philos-
ophy will be definitely theo-centric (God-centered). The professional pro-
gram, in other words, must be fitted into a life ordered according to the
dictates of theistic philosophy. “Inasmuch as ye have done it unto one of
the least of these my brethren, ye have done it unto me”7 will be your
guiding star; i.e. God will be your major reason for aiding humanity, not
humanity itself. The philosophy of a school that takes no stand whatever
on religion is apt to be humanity-centered; i.e., the serving of humanity
will be its primary aim, without any special reference to religious motiva-

2 Twenty-sixth Yearbook of the National Society for the Study of Education. Public School
4 Caswell, Hollis L., and Campbell, Doak S. Curriculum Development. American Book
Company, 1935.
6 Norton, John Kelly, and Norton, M. M. Foundations of Curriculum Building. Ginn,
1936.
7 Matthew 25: 40.
Even though your faculty members may not all be convinced that your aims are the ideal aims, they should at least be acquainted with what those aims are. In a group holding varying philosophies of life, naturally there will be disagreement as to the ideal objectives.

The major professional objectives should be clearly defined also. If the course is the usual professional course of three years, then the faculty should understand very definitely that we are attempting to prepare a good bedside nurse but in addition to this, are endeavoring to give her sufficient knowledge of other fields of nursing to enable her to utilize the necessary facts to enrich her bedside nursing as well as to decide whether she will specialize in any of them later. Unless the group understand this, they may aim to prepare a finished public health nurse, or a regular psychiatric nurse and unbalance the program by too much emphasis upon content which should be introduced but not exhaustively treated.

All the preceding material is presented to the entire group, but when one desires to study actual content, it is best to have it handled by committees or individuals who, after deciding upon the objectives of the course (since each course of study has its own particular aims), study each subject separately, determining what is essential and what is useful but less important. After the content of each subject has been tentatively decided, two or three groups may meet to check content, eliminate excessive overlapping and determine where debatable material should be finally placed. For example, there may be some question as to whether preparation for intravenous injection should be placed with nursing procedures or in one of the nursing courses. The decision may be finally decided by such considerations as the frequency of the procedure in your institution, how soon students need this knowledge after being placed on the wards, in which course the time can best be spared for the procedure and possibly what types of patients most frequently receive the treatment in your hospital. Or one may wish to determine where weights and measures will be primarily taught—in the chemistry course or preceding the preparation of solutions and dosage. Again, various factors in your own situation may determine the final decision.

The time most of us can spend upon curriculum revision is limited. Faculty members often have a number of other than teaching tasks upon their hands or, if teaching occupies all their time, they are probably so immersed in endless test papers, assignments, notebooks, and what-nots, that they feel they have very little vision left, blinded as they are by the maze of everyday details, to stand off and take a good bird's-eye view of the whole situation. Yet that is what is needed for curriculum revision. One must grasp the concept as a whole, then try to fit the parts consistently into this whole. This is not so easily done when one is on the job; omitted details and inaccurate details may be more easily noted and corrected than the larger adjustments which are necessary; the director is in a better position to contribute this larger view than individual faculty members, as she is more concerned with the success of her program as a whole than with any of its
individual parts. That is why she discusses the aims and the curriculum as a whole with them.

To gather the maximum benefit from faculty participation, the director must devise a plan of systematic organization so that the work can be done expeditiously and efficiently. Poorly planned meetings, wherein valuable time is wasted in random discussions and unnecessary repetition, sap the enthusiasm of the group. Good committee chairmen must be selected. Certain subjects are much more in need of revision than others, so more time must be devoted to them. When the extra-professional program is under consideration, other than faculty members may need to be brought into the discussion, such as the matron of the residence.

Why should the faculty take part at all, if they are such busy people, immersed in details, perhaps poorly prepared for curriculum revision, or not prepared at all? To add to the difficulties, one may have a faculty unevenly matched, some being very well prepared and proficient, others barely able to accomplish their tasks with minimum satisfaction. Circumstances may make it necessary or at least advisable to retain them for the time being. Some curriculum builders believe teachers should play no part in revision.

Much discussion has been given to the problem who should make the curriculum. Especially has the question of the responsibility of teachers in this regard been a point of dispute. It has been maintained by some that only specialists can perform the intricate tasks involved in curriculum making. Others contend that, since the teacher is closer to classroom situations than the specialist, he should have a major part in curriculum development. Bagley especially emphasizes the former point of view and ridicules the latter one, as well as those workers in the field of curriculum making. He states in a recent discussion of the matter that the tendency for certain individuals to undertake study of the total curriculum problem has resulted in a state of confusion. He holds that study of the curriculum in city school systems by committees of teachers has become an educational fashion which is based on the "silly" and "tragic" idea that each community should have a curriculum of its own.\(^8\)

Others feel that the curriculum should be built through cooperation. Following the passage just quoted, the opposite point of view is also presented and the conclusion reached that:

Curriculum development, then, is a cooperative enterprise. Teacher, research worker, subject-matter specialist, psychologist, sociologist, philosopher, educator, administrator, and supervisor must all make contributions. Some make available basic materials, others provide for the synthesis of these materials, while others are concerned directly with the use of these materials in enriching and guiding the experiences of boys and girls. Efficient production at each of these points eventuates in a good curriculum. Deficiency at any point, either in quality of work or cooperation, results ultimately in a weakened curriculum. A common purpose binds this varied group of workers together.\(^9\)

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\(^8\) Caswell, Hollis L., and Campbell, Doak S. *Curriculum Development*. American Book Company, 1933, p. 73.

\(^9\) Ibid, pp. 80, 81.
sons and since you can scarcely expect busy physicians to contribute more than the barest minimum of their precious time, the number with whom you will deal regularly will be comparatively small, even if all are asked to join in the work. You want them all, even the poorest, because participation will teach them something about the curriculum and certain definite benefits, including the following, should accrue to them: They will learn what the entire program consists of and will probably become more interested in it as a whole than they ever have been before. They are much more likely to put into practice a curriculum which they have helped to revise than one which has been no concern of theirs. They will become more concerned about the content of their courses, check for excessive overlapping and by their closer contacts with other teachers, have a better opportunity to learn to correlate their work with that of others. These contacts also help them to round out their knowledge of their own subjects by enabling them to see other angles and aspects which the ward teacher, the dietitian, or another classroom teacher may present. They should get a good idea of the needs and problems of other teachers and cooperate better with them because of having worked together. All this is educational for the faculty member.

Besides the benefits the faculty members derive, some of them, at least, can render valuable assistance by trying out content, methods, textbooks, tests; they can assist in interpreting the results obtained; and help to determine essential and non-essential content, as mentioned before. Sometimes their ideas of placement are better than those of an expert who has no actual contact with the program in your institution; head nurses, for example, know what students should know when they get to their wards and how they are hampered if they do not have this knowledge. Faculty members can also make available to the group materials which they have found helpful in the classroom or on the ward. Being in the actual situation of teaching students constantly, they should have a good practical knowledge of how certain material may best be presented and to what extent it is assimilated by students. Well acquainted with the average student, they know her limitations and possibilities.

Actually writing out courses of study can be left to a person experienced in curriculum building. By fulfilling the functions mentioned, faculty members perform a large and important share of the task of curriculum revision and probably gain a great deal of real benefit from this participation.

**Faculty Preparation for Curriculum Revision**

*Compiled by Members of the Committee on Curriculum*

As faculties in schools of nursing vary widely in numbers, organization, preparation, and need, it is not possible to set up a staff program which will meet the special requirements of every school. The following plan is intended merely as suggestive of a method which might be adapted for use in either a small or a large school and which might be extended to make a
comprehensive program or telescoped for a faculty already well prepared in the use of curriculum techniques and materials.

Experience in other types of schools has shown that a curriculum cannot be successfully imposed upon any group. Success in the use of any curriculum depends to a great extent upon the insight and understanding of every staff member concerned with the school program. Opportunity to study the curriculum with a group and to work with curriculum materials under guidance tends to develop both a workable understanding of the fundamental psychology and a point of view toward the curriculum which assures right use.

Everyone who teaches in the school, including the head nurse who shares in the ward teaching program, should participate, in so far as preparation and ability permit, in the revision of the school's curriculum. In a large organization the entire faculty may be combined for some portions of the program and divided into groups for other portions, such as the study of individual courses or units of teaching. In small schools, the entire staff may work together in the study of all phases of the curriculum. When several schools are located within a short distance of each other, the faculties may organize themselves into a larger group and cooperate in such a study. In this way, younger members or members with less preparation may work with their own interest groups and so gain more direct help for their individual problems. The grouping is of importance only as it affects group activity. The leader may be the principal or a faculty chairman appointed for the study. Leadership which stimulates group thinking and democratic group relationships, with a real sharing of experiences, may secure better outcomes than autocratic leadership by an individual with superior preparation. Emphasis is placed on the fact that every member should participate in some way and the participation should be a real educational experience for all.

Techniques of teaching and learning advocated in the Curriculum Guide for use in the classroom should be used in so far as possible by the study groups. Principles suggested for use in planning courses of study should be followed in planning the group program. Thus by actual experience, the staff both interprets and tests the new points of view and the new techniques.

The length of the program cannot be determined in any arbitrary way. Faculty and school needs should determine the duration as well as the content of the staff program. The following outline suggests some of the possibilities that might be considered in planning such a program.

A. Organization of the group
   I. Members participating: Principal of the nursing school, assistants to principal, instructors and supervisors, head nurses, part-time instructors, and lecturers from other groups, such as doctors, dietitians, social workers, etc.
   II. Form of organization: This may be developed as a staff conference or divided into committees or study groups, depending on the situation and the wishes of the group.

B. Purpose of the program
   I. To show all members of the teaching staff their relation to the school curriculum
II. To familiarize the members of the staff with curriculum materials and with some of the practical techniques of curriculum study and revision

III. To study the *Curriculum Guide for Schools of Nursing*

IV. To modify the current school curriculum, in so far as facilities and present local practices and demands make modification practical and educationally sound

V. To stimulate the practice of continuous curriculum study and revision

C. Period of orientation: Survey of present school curriculum

I. What does this school offer its students today?

Discussion by principal of the aims, admission standards, and program of studies, also the facilities and resources available for the educational work of this school.

Summary of course outlines presented by respective instructors—these outlines to be placed on file for general faculty study.

Presentation of plans for clinical experience and ward teaching by supervisors and head nurses—these plans to be placed with course outlines for general faculty study.

II. What does the public expect of nurses and nursing today?

Brief reports on trends in nursing and nursing education. These reports may be made from first-hand study of the situation or from books and articles listed in the Curriculum Guide, pages 130–132.


III. Does this school prepare students adequately to meet the nursing needs of the community? Does it meet the personal and professional needs of individual students?

Analysis of accomplishments and shortages in terms of present-day needs and nursing standards.

Data to be secured from above articles or other reading; from patients' comments; opinions of nurses, doctors, representatives of the public, officers of visiting nurse associations, city health departments, et cetera.

D. Period of study: Comparison of curriculum of school with recommendations of *A Curriculum Guide for Schools of Nursing* (following suggested steps in the revision of a curriculum)

**SUGGESTED STEPS**

I. Consider the functions and purposes of the school.

**SUGGESTED ACTIVITIES OF STAFF**

Study of functions and aims to be made by a subcommittee. The committee to report to the group on a study of the present school aims, indicating possible need for redefining, broadening, or completely revising as indicated by community needs and present shortages. Discussion of committee report by the group.

6. The standards of health, recreation, and social life to be accepted.

III. Consider the general time plan and curriculum pattern and decide:
1. How years are to be divided and named, length of terms, et cetera.

2. How time is to be divided daily and weekly during each term in relation to class and laboratory, nursing practice, study, extra-professional activities, et cetera.

3. What the main strands or divisions of curriculum materials are to be; what the main course divisions are to be and how they are to be named.

4. How time is allocated to each of these course divisions.

5. How courses are to be placed in the program and flexibility of operation, concentration, and continuity provided for in the program as a whole.

6. What plan is to be adopted for articulation of courses and for integration of instruction and practical experience?

Discussion of adequacy of the present standards and conditions of nursing practice and the changes which appear necessary; to be led by instructors of nursing arts, ward instructors, and head nurses.

Conferences with residence director and social director. If possible, a student committee might report on needs felt by student body.

Suggested Readings


Committee to make one plan of the present division of time and a second plan as suggested in the Curriculum Guide. Plans to be on paper large enough for group study or copied on blackboard.

Each instructor to present what she feels is optimum for her course considering the time needed for other courses and for ward practice.

Through either general discussion or panel discussion: (1) bring out the present strands or divisions of curriculum materials and consider how satisfactory they are; (2) review the suggestions of the Curriculum Guide and secure opinions on their practicality and the need for adaptation.

Have prepared by individuals or by a committee a plan showing how clinical experience may be rotated for groups of students and what class load will be necessary at all periods. If affiliations are needed, the plan should show how the program can be worked out around them.

General discussion should include consideration of "heaviest" and "lightest" spots and also where experience and courses should be rearranged to have greater flexibility and best integration of instruction and practical experience.
IV. Consider the outline for each course.
1. The general arrangement as to time, placement, type of teaching facilities needed, type of instructor, et cetera.

2. The specific objectives of the course.
3. The content of the course.
4. The methods suggested for teaching.
5. The general organization of the course.
6. The suggestions for study and illustrative materials, texts, et cetera.

Suggested Readings


DRAPER, EDGAR MARION. Principles and Techniques of Curriculum Making, Chapters 4 and 5 (for methods used in the field of education). Appleton, 1936.


Each instructor should work with her own course, studying each point as suggested under IV and deciding what she considers desirable. When subjects are closely related, conferences should be held, e.g. the instructor in nursing arts with instructors in clinical nursing subjects or instructors in clinical nursing subjects with instructors in diet-therapy and materia medica.

If the situation warrants, head nurses in medical, surgical, or other wards may work with the respective instructors of clinical nursing subjects. Meanwhile, the head nurse on each ward may begin an analysis of the diseases represented in her ward. The results of this analysis should be compared with the master list of disease conditions in the Curriculum Guide. It may then be used as a guide in setting up clinical course content and the plan for ward teaching.

Suggested Readings


PARISA, FLORENCE R. The Teaching Unit in the Combined Course in Medical and Surgical Nursing. Forty-third Annual


For selection of objectives:


Curriculum Guide for Schools of Nursing, Objectives of various courses.

For selection of content:


Curriculum Guide for Schools of Nursing, pp. 91-92. Also content of various courses.


For determination of methods of instruction:


E. Period of evaluation and action on recommended adjustments

I. What changes should be made in the present curriculum of the school?

II. How can these changes be incorporated into the program of studies so that the best results will be secured with the least confusion and delay?

III. What additional resources and facilities would be needed to put such a program into effect? What administrative adjustments are implied?

Each individual or group responsible for any part of the program should present recommended changes and be prepared to give reasons for each recommendation. The group should consider each course to determine whether there is overlapping between courses, whether there are any omissions, whether the course is consistent with the aims of the whole program, and where the course should be placed in the program to secure the desired outcomes.

Discuss each recommendation in terms of its practicability, including resources, general set-up, and administrative adjustments involved. Decide which of these can be made at once and which can be worked out in the immediate future.
IV. What outcome should be expected from such a program? How can such outcomes be measured?

V. What has been accomplished through this staff program in providing for a better plan of education for students in this school? In faculty preparation to participate in such a plan? What additional preparation is needed? What further work on the curriculum?

A COOPERATIVE PROGRAM FOR REVISING THE NURSING SCHOOL CURRICULUM

EDNA S. NEWMAN, R.N., Director, Department of Nursing,
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The progress made and rapidity in putting this program into operation depends, among other things, on (1) the qualifications, experience, and preparation of the faculty of the nursing school and (2) the stage of development of the curriculum.

In many schools, the problem is not so much that of variety and amount of clinical material (around which clinical instruction may revolve) as it is a shortage of well-prepared faculty, lack of appreciation for the importance of individual preparation, and knowledge of techniques and teaching principles, which will make this clinical material of greatest educational value.

The curriculum itself may be at a low stage of development but if the faculty is ready to take on the task of curriculum revision and adaptation, the work of organizing the faculty is the first step.

Otherwise, the work must proceed gradually along parallel lines. These may be: (1) using the members of the faculty with superior qualifications (usually instructors and administrative assistants) as a nucleus, and organizing these as an executive committee, (2) through these, beginning to build up the curriculum, teaching them gradually, developing their responsibilities and initiative; (3) simultaneously with curriculum development, beginning to emphasize importance of faculty development and education. Individual preparation and education should be encouraged by means of “in-service” programs of staff education, as well as programs offered in institutions of general education.

After the foundation has been laid, there may be various plans of procedure. (1) Faculty organization; appointment of committees, e.g., com-
mittee to study procedures and routines, committee on records, case studies, and ward teaching. These may have representation from the medical staff engaged in teaching, other instructors of sciences, social workers. Introduce to these persons the new curriculum, carry out its provisions, if only partially, in the subjects which they teach. (2) Planned faculty meetings with definite objectives to be accomplished. These may be held to include only instructors when considering related problems; conferences for head nurses and supervisors to consider administrative policies and routines. (3) Acquainting these with progress of school, education program, study of curriculum developments. (4) Appointment of subcommittees in special departments, e.g., nurse teachers in medical nursing, obstetrical nursing, and pediatric nursing. (5) Reports from the subcommittees to the faculty meetings.

The work of actual curriculum construction may come later as the logical step in the process. Just where the greatest activity in installation will occur depends upon the stage of development and readiness for assuming responsibility. Supervisors and head nurses doing no formal teaching may aid in working on development of ward teaching program. The general curriculum committee is appointed. It may consist of the instructors in the biological and social sciences, in nursing arts, in special clinical fields, such as operating room technique, obstetrical nursing, and pediatric nursing. Selected members constitute subcommittees which work out the more detailed problems in their subjects, such as social sciences, pediatrics, obstetrics, medical nursing; the teaching supervisor may act as chairman; the other members to be head nurses and supervisors.

The general principles enunciated in Bulletin AII, Problems of Curriculum Administration, have been and will continue to be sound and helpful.

ANOTHER COOPERATIVE PROGRAM FOR REVISING THE NURSING SCHOOL CURRICULUM

EDNA E. PETERSON, R.N., Principal, Jewish Hospital School of Nursing, St. Louis, Missouri

Those of us who have been concerned directly or indirectly with the preparation and development of the student nurse in the past few years have been faced with a very definite and primary responsibility. This has, I believe, led to a personal inventory.

The theory of a democratic philosophy of education is not a new one. Dewey stated years ago that "By good teaching we mean that provision of school experience wherein the child is wholeheartedly active in acquiring ideas and skills needed to deal with the problems of his expanding life." Have we generally provided the best possible teaching in our schools of nursing? Too often, as directors of schools of nursing, we have been content to sit back and say, "We are doing the best we can under the circumstances." Have we? A careful survey of the Curriculum Guide would lead me to state that we have not. Study of the Curriculum Guide points out clearly
the way to an understanding of the adjustment aim in our education. We find that suggestions made in the Curriculum Guide are not impossible to initiate. The plan is not one of revolution but of evolution. The program as suggested is not one of adaptation of ourselves to conditions, but rather a bringing about of harmonious adjustments and relationships. In many instances the materials and facilities are at hand, but we ourselves have failed to make the correlations.

Our school of nursing does not have an endowment. The principal of the school of nursing, in conference with the hospital administrator, makes out a definite budget for the school. In setting up the program for the three-year course in the school with which I am associated, we have attempted to slowly work out the "evolution" as it is possible to do so in our particular situation.

The obstacles have been many, the progress slow, but the results exceedingly gratifying.

The faculty of the school of nursing consented to serve as a curriculum committee. The hospital administrator participated in the weekly study conferences whenever time would permit her to do so. When this was not possible, a summary report of the progress of the study was given to the administrator. Our first task was a study of the philosophy of the educational program, with its objectives as stated by the Curriculum Guide. It was then necessary to interpret these in the light of our own situation.

We at once recognized that one of the paramount difficulties we had to face was the problem of providing integration in our three-year program and at the same time insuring adequate nursing care. This meant a complete understanding of the attempted program by the administrator of the hospital, since proper blocking and paralleling of courses meant additional general duty staff nurses. This was accomplished through the suggestion of the administrator that we make time studies on the various wards and then present these time studies to the training school committee in order to clarify the need for more staff nurses. Two members of the training school committee are members of the board of directors of the hospital. This gave us an opportunity to acquaint the board with the nursing load and the fact that it would be impossible to give satisfactory nursing service to the public and at the same time conduct an adequate educational program, unless we were able to add to our personnel. With the coming program in mind, we had already secured the cooperation of the administrator in making gradual additions to the personnel by introducing subsidiary workers. We felt that introduction of more subsidiary workers was a logical beginning. Many of the duties carried by the subsidiary workers relieve graduates and students of tasks which are not of educational value and at the same time provide service that is less costly to the hospital, because the nurses' time is conserved for actual nursing duties and the patients' comfort and welfare are not sacrificed. We have during the last year been gradually increasing the staff of general duty nurses from twelve to thirty-two.
The second problem which we faced was the matter of thoroughly acquainting the staff of head nurses with the adjustment aim. It was absolutely essential to give them a conception of integration in order that they might get the perspective of their function and responsibility in relation to the ward teaching program. We cannot too definitely impress the head nurse with the fact that she is a key person in the evaluation of instruction. Theories, experiments, organization, and intentions may be ever so good, but if failure occurs at this point, much of the structure falls. Weekly planned seminars were conducted with the head nurses over a period of nine months, in order to acquaint them with the integration program. We attempted to keep before them the fact that the program must be built around the functional experiences of the student. This can be accomplished only when the head nurse and supervisor are led to recognize, through their own study, what we are trying to accomplish. We have received many helpful criticisms and suggestions for our ward teaching program from our head nurses.

The faculty, acting as a curriculum committee, received assistance and added stimulation from a consultant who was a specialist in the field of teaching, being a critic instructor at one of our local universities. It was she who kept us ever mindful of the democratic philosophy of education and assisted us in identifying our situations in order to utilize them in carrying out our aim.

In building up the students’ program, we feel we have much yet to be desired, particularly with relation to the time element. The students have a 46-hour week, and 28 days’ vacation. The whole program is in a state of experiment and transition, since we are introducing changes slowly. In the selection of applicants, we are guided by the following standards:

I. Rank in upper third of their high school class (with definite attention to the subjects taken while in high school)

II. Results of a personal interview

III. Results of a battery of tests given prior to entrance

IV. Results of a physical examination given by the school physician, which includes a Kahn test and x-ray of the chest.

All other entrance requirements having been satisfied, preference is given to those students who are older than the age requirement of eighteen years, and who have additional preparation beyond high school. At the present time, our student enrollment for a 300-bed hospital is 95. Out of these 95 students, 17 per cent have some college work, ranging from a degree in Education to one year of college work.

In setting up the three-year program, we have planned the course of studies as follows:

During the preliminary period, the students receive 105 hours of anatomy and physiology, 80 hours of chemistry, 60 hours of microbiology, 30 hours of psychology, 30 hours of sociology, and 120 hours in the nursing arts. Although a course in the arithmetic of solutions was not suggested by the Curriculum Guide, we found it to our advantage to include a course of 20 hours. The major sciences are given more intensively during the introductory period in order to build up a background for the nursing arts classes. Upon the conclusion of this
class block, the students are introduced to history of nursing, introduction to medical science, and foods and nutrition. After completion of introduction to medical science, and foods and nutrition, the work in medical and surgical nursing is begun, along with diet therapy. The medical and surgical nursing classes continue through the second year, and include units formerly isolated as dermatology, orthopedics, and gynecology. The second-year students study obstetrical nursing in their second semester, at a time when the majority are actually on the ward.

The senior year is partly given over to affiliation in public health nursing and communicable disease nursing. It also includes 20 hours in professional adjustments, 45 hours in pediatric nursing, and 20 hours in psychiatric nursing. Present plans are to increase the scope and content of the course in psychiatric nursing this coming year.

Case studies parallel the work in medical and surgical nursing, and for the most part the same instructor who conducts these nursing classes supervises the case studies, having a personal conference at the close of each study.

The organized ward teaching, including morning conferences, individual conferences, clinics, demonstrations, and seminars, parallels much of the work in medical and surgical nursing, pediatric nursing, and obstetrical nursing. This program at present provides 50 hours per year and has necessitated the development of methods for keeping records and planning conferences with the head nurses and supervisors to insure a planned ward teaching program.

The changes in our plan of teaching have meant not only the addition of some courses and increased hours in certain courses, but a concerted effort to include head nurses and supervisors in a program to gain a concept of what integration means in the functional experience of the student nurse. The changes in courses have consisted chiefly in placing more emphasis upon the social sciences, sociology and psychology, and upon an increase in the hours of chemistry, with an application of chemistry to nursing and household arts, emphasis upon the positive side of health, and prevention of disease in the first part of nursing arts.

This has been followed by a rearrangement and combination of courses in medical and surgical nursing. We feel the paralleling of units in the courses of medical and surgical nursing has been an important factor in assisting the student to integrate in her own mind. It has been necessary for us to spend a good deal of time in personal interviews, to explain our program to the doctors who were cooperating with us in giving the lectures. Many of these staff men have been working with us over a period of years, and explanations were important since adjustments had to be made in the lecture courses as well as the nursing classes. In addition to these personal interviews, we placed in the hands of each doctor outlines for the entire course, stating the objective.

The difficulties which we are facing at the present time are the necessity of repeating courses more than once a year, the immaturity of many of the students, and a lack of recognition on the part of head nurses and supervisors that when we do bring the students to the wards, the initial period of adjustment is longer than it was previously. The program demands a
gradual introduction to nursing duties, rather than a precipitation into the responsibilities of the various services in the hospital. Added problems have been the need of additional preparation on the part of all nurses concerned with teaching the students, and the necessity of instituting a guidance program for head nurses and supervisors. The present semester finds us with an experimental program in giving our head nurses and supervisors a guidance program which is being conducted by the consultant who assisted us in interpreting the objectives of our program in our attempt to set up a democratic philosophy of education.

Of this we are convinced—it is not impossible to set up many of the suggestions in the Curriculum Guide, and it is possible to gradually institute such changes without neglecting the nursing service in our hospital and at an expense which is offset by the benefits derived by the student nurse and the improved nursing care of the patients.

METHODS USED IN PUTTING THE NEW CURRICULUM INTO EFFECT

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The Bishop Johnson College of Nursing is associated with The Hospital of the Good Samaritan in Los Angeles, which is a private institution under the auspices of the Episcopal Church, with a daily patient average of 536. There are 200 staff nurses employed. The student enrollment is 70.

In the spring of 1936 the Southern Branch of the California League of Nursing Education planned study groups where the tentative course outlines of the proposed curriculum were reviewed. Copies of the outlines were then given to local schools for further study. Following this, in the fall, the Bishop Johnson College of Nursing acted as a collaborating school in studying the practicability of the proposed curriculum. Participation in these activities resulted in stimulating interest and eagerness to install the new curriculum in so far as seemed feasible.

The object of this report is to describe the methods used in the study and application of the new curriculum thus far.

The work was facilitated by the fact that some of the administrative details as suggested in Bulletin A II were already in effect, such as: (1) the separation of nursing service from the school of nursing; (2) the inclusion of classes in the eight-hour day; (3) the employment of graduate nurses and subsidiary workers; (4) the requirement of one year of college before entrance. The college subjects were specified, and included all of the biological and physical sciences listed in Group I and some of the social sciences in Group II of the Curriculum Guide.

The proposed course outlines were distributed to instructors of the various subjects, who were asked to study, use, and give opinions of same. The group concerned consisted of fourteen instructors, seven of whom were faculty members; the remaining eight consisted of a dietitian, a laboratory technician, and staff physicians.
The reports from the individual instructors were quite varied. There was some adverse criticism, but on the whole those concerned were enthusiastic, and found the use of the tentative outlines a stimulating and worth while venture.

The reports, both favorable and unfavorable, were sent to the Central Curriculum Committee through the education committee of the local league of nursing education.

Conferences with the instructors then followed, and the decision was made to integrate the teaching of Introduction to Medical Science, Pharmacology and Therapeutics, Diet Therapy, and Medical and Surgical Nursing.

This block was started at the beginning of the second term rather than the third term as is suggested in the Curriculum Guide. This seems logical since so much of Groups I and II is required before entrance, making the student ready for the subjects of Groups III and IV earlier in the course. In the Bishop Johnson College of Nursing this is a necessity because six affiliations are provided which together total 41 weeks.

Before the study of the Curriculum there was no regular ward teaching program. Supervisory guidance of individual students was all that was expected. Quoting from the Curriculum Guide (page 50): "Supervisory guidance is considered as an essential constituent of any nursing practice that can be called educational, the time for such supervision being counted in with the hours of practice." Now a regular ward teaching program is in operation. These classes are conducted by supervisors and head nurses.

Bedside clinics previously were infrequent, but now they have become a part of the regular teaching program.

In addition to the instructors the following groups were informed of the study and application of the Curriculum Guide: hospital administrators (superintendent of hospital and director of nursing service), the board of trustees, the advisory board, and supervisors and head nurses.

After more than a year's use of the new curriculum, in part, the teaching faculty is quite convinced of its practicability. It is now realized that there are some ways in which it could have been introduced to better advantage. For instance, other than reports now and then to the head nurses, this important faculty group was not sufficiently encouraged to take part in its study or adaptation, so naturally their interest was not lasting. The same is true of the supervisory group. Their interest was stimulated, but it was not sustained, and while the hospital administrators were kept informed of the changes made, they did not actually participate in the discussion and study which led to those changes.

The new Curriculum is an excellent stimulus for the older teacher. It is a very helpful guide for the younger teacher. It is a tool which should be used constantly, discriminatingly, intelligently, not by the classroom instructors only, but by the entire teaching faculty.

The end result is bound to be a better product—a nurse with social and professional growth, one properly prepared to practice nursing as an art and a science.
Round Table 1

Thursday, April 28, 2:30 p.m.

Presiding: May Kennedy, R.N., Chairman, Committee on Mental Hygiene and Psychiatric Nursing.

Subject: MENTAL HYGIENE AND PSYCHIATRIC NURSING

PSYCHIATRY IN NURSING EDUCATION

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To present the rôle of psychiatry in nursing education, I appreciate that one should have not only a close acquaintance with psychiatry, but likewise should have a sound orientation in the field of nursing education. One might distort the title to include a psychiatric study of nursing education as to its motives, its methods, why individuals go into nursing, or how individuals use the nursing profession to meet their own particular needs. This would perhaps be safer for me since I admit a lack of familiarity with the details of the plans and methods of nursing education. On the other hand, on the basis of my experience in psychiatry, I have formed certain opinions and beliefs with regard to the rôle that psychiatry should play in nursing education. Unfortunately, to the detriment of both the fields of medicine and nursing, the study of psychiatry by nurses has been largely ignored. Consequently, as a psychiatrist associated with a mental hospital I have seen the results of this and shall speak from this point of view.

Despite the fact that many of the leading educators in nursing education agree that the study of psychiatry by nurses is important and desirable, many others have not regarded it so, as evidenced by its status in the curricula of schools of nursing.

In 1932, 80 per cent of the nursing schools gave no psychiatric experience whatsoever and an additional 8 per cent gave only one month’s experience. There has been a trend, however, to include this service and in 1935 55 per cent of the accredited schools gave the nurse some experience. Nevertheless, this means that out of 1,385 schools in the United States on May 1, 1937, approximately 660 gave no psychiatric experience, and more than 50 per cent of the remainder offered less than two months’ experience. In contrast, 92 per cent of the schools gave two months or more of pediatric service and 99 per cent provided an obstetrical service.3

The evolution of the attitude in nursing schools toward psychiatric training is similar to that in the medical schools. It has been only within the last ten years that the attitude of medical educators has been changed from one of disinterest to that of laying major emphasis on the place of psychiatry in medicine. The trend is equally definite, however, in nursing education, as shown in the above figures, in that more emphasis is being placed on

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3 Statistics furnished by National League of Nursing Education, Claribel A Wheeler, Executive Secretary.
psychiatric training and experience—so much so, that the director of nursing education in one of our large hospitals told me that she would not employ anyone to have charge of a department such as surgery, medicine, obstetrics, or pediatrics who had not had psychiatric training. From my point of view, psychiatric knowledge seems even more important to the nurse than surgery or pediatrics or medicine, for the reason that it is fundamental to all of these. The fact that I regard it as fundamental, however, makes no brief unless facts can be presented which may lead you to see why it is fundamental and a necessary part of the education of every nurse. For this reason, I will attempt a reorientation of the attitude toward this subject.

THE RELATION OF PSYCHIATRY TO MEDICINE

Perhaps first it is desirable to explode the phrase "mental nursing." Miss Kennedy 2 has effectively done this in the paper she presented to a group of psychiatrists and yet nurses themselves are probably equally guilty of using this appellation. We do not speak of "physical nursing" and we have no justification to speak of "mental nursing." It is not synonymous with psychiatric nursing which is a specialized branch of endeavor, just as is surgical or obstetrical or public health nursing. The phrase "mental nursing," however, arises on the basis of the long standing illusion that all illness can be divided into "physical" and "mental" illness.

This false division may be understood in part, at least, in light of the evolution of medical knowledge, a small portion of which I wish to review. 8 Going back only to the Middle Ages, medicine was dominated by a cloud of spiritualism and religiosities, when man was a prize sought after by the demons who waged battle with the Lord for his possession. Priests played the rôle of physicians since only the spirit and soul mattered, and the body needed chastisement and torture. Then followed the struggle through the Renaissance and Reformation with the spectacular materialistic discoveries of Harvey, Koch, Pasteur, Ehrlich, and many others. The result was to discredit the existence of all phases of disease that could not be viewed in some kind of a scope or measured or tested in some quantitative fashion. These anatomical, chemical, and mechanical advances have continued, and until thirty years ago did so proportionately much faster than advances in the psychological field. But the pendulum which swung so far to the right and then to the left is beginning to approach an equilibrium again, where both physical and psychic factors are viewed with equal scrutiny.

Sooner or later most physicians and nurses have moments of a philosophical turn when they are interested in considering the ultimate cause of disease. With their immediately allied workers they hold the unique position of being the army against death—some intangible force toward which all life is attracted. From the moment of birth onward the individual starts

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this battle—a struggle against death. Expressed in more positive terms, it is a struggle to maintain life, and in the crises of disease, the physician and nurse are the last stronghold. Man, in a biological sense, reacts as do all protoplasmic masses, aided (or perhaps hindered) by his greatly increased sensitivity. Biologically we must conceive of him as reacting as a unit, a total organism, to all stimuli with either flight or fight; and the result of either may be health, disease, or death. This flight or fight reaction is not accomplished in terms of muscle alone, or liver, or brain, but as a complete entity which defies any separation into parts or segments. The older conception of a division into brain-mind-spirit and body-soma-organism is untenable; every reaction and every function of the individual in health and disease is a total one—psychosomatic, or to use Draper’s term, “psychosomatic.”

Much as I wish to believe differently, I know that only a minority of physicians or nurses make practical use of such a viewpoint. The chemical and physical advances have given us an illusory pragmatic attitude which tends to limit our diagnostic procedures to physical means, to attempt explanations only in physiological and chemical terms, and to rely for treatment on chemical or mechanical means. But every practicing physician recognizes intuitively that his extreme pragmatism in sticking to materialistic conceptions is only part of the truth. Even though he cannot reduce this particular imponderable to a ponderable and for practical reasons treats his patient for a specific organ disease, for instance of the gall bladder, he knows that the man functions in only a small part through his gall bladder. The organ is only the focal point of struggle that is also expressed in part through the autonomic nervous system, the endocrine glands, and the emotions—in short, through every body system. In this particular example of gall bladder disease, the intuitive judgment of the physician is shown in the common knowledge of the three well-known alliterative terms “fair, fat, and forty,” each of which refers not to gall bladder disease per se but to the total reaction of the individual.

We may grant that man’s struggle for life is always a total organism reaction. Disease represents a particular type of flight or fight reaction in which we can readily see that there may be varying degrees of emphasis on either the psychic or the organic components. But all disease is included in this description, even though in some instances the emphasis is chiefly on the psyche and in others chiefly on the soma; never is it entirely on one or the other.

To illustrate that every disease has both psychological and somatic factors, one may observe that even in the functional mental illnesses referred to as psychoses there are many physical disturbances, frequently metabolic disturbances as well as chemical alterations in the blood, urine, and other excretions and secretions. There are many physical disturbances which even the layman recognizes as being only a mirror image, a reflection, of the emotions. Thus,

blushing is a concrete physical expression of an emotion. Most of us are equally convinced that polyuria or diarrhea or palpitation and even gastric distress may be entirely emotional in origin. There is a large group of organic illnesses—hyperthyroidism, gastric ulcer, hypertension, migraine, certain types of asthma—which are consistently found in individuals in whom we can readily discover conspicuous psychological maladjustments. It seems quite probable that these illnesses may represent an end result of prolonged psychological conflicts.

There are a great number of illnesses in which almost the entire symptomatic expression appears to be physical in nature, including the toxic, the infectious, the neoplastic, the traumatic, and the degenerative disorders. It is this group that comprises the major work and interest of most of the practitioners of medicine, and consequently, of most nurses. It is my thesis, however, that every disease reaction is an expression of the total individual, and that in these instances the psychological component, even though inconspicuous, is of great importance.

To illustrate my point, I shall use the example chosen by Draper of a fractured femur, a condition which certainly would appear to be entirely somatic. Even though we limit our investigation to the conscious attitude and life situation of the individual, we can determine various highly important psychological responses which must certainly influence the healing process. One may first investigate the circumstances under which the accident occurred, a problem that might logically be considered first by the individual. The accident may have occurred in the line of duty, in which case it was caused by faulty machinery or some one's carelessness, and the immediate concern may be the fixing of damages and responsibility. The accident may have occurred as an act of valor, in which case the individual may have the feeling of righteous honor, possibly a sense of martyrdom or increased self-esteem. On the contrary, if the accident occurred through carelessness or recklessness, the individual may have a sense of humiliation and guilt, which are undoubtedly increased in proportion to the degree of stupidity or clumsiness involved in the causes for the trauma.

A second factor influencing the psychological reaction is the economic status of the individual. For a few, the wealthy, the holders of accident insurance, and those for whom the accident would merit compensation from the employer, there might be no concern. But for the average man with an income of $100 to $200 a month, a fractured femur entails a major psychological adjustment. What must he sacrifice? Will his job be held for him? How will his family suffer? How will he meet the medical and hospital bills? Many other similar important problems take form also.

A third situational factor may require a major psychological readjustment, and this is the factor of occupation. The individual is totally, though perhaps temporarily, disabled. If he is a professional man, he may be annoyed and concerned at the inconvenience of a forced three months' absence from

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6 Draper, op. cit.
business, but he may be able to easily adjust by utilizing the opportunity for reading, enjoying the association of his friends, and in other ways making the most of the bad situation. On the other hand, if he is a professional acrobat or dancer, the broken leg may necessitate a change in his life’s work, a condition which at best is difficult to accept.

A fourth factor in determining the total reaction and thus the adjustment to the situation is the knowledge the individual may have of fractures. This factor is strongest if the patient happens to be a physician whose mind may run immediately to deformity, shortening, fat embolus, infection, non-union, and other eventualities.

With all of these influences, I have not mentioned the individual’s immediate reaction to and acceptance of pain, discomfort, forced inactivity, the vicissitudes of life in a Balkan frame, a relative isolation from family and friends, and all the other difficulties encountered by a life in bed with one’s leg in suspension and traction. All of these factors are conscious realities, and I have given no consideration to that well-recognized dynamic portion of the personality referred to as the unconscious. It undoubtedly motivates much of the flight and fight method of every individual, and does so without his conscious recognition. It seems probable that some accidents are motivated by unconscious demands, i.e., they are purposeful, or occur “accidentally on purpose.” In every instance, it must be assumed that the unconscious plays some rôle in both the cause and the reaction to the accident.

One could apply these same considerations and others to every instance of organic disease. In fact, if we accept the concept of disease as a psychosomatic expression, one should do so. Unfortunately, we must recognize that the pragmatic point of view of the internist or surgeon usually excludes such considerations. The practical results, as shown in the average ward of a general hospital, are twofold: the individual with emphasis on the organic component is regarded as an “interesting case” whose blood cholesterol is very high and whose reticulo-endothelial system is obviously disturbed; he is a case, pure and simple, an anatomic-chemical unit whose situational and life struggles are usually not considered of sufficient importance to bear inquiry. The second and even more lamentable result occurs in the individual whose reaction carries chief emphasis on the psychic component. Such individuals are hastily passed by because the story is tinted with a functional coloring. The physician feels that such individuals are excluded from the realm of internal medicine or surgery and simply calls the condition “functional,” as if that explained everything.

While I have talked chiefly about the physician’s attitude in the above remarks, there is reason to assume that nurses take the same point of view. The results, so far as the nurse is concerned, supplement those that I have ascribed to the doctor. She is annoyed by such cases because she feels frustrated in her efforts to help them. She realizes her own lack of understanding of them and she is usually glad to be rid of them. She is all too

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willing to subscribe to the belief that nervous symptoms are a matter of perversity, or a pretense, or a bid for sympathy.

*Why Does This Situation Exist?* The answers to this question are numerous. When the attention of an alert nurse is called to such facts she is almost always willing to admit them and deplore them, but the practice continues. The answer lies entirely within our attitude which in part is explained by the present status in the evolution of medicine (referred to earlier in the paper), in part by the fact that our nursing education has never equipped the nurse to adequately handle such situations. It is this psychological component in all illness (as well as health) that leads one to the conclusion that psychiatry is fundamental and thus essential in the nurse’s education.

**The Value of Psychiatry to the Nurse in Relation to the Patient**

One may ask, what is the concrete value of psychiatry to the general duty nurse in relation to her patient? She may feel that she can do nothing about a patient’s vocation or his financial status or any of the other psychological factors cited above which may influence the healing process. Such an attitude is erroneous. She probably can do nothing about the external factors but with a psychiatric training she can do much to mold her patient’s point of view. And furthermore, if we accept the fact that every patient presents an emotional component in illness, psychiatric training enables the nurse to evaluate this factor and its management. Consequently, a knowledge of the personality and how it functions can enable the nurse not only to understand the psychological factor in the causation of disease, but place her in a position to treat the sick person and not merely his sick organ.

A working knowledge of psychiatry can help the nurse in a second important function, namely the interpretation and best method of management of the secondary symptoms in every illness—those symptoms which result from the fact that the patient must give up his work, that he is incapacitated and does not know what to do with himself, that he must be separated from his family, that he must be in a hospital, that he is a strong man reduced to a helpless invalid’s position. The results of these forced changes are familiar to every nurse in the form of infantile behavior, irritability, fussiness, complaining, exaggerated worry, increased sensitiveness. These are all symptoms of illness, illness in the broad use of the term, and are just as concrete and often far more difficult to manage than pain over McBurney’s point. Certainly, it cannot be expected that the nurse will have some intuitive knowledge of the causation of these symptoms, nor the way to manage them unless she has had a thorough-going course in theory and practice which will teach her the structure and function of the personality.

A third value of psychiatry to the nurse is its opportunity for her to make herself a therapist rather than merely being a doctor’s handmaiden. In the evolution of nursing, the nurse has changed from being a charwoman and a hospital roustabout to being the physician’s chief aid in combating disease. Nevertheless, there are far too many nurses who conceive of their
responsibility as being merely to execute the doctor’s orders. Such a nurse limits her ministrations to the physical factors—the taking of temperatures, the making of beds, the carrying of bedpans, the arranging of flowers. She charts automatically; and although the fact that the patient is tremendously worried about his mortgage being due or that he has had twenty visitors is far more important to record than the fact that his temperature is 99.2, the latter is noted and the former is ignored. Psychiatry can teach the nurse that she herself automatically becomes “medicine” for her patient. This is most clearly demonstrated in psychiatric cases but is no less true in every form of illness.

THE VALUE OF PSYCHIATRY TO THE NURSE HERSELF

In presenting the advantages of including the study of psychiatry in the curriculum of nursing education one must not omit the personal benefit that may be derived by the nurse. This has been excellently summarized by a psychiatric nurse\(^7\) as follows:

“In the course of her study of the anatomy of the personality and how it functions and misfunctions, the nurse becomes aware of difficulties in her own make-up. She gains ‘insight’ and understanding of her own idiosyncrasies, her own peculiarities, along with her knowledge of these same difficulties in other people. Her sympathy for the struggles of others is extended and her tolerance and patience toward her immediate associates are increased. Her relationships to the members of her own family become more clear and consequently her adjustment to them is facilitated. Her understanding is further increased by her observation in patients of the significance of mood fluctuations, the methods individuals use to defeat themselves. She learns the significance of aggressive behavior, of suspicion, fears, and compulsions. From all of these observations the alert nurse is able to utilize the knowledge and experience that she has received to increase her own efficiency and to help her own adjustment.”

In addition to the point made above of gaining insight into her own difficulties, psychiatry can be of value to the nurse in aiding her adjustment to her chosen profession. A simple example will make more specific the ways in which psychiatry can make her a better nurse. In the course of her education the nurse learns to accept many of the unpleasant features of her work without emotional cost and in fact the education aims to aid her in this direction. Thus, she learns to accept the sight of blood, her unpleasant proximity to suppuration or vomitus or feces with commendable objectivity.

On the other hand, the nurse without psychiatric experience continues to take the layman’s attitude toward many psychological symptoms. Many

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times I have heard a nurse visiting at our sanitarium ask one of our nurses, "How can you stand being around all these nervous people?" Psychiatric experience teaches the nurse to take an objective rather than a subjective attitude toward mental symptoms, toward even psychotic behavior such as tearfulness, disagreeable actions, mutism, excitement. By taking an objective attitude is meant more than merely becoming accustomed to such behavior; the nurse learns to evaluate it, learns what it may mean for the patient and to the doctor, and how she may most effectively help the patient overcome it. Most of all she learns to accept it without an emotional response.

THE PREVALENCE OF MENTAL ILLNESS AND THE GREAT NEED FOR NURSES TRAINED IN THIS FIELD

In addition to all the reasons and advantages that I have set forth above for psychiatry being given a fundamental and important place in the nursing curriculum, I cannot pass the opportunity to call attention to the crying need for psychiatric nurses. I recognize that the nurse who goes into obstetrics needs training beyond her general hospital experience, and similarly in any other field, so that to include psychiatry in the nursing curriculum would not necessarily prepare a nurse for psychiatric nursing. On the other hand, it does give her an awareness of the field. If nurses were not given any obstetrical service in their nursing education, it is not likely that many would go into obstetrics. The fact that they have had this experience, however, leads them to go further in this field and the same is true of psychiatry. So long as the great majority of nurses have no such service or at most have a month's contact with it, not many will go into that field.

The tremendous need for psychiatric nurses can be tersely stated. It is a well-known fact that over 50 per cent of all hospital beds in the United States are occupied by individuals suffering from mental illness, and yet less than one per cent of all graduate nurses are employed in this field. It is significant that more patients die from one symptom of mental maladjustment, suicide, in one year than from the five most common communicable diseases—diphtheria, typhoid, pertussis, scarlet fever, and measles. The National Committee for Mental Hygiene has computed that one out of every 22 persons in the United States will develop a mental disorder that will require hospitalization at some time during his life, and at the same time there are between 60,000 and 70,000 new cases admitted to mental hospitals every year. In the state hospital system in this country at the present time there is only one graduate nurse to every 92.5 patients. Despite the fact that psychiatric nursing is in its infancy and that there is only a minimal awareness of the advantages of having graduate trained nurses, I know from my own experience that there are not nearly enough nurses with psychiatric training to meet the needs.

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SUMMARY

In light of the facts as I have attempted to present them, I want to conclude with my initial remarks that psychiatry should be included in the nursing curriculum as one of its most fundamental subjects. Because the psychiatric point of view embraces every other field of medicine—surgery, medicine, obstetrics, pediatrics—it should precede these subjects. Furthermore, one cannot learn psychiatry from a textbook or from didactic lectures, but should have a period of actual contact and experience with psychiatric patients of at least four months, though this is probably too short a time. During this part of her education the nurse should learn not only the structure of the personality and how it functions, but should have the opportunity to learn what attitude she should assume toward various types of emotional problems, should have experience in individual supervision of the mentally ill patient, in occupational therapy, recreational therapy, and physiotherapy in relation to the different types of illness. Again I repeat that every illness presents psychological aspects both in causation and in symptoms, and that more than 50 per cent of all hospital beds are devoted to patients in whom the psychological component is the most conspicuous symptomatology. Nursing educators, and more specifically nurses themselves, cannot continue to neglect this field and expect to be efficient or well educated as nurses.

FACILITIES FOR THE PREPARATION OF NURSES IN PSYCHIATRY

MARION FABER, R.N., Assistant Director, Cook County Hospital School of Nursing, Chicago, Illinois; in charge of Psychiatric and Neurological Nursing Service

Nurse education for the care of the mentally ill as we find it today is of three types:

1. Affiliating and graduate courses in state and private mental hospitals
2. Affiliating and undergraduate and postgraduate courses in psychiatric departments of general hospitals
3. Undergraduate courses in state and private mental hospitals.

Each of these types of hospitals has certain advantages and limitations which are of interest to those of us who are concerned with the preparation of nurses in the field of psychiatry. Let us discuss these limitations and advantages.

The large public general hospital or the endowed general hospital with a good psychiatric department has some advantages which the other types of institutions do not offer. The affiliating students who are sent by the home school for psychiatric experience and theory to one of the larger general hospitals usually register for other types of experience. This gives the student coming from a smaller hospital the opportunity to gain other types of experience which her home school cannot offer. If students in a small affiliating school are sent for psychiatric experience, and their experi-
ence in medicine or obstetrics has been poor, preparation in psychiatry will not compensate for poor preparation in such fields as medicine, pediatrics, or obstetrics.

It is in this one aspect that the general hospital with a psychiatric department can offer much to an affiliating student. There are, however, general hospitals which offer complete experience in the basic nursing courses. Students from these schools do not need added experience in basic types of nursing and for these schools the mental hospital can offer affiliate courses without thought of other preparation. In their eagerness to establish courses for affiliating and postgraduate students, the mental hospitals should not, on the other hand, accept students whose basic training needs supplementing.

There are one or two similar advantages, too, for the graduate nurse who registers for a course in psychiatric nursing in a general hospital with such a department. If the school of nursing has worked out entrance requirements for all graduate courses, certain supplementary basic courses may be planned for the graduate nurse whose undergraduate work shows inadequacies in the basic types of nursing before she is allowed to register for the additional courses which a general hospital offers. Or she may wish to register for correlating courses in such subjects as psychology or sociology at a nearby university. Some of our best psychiatric hospitals are not situated near universities and cannot conveniently offer this privilege to the graduate nurse because of the distance she must travel.

As for the limitations of a general hospital with a psychiatric department there are several. The number of students registering for psychiatric courses in general hospitals with psychiatric departments must always be carefully controlled so that these students receive adequate experience, since psychiatric departments in these hospitals seldom average more than one hundred patients per day. In state hospitals the number of students who can be accommodated is dependent mainly on housing facilities, budget, and the number of wards suitably staffed by graduate nurses, and not on the daily average of patients.

Another disadvantage which a general hospital with a psychiatric department presents, when situated in a large city, is that patients do not often remain long enough for students to see them get well. Often all the facilities for newer methods of treatment are not in use because of the shorter stay of patients. Because of limited space, patients can have little or no outdoor exercise, work, or play, all of which are an essential part of the treatment of the mentally ill.

As has been said, in the state hospital opportunities for educating students are almost entirely dependent upon proper staffing of the hospital with a well-qualified graduate nurse corps, upon proper living accommodations for nurse students, good library facilities, and supervisors, instructors, and nurse directors with an educational background comparable to that of the same type of personnel in the better schools connected with high grade general hospitals. As state hospitals remedy defects in the facilities at hand and
supplement facilities which are inadequate, the number of students who can be accommodated is practically unlimited.

In reviewing courses in psychiatric nursing offered today, the lack of standardization and uniformity seems to be their most glaring defect. Let us look at two other professions which use the hospital as an experience field to see why these professions seem to have accomplished so much in the way of standardization. I refer to hospital dietetics and medicine. Hospital dietetic courses were only standardized in 1927. Yet today courses in this field have thoroughly standardized curricular requirements. In addition, the content of the courses given in a year’s internship in the hospital in this field must have the approval of the professional education section of the American Dietetic Association in order to attain recognized professional standing. There are today only approximately fifty-two approved courses in hospital dietetics in this country.

The same type of standardization has taken place in medicine as proved by the fact that there are less than eighty grade “A” medical schools in the United States today. Since medicine, hospital dietetics, and nursing must all depend upon the hospital as their learning field, these three professions are somewhat analogous and can be compared in respect to standardization of curricula. In contrast there are more than thirteen hundred schools of nursing connected with hospitals and little or no agreement as to the curricular requirements or the content of courses in theory or practice except that which state boards of registration require, and the state board requirements still vary considerably in various states.

The National League of Nursing Education through its old standard curriculum and the new Curriculum Guide has exerted and does exert a powerful influence in improving nursing school standards. But this organization has no mandatory power over schools of nursing. The work of the Accrediting Committee of the National League of Nursing Education will no doubt in time bring about greater standardization and uniformity in all nursing school curricula.

We of the nursing profession must face squarely the statement of the Grading Committee in its publication, Nurses, Patients, and Pocketbooks,¹ that, “In nursing there has apparently never been any nationally accepted policy for the control of the numbers of nursing schools or the standards for admission and graduation.” This statement applies to all types of hospitals, special and general. However, this discussion concerns only facilities offered in the education of nurses for the care of the mentally sick. It is only one phase of the larger problem of standardization of nurse education, and the inadequacies of education and experience in psychiatric nursing are those of the profession as a whole. The remedy for all types of nurse education, whether general or special, is much the same as that of standardization so that there will be uniformity and security for all members of our profession.

¹ Burgess, May Ayres. Nurses, Patients, and Pocketbooks, p. 35.
We ask ourselves why medicine and hospital dietetics have made greater strides in the setting-up of policies of standardization? Is it not perhaps because they began with so much higher educational standards than did our nursing schools? We have a longer, harder road to travel to accomplish standardization because to begin with, our educational and professional standards were not so discriminating.

May I quote Dr. George H. Stevenson, chairman of the Committee on Nursing, of the American Psychiatric Association, as to what he believes to be necessary in order to standardize and improve courses of study not only in psychiatric nursing but in any type of nursing? His opinion is of value as he is vitally interested in the care of all patients and particularly in the care of the mentally ill. In his paper, Ward Personnel, which was read four years ago before the American Psychiatric Association, he states clearly that he believes standardization should come from within our profession rather than from the hospital administrator whose main interest is the care of patients and not the education of the nurse. He says, "One might ask the question if the time has not definitely passed that any hospital should presume to set up a training school for nurses without the permission of, or at least consultation with the governing body of the nurses’ organization?"

There were in 1937, forty-six approved undergraduate schools of nursing in psychiatric hospitals (accredited by the American Psychiatric Association). In addition there were sixty affiliate courses and thirty-three postgraduate courses also accredited by the American Psychiatric Association and the Committee on Psychiatric Nursing of this body.

Let us look at the content of some of the courses given. Let us consider these courses first as to length. Affiliating courses vary in length from four weeks to four months. The new Curriculum Guide recommends a three-month affiliating course.

Let us look at the subjects offered and the variation in hours allotted to these subjects by some of the schools giving courses in psychiatric nursing. For the sake of clarity we will divide these courses into two major divisions and list other subjects which are taught but not specifically related to experience in this type of nursing. These two major divisions will be lectures and clinics given by a psychiatrist (Principles of Psychiatry) and nursing lectures given by the nurse instructor and other specialists in closely related fields (Principles of Psychiatric Nursing). In some instances such subjects as mental hygiene were included in one division and some times in the other division. Some courses included neurology, neuro-anatomy, psychology, and child behavior problems. Some schools included all of these subjects, other schools included none of these additional subjects. Most of the courses included a varying number of hours in occupational therapy, recreational therapy, social case work, hydrotherapy, massage, and case study in their nursing lectures and classes.

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There is therefore some agreement as to subject matter in the nursing classes, but there is considerable variation in the number of hours to be devoted to each minor topic and to the total number of hours in the course. In the lecture and clinic material the variation in total number of hours ranged from 16 to 70. The classes given by the instructor varied in number from 10 to 85 hours. These illustrations show how great a lack of uniformity there is in content and number of hours. Some institutions averaged only two hours of class per week and others gave as high as 10 hours of class per week. One psychiatric hospital with a 50-week course and a daily average of but 50 patients required the students to work a 56-hour week. Have we no basis for a ratio of class work and nursing practice? The final report of the Grading Committee 4 recommends that the minimum ratio of class hours to hours of practice on the ward should be 1 to 7. This should serve as a basis for deciding the amount of class work a student needs in learning the art of nursing any kind of patient.

Much the same variation of class hours and ward experience is found in schools of nursing offering graduate work in psychiatric nursing. These courses showed the following variations in length: three months, four months, six months, eight months, nine months, twelve months, and fifteen months. True, most of the longer courses offered experience and practice in teaching, supervision, and head nursing. The difference in the length of experience periods is justifiable only to the extent that these courses represent progressive levels of experience. In some schools postgraduate students were given an honorarium varying in amount from $10.00 to $25.00 per month. In several schools the student was required to pay tuition in varying amounts ($10.00, $22.50, $25.00). One wonders upon what basis this difference in honorarium and tuition was made. Schools of nursing with established reputations and many applicants appeared to have the highest tuition rate.

In considering facilities for teaching student nurses, there are a number of factors which we have not yet mentioned. Perhaps some of these factors are also responsible at least in part for the variation in course content, since each individual school of nursing is more or less a free agent in deciding what it has to offer to or demand of students. I mean the proportion of graduate staff nurses to students and the educational and professional background of those who teach students. "According to statistics furnished by the National Committee for Mental Hygiene," (I am quoting Dr. Menninger in the March 1938 Bulletin issued by The Menninger Clinic) "state institutions throughout the country have only one graduate nurse for every 92.5 patients." The American Psychiatric Association cites a 1-8 ratio as a minimum of personnel to patients in any hospital in which nurse students are receiving experience and also an eight-hour day for students. There are but few state hospitals which maintain such a high ratio of personnel to patients. Psychiatric departments in some general hospitals and some private

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4 Committee on the Grading of Nursing Schools. Nursing Schools Today and Tomorrow, 1934, p. 166.
psychiatric institutions have even a higher ratio of personnel to patients. However, we must discount the large number of chronic patients in state institutions. The average stay of the mentally ill patient is three years as compared to that of 14 days in a general hospital. In many state hospitals which offer education and experience to student nurses, certain wards have been set aside for the students’ experience. In these wards the ratio of personnel to patients is usually much higher than in wards where there are no students.

The question of whether undergraduate schools of nursing in state hospitals are giving proper nurse education and experience is becoming less of an issue than it was formerly since affiliate and postgraduate courses are being organized in increasing numbers, and undergraduate courses are gradually being discontinued.

May I again quote Dr. Stevenson on this point? "It is at direct variance with accepted standards of professional training inasmuch as specialization should follow general training ... therefore such training is pedagogically unsound ..." and again he states, "Graduate and affiliating courses as a method of training psychiatric nurses are sounder pedagogy. We admit the standards of care of patients in mental hospitals are raised where there are student nurses receiving mental hospital training but what of the nurse? Would we train a psychiatrist in a mental hospital without first giving him a general medical education. I think not."

From the standpoint of the mental hospital superintendent, preparing his own nurses is the short range answer to his problem of good patient care. But again let me quote Dr. Stevenson as to the soundness of such training. Dr. Stevenson says, "We should ask ourselves the question whether any mental hospital has all the facilities, didactic, clinical, and pedagogical to produce the fully developed and fully qualified nurse. ... It is a matter of considerable doubt if any special hospital, mental, tubercular, orthopedic, pediatric, should operate a training school for nurses even with general hospital affiliation because of the overemphasis on the specialty and inadequate instruction in general nursing. But if mental hospitals are to be staffed, general hospitals must require this type of nursing in the basic nursing experience of the student nurse. The mental hospital must prepare itself to give such experience. ... Training of so-called 'psychiatric nurses' is as unsound as the training of tuberculosis or pediatric physicians without first giving them a general scientific background. The same is true of teachers. They must first receive a sound general education and then specialize."

We must help to make psychiatric nursing a part of the necessary education of every student nurse, just as experience in communicable disease nursing has now become a requirement of the public health nurse's experience. There must be proof also for the medical superintendent of a psychiatric hospital that if undergraduate schools in these institutions are discontinued, he will be assured of enough nurses who will be adequately prepared to care for his patients.

There is evidence that the number of general hospitals now giving psychiatric experience to their undergraduate students is increasing. Last year there were but 288 general hospitals in this country and Canada that gave this experience to their undergraduate students. At the present time there are 335 general hospitals offering their students this preparation. On the other hand, if we are to organize affiliating and graduate courses in psychiatric hospitals, these courses will have to be of high standard to win the confidence of the directors of schools of nursing in general hospitals so that they will send students for affiliation and recommend these courses to graduate nurses. Working conditions and salaries must be such that it will be possible to staff these hospitals adequately with graduate nurses.

To prove that the number of nurses who are receiving preparation by affiliation or through graduate courses is increasing, allow me to quote some figures from the records of several schools in mental hospitals and a psychiatric department in a general hospital. A psychiatric department in a general hospital which offers both affiliating and graduate work, has given this experience to 209 of its own students, to 913 affiliating students, and to 473 graduate students over a period of six years.

The records of one state hospital show that in a three-year period only five students were graduated from its undergraduate school which was discontinued at the end of that period. The affiliating and graduate courses which were organized in the same year (1919) show that from 1919 to 1938, 1,519 affiliating students finished their course of study, and 381 graduate students completed a six-month period of work. Another state hospital in its thirty years of maintaining an undergraduate school of unusually high standard had graduated only 199 nurses in this period of time. This state hospital recently discontinued its undergraduate school and organized an affiliating course. In the first year seventeen affiliating students completed the course. This year promises 48 affiliating students which is all for which housing has been provided.

Another large state hospital closed its undergraduate school in 1936. From 1930 to 1936 the following comparison of undergraduates (three-year school) and affiliating students who finished their courses may be cited. There was only a total of 99 graduates in this six-year period as compared to 664 affiliating students in the same period.

Another hospital, a private mental hospital, has its own school from which approximately 12 students are graduated each year. This school also enrolls an average of more than one hundred affiliating students for a three-month course annually.

There have been other successful demonstrations of affiliate and postgraduate courses than those cited in this discussion. But the above-mentioned schools of nursing prove that such courses can be conducted successfully in any type of mental hospital, if only the nursing schools in general hospitals awaken to the growing need for this type of nursing and the ever-growing menace of mental illness.
Let us view this question from another angle, that of the mental hospital superintendent and the nurse herself.

In one state there are 198 registered nurses employed as nurses and 110 registered nurses employed as attendants. Forty-six graduates (not registered) are also employed as attendants. In spite of the fact that numbers of registered nurses (110) work at the wage of attendants, the Director of the Department of Public Welfare, in discussing the question of abolishing undergraduate schools of nursing in state hospitals, said that "not all undergraduate schools in state hospitals should be closed because student nurses are good for the patients and create a wholesome atmosphere in the hospital." Yet when the student nurse graduates and becomes registered through a year of affiliation in a general hospital she is not assured of employment as a graduate nurse in the mental hospital and she may be forced to take the same wage as an untrained attendant and work in that capacity.

One medical superintendent of a mental hospital states that "pupils with two or three months of affiliation contribute little to the nursing service." If we have a large enough graduate staff, students will be able to fulfill their proper function—that of learners rather than being merely a means of cheap labor for the hospital.

Let us see what state boards of nurse examiners say concerning the question of the undergraduate school of nursing in the state hospital. In one state in which there are a number of psychiatric courses of all three types, the decision concerning the continuance of the three-year undergraduate course is stated as follows:

"The state board of nurses examiners is to consider which year shall be stipulated as the last one in which students lacking a course in psychiatric nursing, will be accepted for registration in the state."

The state board in another state, through its secretary, expresses itself as follows: "Under present conditions we would not care to send students there (to the state hospital) for affiliation, but would like to see the time right for closing these schools and using the service for affiliation and good postgraduate courses."

The visiting representative of the state board in still another state says, "We should . . . much prefer to have these special hospitals give us good affiliating and postgraduate courses instead of conducting schools of nursing. We have not been able to convince them that these courses would be satisfactory substitutes for their own nursing students. Several of our schools of nursing are interested in the possibilities for affiliation in mental nursing, but there are many steps which must be taken before such courses are offered." Another member of the state board states, "There has been a definite effort to establish affiliating courses with state hospitals, but various difficulties have made this impossible up to the present writing."

One well-organized course of study for graduate nurses in a city institution has had such an interesting inception that it should go on record because of its very uniqueness. This course was organized and sponsored by the state nurses' association and the league of nursing education. The work
was financed for one year by these two organizations, after which it has become a permanent part of the public welfare program of the city.

The expressions of opinion cited above have purposely been taken from widely separated sections of our country, from the north, south, far west, far east, and middle west. Names and places have not been mentioned, but the data were gathered by the questionnaire method and there was an 80 per cent response to these questionnaires. A questionnaire was sent to the state board of nurse registration in every state in the country. May I take this opportunity of expressing my appreciation of their whole-hearted interest and cooperation? These answers I believe will express the wide interest of the nursing profession in furthering all professional nursing activities and the solution of this problem in particular.

The experiences of these institutions which have been cited as examples of successful affiliate and graduate preparation for nurses should prove two points: (1) allay the fears of medical superintendents that such courses will not provide large enough numbers of graduate nurses to care for patients if this field offers compensation comparable to other fields of nursing.

(2) from the standpoint of nursing education as voiced by members of our own profession as well as eminent members of the medical profession, affiliate and graduate courses afford a much sounder form of experience and education than that given by means of three-year undergraduate courses in mental hospitals.

Resources for training and experience in psychiatric nursing are manifold. The task remains for us to standardize and make more nearly uniform our affiliating and graduate courses. We must decide what experiences and what theoretical courses are necessary to give the nurse adequate knowledge and inspiration to care for the mentally ill patient. We must not overload with theory the affiliating student who comes to us for a short period of preparation. We must have well-trained teachers who understand thoroughly the general hospital environment from which the student comes so that the student’s difficulties of adjustment in the state hospital environment can be anticipated.

Before we bring the student to the state hospital we must be sure that the home school has confidence that the living conditions, the library facilities, the supervision, and teaching of the student are of as good quality as that in her home school, if not better. We cannot demand that this type of education be compulsory until we have proven to the nursing world that there is a field well prepared for its student nurses. There must be a board of directors whose sole interest is the education of the student. Political interference must be abolished so that all appointees to the graduate staff are selected on merit only. Finally, we must have a long range vision for the future and try to weather this period of transition with helpfulness.

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**Round Table II**

**Thursday, April 28, 2:30 p.m.**

Presiding: Alfhild J. Axelsson, R.N., *Chairman, Committee on the Care of the Child.*

Subject: **Newer Phases of Pediatric Nursing**

**How to Stabilize a Pediatric Nursing Service to Provide for an Educational Program**

M. Corinne Bancroft, R.N., *Director of Nursing Education, Children’s Hospital, Cincinnati, Ohio*

One can scarcely approach the subject of stabilizing the nursing service in a pediatric ward, division, or hospital without thinking, for a moment, of the peculiarities of this service when compared with the adult service with which the student is familiar.

In most instances, the student nurse is ready for her experience in the nursing care of children at the end of the second or the beginning of the third year of her course. During this time, she has been introduced to the nursing arts and has had clinical practice in the care of patients with medical, surgical, orthopedic, ear, eye, nose, and throat conditions, and in most instances, with obstetrical patients. True enough, she has had to make many adjustments to patients with these varied conditions and to patients in all stages of illness and convalescence. Her patients, however, have been adults. The adult reaches out to meet the nurse at least part way or expresses himself in a manner that is familiar to her. In other words, the nurse and the patient are adults and have that common basis of understanding.

When the nurse begins her service in the nursing of children, however, she is in most instances in an unfamiliar field. Even though she has studied or
is studying child psychology, even though she may have observed or even
given care to children in a nursery school or observed older children of
school age and is acquainted with the kind of environment necessary in their
care, she is now in a different situation. She is brought into a close relation-
ship with the child who is sick.

She may know nursing care in relation to the treatment of disease but now
her patient is a child, and she is unfamiliar with his reactions as a child and
more especially as a child who is sick. The child the nurse cares for may be
an infant for whom she must do everything, he may be a young child in any
stage of learning or of beginning to be independent, or he may be an older
child; and we know there is a vast difference in the stages of mental, emo-
tional, social, and physical development between the ages of five and fifteen
years. If the nurse is to give the kind of care that will help the child to
maintain or gain mental and physical health, she must become familiar with
all of these differences. In addition, many of the factors of the environment
she must learn to control and much of the equipment she will use will be
new to her. Another unfamiliar phase in the situation is the parent-child
relationship and the parent-child-nurse relationship. These are new situa-
tions with which the student is faced when she begins her study and practice
in the care of children.

As members of the hospital staff, we are familiar with our responsibilities
to the patient. These have been well defined in the Manual of the Essentials
of Good Hospital Nursing Service—to give the kind of nursing care and
assist in creating the kind of environment that will help to make the patient
well mentally and physically. We all know our responsibilities to the student
nurse so well brought out in the Essentials of a Good School of Nursing
and in the Curriculum Guide—to give the student the basic principles of
good care of the child and the essentials of medical care and treatment of
children who are sick and then to put the student in a situation inductive to
learning. She must have time to think about these principles and to relate
them to her activities and to practice them until the relationship between
principle and practice becomes a part of her. While she is learning,
she must be in a situation in which she has time to adjust and to develop as
an individual and to express herself as an individual. This she cannot do if
she is submerged in activities, the whole objective of which consists of get-
ting work done. Nursing education its truest conception means that the
student is part of an organization whose plan is flexible enough to reach
out and beyond its walls and give the student opportunity to learn basic
principles in nursing that she can carry with her and use in her work with
the child in the community.

Now, what do we mean by stability? As it applies to nursing service, it
is to so organize and staff the ward or division that the care of the patient and
the educational activities of the student are not materially interfered with
or disrupted by change in the number of students or the number or the
degree of illness of the patients. It must provide the kind of nursing that
is needed by each child and the amount of nursing according to the standards established in the particular institution. These two factors will need to be considered in planning for the staffing of the ward or division. We have been guided in this planning by the *Hospital Survey for New York*,¹ the *Manual of the Essentials of Good Hospital Nursing Service*, and studies made by Margaret Tracy while at the Yale School of Nursing.

In stabilizing any service it will be necessary to give consideration to the plan of the division, as the ratio of nurses to patients will be somewhat different if children of all ages are in one division or are grouped according to age, such as, infants, young children, and older children. However, regardless of the physical plan of the ward, adequate bedside care must be given; the teaching of the student must be carried on as teaching situations arise; provisions for the change in student rotation must be considered; and all plans must allow for stability with flexibility. If the latter is not properly provided for, unusual situations will completely upset the plan for both care and instruction resulting in disorganization.

For example, in order to stabilize the division in the care of the child from two to five years, so as to give the kind of bedside care which a child of that age needs and to provide about five hours of nursing care to each child during the twenty-four hours, we have found that one head nurse, one assistant head nurse, three graduate staff nurses, four nurse aides, and ten student nurses will be needed. With this plan of organization, the head nurse will be able to give the supervision necessary to assure a smooth functioning ward and to have time to carry on a definite plan of ward teaching, taking advantage of teaching opportunities as they arise. It should give her time to develop the executive and teaching ability of her assistant and graduate staff nurses. I believe personally that this function of developing the potentialities of her assistant and the graduate staff nurses under her supervision is more commonly disregarded than any other. This may be due to lack of time allowed in the plan for the ward.

There must be close cooperation between the head nurse and the nursing administrative office and the office of nursing education so that the head nurse will know when change in her student personnel is expected. In an affiliating school, she will probably have a change in half her student group each two weeks, and every two or three months she must be ready for students who are just beginning their children’s service. She must have her own plan of instruction formulated according to the preparation and experience the student has had and the particular care her patients require. This latter phase of the work can be adequately carried out only where a close relationship exists between the instructors and the head nurse.

One of the outstanding factors in providing stability is the plan for the introduction to pediatric nursing. I believe that when the student reports to the ward for duty she must already have been instructed in some of the

¹ *Study of the Nursing Service in Fifty Selected Hospitals*, National League of Nursing Education. 1937. (Reprinted from Vol. II of *Hospital Survey for New York*.)
routine procedures which must immediately be carried out: for example, isolation technique, thermometer technique, bed making, etc., as carried out on that particular service. In addition, further time must be allowed in the beginning of her course for adequate instruction in adapting basic principles of nursing to pediatric nursing.

Other factors, aside from the instruction offered the undergraduate student, which aid in stability are a carefully selected personnel in the nursing department, organization and delegation of authority within the permanent staff, a carefully worked-out plan of instruction for the attendant or nurse aide group, and a plan for staff education and educational advancement.

PROBLEMS IN RELATION TO GIVING STUDENT NURSES EXPERIENCE WITH WELL CHILDREN

Minnie E. Howe, R.N., Director of Nursing, Children's Memorial Hospital, Chicago, Illinois

The subject, Problems in Relation to Giving Student Nurses Experience with Well Children, might logically be discussed as the problems involved in giving student nurses experience with children outside of the hospital where the behavior of children is less restricted and their physical condition is not affected by illness. It is agreed that this type of experience for nurses is essential, but we would like to discuss this subject today from the angle of the possibilities for giving care to children while they are in the hospital that is comparable to care which should be given to them in any situation.

At the present time there seems to be little hope of a radical departure from the general pattern of giving student nurses the major part of their course in pediatric nursing in the senior year with a time allotment of from fourteen to sixteen weeks. Furthermore, the greater part of this period must be spent in the hospital wards. With these facts in mind and without lessening the emphasis on the value of experience with well children in a more natural environment than the hospital, let us study the hospital situation for opportunities for teaching students the use of good methods in the care of children.

Hospitals caring for children are concerned with providing an atmosphere that is suitable for them. But, much remains to be accomplished. However, a hospital experience for a child may not be a detrimental experience for him.

Consider briefly the philosophy of modern education. Is it not to prepare our growing youth for living? Schools are attempting to provide experience for children based upon actual situations taken from life. Would it not be possible to consider the hospital experience for children as an experience in living and endeavor to develop this experience for them to its greatest possibilities? Perhaps the idea seems somewhat fanciful, but if every angle of the experience of being ill were carefully guarded and made an educational adventure for the child, the hospital environment would lose much of its present atmosphere which is so foreign to a child's best interests.
With your permission we will discuss a few principles we consider essential for the care of hospital children. They are as follows:

1. The importance of securing upon admission accurate knowledge as to the level of the child's physical, mental, and social development.
2. The value of play as a regular activity in the hospital situation.
3. What the convalescent ward has to offer in teaching students sound methods in the care of children.

Consider first the admission of the child to the hospital. This is the first step in the transitional experience for the child from his home environment. The parents, or parent, most frequently the mother, and the child are the chief actors in this situation. It is necessary to establish for them security and confidence in this unfamiliar setting. Perhaps the mother is of greater importance for the moment. She is going to leave her child in our care. We must bridge the gap between the home and the hospital for her and her child. This is done by familiarizing ourselves with the home situation, as well as to acquaint the mother and child with the hospital situation. A knowledge of the home should include the family, the school, the neighborhood, the church, or in fact the sum total of the social situation from which the child and the mother emerge.

A method we have found helpful in successfully promoting this transition from the home to the hospital, and at the same time teaching students how to participate in the procedure, is by the use of a habit guidance record.

The function of the habit guidance record is to furnish information relative to the child's stage of development in the control of his body functions and his intellectual and social development. This information is secured as quickly as possible after the child's admission to the hospital and the necessary conference furnishes an excellent opportunity for establishing a good relationship with the parent. The special information included in the record is as follows:

- The pet name by which the child is known in the family
- The place of the child in the family
- The number of adults in the family
- The language spoken in the home
- The language the child responds to best
- Does he understand English?
- The school grade attained
- The date of last attendance.

In response to the question of pet names, we get the usual assortment of informal affectionate terms which often carry interesting significance. They range from "Peggy" for Margaret, "Sugar" for John who is seven years old and the youngest of three children in a family where there are six adults, to "Hot Papa" for the colored infant boy of less than a year. We learn also that Elmer who is blind, 5 years old, and mentally retarded responds best to the pet name of "Jackie" which was given him by his doting grandmother.
Under the heading of elimination such questions are asked as:

What is the term used for urination?
Is the child accustomed to a toilet chair, chamber, or bathroom?
What is the stage of training relative to elimination—begun, not begun, or well established?
What is the approximate time of daily bowel movement?
Is he taken to the toilet at night? etc.

It is important for the nurse to know that "toy, toy" is used for toilet; or that the child waits upon himself. Every effort must be made in order to avoid interference with good habits which have already been established.

Information as to the stage of the eating habits is also important. If we are inquiring about a young child just beginning to talk, we ask:

What word does he use for food?
What is the method of feeding?
Does he drink from a cup or a bottle?
Does he use a spoon?
Does he feed himself? What degree of help does he need?
Does he eat slowly or rapidly?
Is his appetite large, medium, or small?

Knowledge of habits of hygiene are necessary and are secured through questions as to the degree of help he needs, if any, when he washes, combs his hair, brushes his teeth, etc. Sleeping and play habits complete the subjects for definite questioning except for a division indicated under remarks where miscellaneous information may be noted. The diagnosis is always included in this section as it has its bearing on the situation.

With these brief facts as a background, we attempt to formulate a picture of the child's development, so that it will be ready for quick reference for nurses who will care for the child, as well as to furnish a basis for study of child development. The teaching possibilities in the use of information of this nature are numerous. In using the habit guidance record for definite teaching purposes, the student makes and records her own actual observations following a similar outline. Comparison of the actual progress made by a young child in habit formation during his hospital stay is possible. If a child is in the hospital for a period long enough so that the course of habit formation may be traced, habits which have been interfered with may be noted and the causes studied. Has the illness been the cause of a reversion in habits? Or has the hospital situation and the nursing care been at fault? This point has been such a definite target for criticism of nurses, that it is well worth our attention and study.

The value of play as a regular activity in the hospital situation is of vital importance. While there is nothing new in the idea that children like to play, greater recognition of its value in the development of children, and for the study of their development, is gaining new emphasis in many fields. For example, sociologists have recognized the value of play for its socializing influence in normal situations. Observation of children playing is used for diagnostic purposes in certain fields such as orthopsychiatry, and play is
being recognized as a means for promoting a satisfactory atmosphere on the hospital wards for children.

To illustrate briefly how this subject is presented to the student nurses, we will quote from the outline of our instructor in Children’s Recreation, Miss Bernardine Kern.

The aims of the course are stated as:

"a. To give students new attitudes, new methods, and new abilities in dealing with sick children through play

"b. To have the student realize by her play experiences with the child his eager acceptance of play

"c. To stimulate in the student a realization through experience how play meets the child’s emotional, physical, mental, and social needs."

While play activities are adapted to the needs of the sick child in his varying stages of illness and convalescence, the student’s general knowledge of children’s normal reactions is broadened by a knowledge of the fundamental principles of play. Through play the nurse sees the child responding to activities which are essential for his normal development. Also she sees him as he reacts in normal situations. The happiness he displays in responding to a favorite game or interest helps to give the student nurse an insight into his personality.

Quoting further from the outline of this special course in play which is given to student nurses, the application of play to the hospital situation is indicated:

"a. Activities easily played in bed

"b. ‘Tuck In’ types of play to use while giving nursing care

"c. Play suited to the varying ages and different degrees of convalescence

"d. Play requiring little or no equipment: games, puzzles, tricks, finger plays, songs, stories, etc.

"e. Group activities where all patients in a room play together. When it is necessary to observe isolation technique, games without physical contact are used

"f. Individual play."

While the play activities are the same as those used in normal situations, selections are made according to their suitability for the hospital situation and the child’s needs.

Probably one of the greatest practical values the student nurse receives from her play experience is the relaxation and fun she herself feels in play practice classes and in playing with the children on the wards.

Furnish the hospital child with an environment which includes experiences desirable for him and much will be achieved in securing natural reactions from him. Subsequently, your opportunities for teaching nurses the behavior of well children will be increased. A hospital day including play, a library, and a school program from kindergarten to eighth grade, is provided on all the wards. The children participate in it according to the degree of their illness. These activities greatly emphasize a normal approach
to their care. However, medical care is of first importance and necessary hospital procedure must always more or less predominate.

The convalescent ward in the hospital affords a somewhat different atmosphere. The day may be planned so that the normal activity needs of the child may have greater prominence, that is, a schedule based on good routine. A regular daily program is possible, which begins with the morning toilet and includes meals, group participation of the children more comparable to a family or neighborhood situation, regularity of schools, and a play program with a wider range of activities. The opportunities for teaching students normal development of children are undoubtedly made easier than on other wards. This is true for the same reason that the child’s convalescence is also promoted in this environment where a typical hospital atmosphere is lessened.

The student has a period of two weeks on the convalescent ward and during this assignment she prepares a case study with the major emphasis on child development. The outline for this study differs from the usual type of case study in that the course of the disease, which has made it necessary for the child to be a patient in the hospital, is included only as an incident in the picture of the child’s development. The study of the course of the disease has been presented elsewhere. Further use is made of the habit guidance record on this ward and all organized ward teaching classes are based on the study of children as children.

Experience in play free from regular nursing responsibilities has proven to be a valuable assignment for students. Also it has helped to meet the ward situation by giving full attention to desirable activities for the children. Late afternoon and early evening are periods when the activity needs of the children may easily be neglected. The nursing in the ward may be greatly improved by assigning a nurse free from other duties to play with the children. Of course, play includes story-telling, reading, discussions of stamp-collecting with the older boys and girls, or attention given to the particular group interest in the ward.

We would not have you think the type of experience we have attempted to discuss today is a substitute for an experience with well children in a situation more favorable than the hospital, but we do believe that hospital children should be looked upon as children, with the proper emphasis given to the fact that they are ill. Provided with a suitable environment and with activities which contribute to their well-being, children will react as children, whether it be on the playground, in the home, in the school, or in the hospital.

THE REACTION OF NURSES TO THE NURSERY SCHOOL

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At the outset it is well to remind ourselves of a commonplace observation, that modern life is characterized by increasing complexity, by change and
flux, and with the persistent multiplication of human needs and wants. Many matters that were traditionally conceived as self-evident have now, in view of scientific and technological changes, turned into serious problems.

Everywhere we hear of problems concerned with this and that. We have with us the problem child and the problem parent, the problems of infancy, childhood, youth, and adulthood. Fortunately, for all of us, the division or specialization of labor and the variation of human interests assures us that different problems attract the attention of different students so that a solution may be forthcoming sooner or later.

The problem which is before us is the response of nurses to the nursery school. The nursery school is of recent appearance in modern society. What are some of the influences that account for its coming?

At first glance it would seem a reflection on the inadequacy of the home and family life. This would be true in many instances since the family case workers and public health nurses can corroborate. Secondly, the modern trend toward controlled parenthood, the small family with one or two children, causes a higher value to be set on the child. Third, there is a growing awareness of the importance of developing individuality in a world where the herd spirit can be too readily inflated. Fourth, the psychology of individual differences and the principles of learning make it necessary, as well as desirable, to have small groups so as to permit more individual attention and self-activity.

The nursery school is an agency which can supplement and do better some aspects of early childhood education than is possible in many homes. From the point of view of the nursing profession, the nursery school is a social area affording possibilities of enlarging professional experience. The nature of our responses to this new situation is conditioned of course by a number of factors, such as our education, training, experience, attitudes, and other traits of personality. A brief statement of the characteristics of the nursery school will reveal some of the possibilities for professional development and service.

1. The educational philosophy that guides the nursery school at its best commits it to an alignment with experimental education.

2. The nursery school functions as a laboratory for the training of the young child.

3. At its best the nursery school is engaged in promoting the optimal growth and development of the young child, each according to his capacity.

4. Within its program is included parent education, and the area of preparental education is reached, though often by indirection rather than by a formally planned program.

5. The principles of child development control nursery school procedure.

6. The nursery school presents an organized educational environment for the young child.

The environment, including all physical equipment and supplies, is designed to meet the growth needs of the child. The routines that constitute
the school day take into account the needs of the child rather than the needs and wishes of the adults. Good nursery school practice insures the minimum of adult interference. Freedom of the child is essential to his growth in learning. Learning is guided in order that the child may participate in a variety of constructive experiences; for example, opportunity to gain control of the basic habits, a rich play experience, companionship with other children, experience also of being alone, and such experiences as can be anticipated as to his future adjustments in meeting the crises of life.

*What the nursery school is not.* The nursery school is not a place where little children may be taught "subjects" or "parlor tricks," or to "behave nicely." Neither is it a "play school" in the sense of unguided activity. It is not simply a special place where children disport themselves among "cute little" furniture, gayly colored gadgets, and "arty objects," where the teacher "has nothing to do all day but to amuse the children," and visitors visit to amuse themselves.

*What responses have been made to the nursery school in the nursing profession as a whole?* An answer to this question would include: (1) the new Curriculum Guide, (2) the work of the Committee on the Care of the Child, (3) the activity of some outstanding individual nurses in the field, (4) the responses of the public health nurses, and (5) the responses of student nurses.

The new nursing curriculum reveals the growing understanding of the importance of the child as an individual, as a member of the family, and as a member of the community.

The work of the Committee on the Care of the Child is expressed in the course of study termed Nursing of Children, in exhibits, in conferences, and in organizational promotion.

This is not the place to review the work going on in the whole field today, but we do wish to mention some nurses who have made special contributions.

Nursery school education is properly identified with the name of Harriet Johnson whose courage and industry established and directed over a period of eight productive years the nursery school associated with The Bureau of Educational Experiments in New York City.

We also acclaim that "Mater Builder," Winifred Rand, whose educational insight epitomized in her speech before the American Child Health Association’s meeting at the Capitol in 1932, It is the Children with Whom We Are Concerned, re-directed educational effort in relation to the child and the family.

The nursery school at the Bellevue Hospital, New York, with its excellent record of promotion of both nursing and nursery education, is a tribute to Mirra Wallace, a pediatric nurse with expert knowledge in nursery school education. Her example has had extensive influence.

Dorothy Rood’s doctoral thesis, *The Nurse and Parent Education,* emphasized the "shortages" in nursing preparation for child care and the importance of educational policy for meeting these inadequacies.
The public health nurses' response: The public health nurses responded quickly (a characteristic of this group) to the possibilities of the nursery school. To cite but three examples: Genevieve F. Hoilien in an article, The Nursery School and Public Health Nursing, (Public Health Nursing, May, 1934) states the needs of the community (i.e. Albany, N. Y.) with special reference to the preschool child—"It is for this reason that we have aligned ourselves with the nursery school knowing that this organization can give us stimulation, inspiration, and guidance in the emotional and mental problems of childhood in our city."

Ruth Gilbert in her article, The Nurse Goes to Nursery School, (Public Health Nursing, May, 1931) says: "One of the most helpful contributions to nursing education of even a brief nursery school contact is a re-interpretation of meaning of routine. . . . During her affiliation with the nursery school, the nurse has an opportunity to see in practical operation the rules of positive health which she has been taught academically. Here the constructive side of routine is so apparent that in later home visiting it is possible to preach health régime to mothers with a conviction born of observation."

Sebra Sturt's interesting article, What I Learned in the Nursery School, (Public Health Nursing, May, 1936) discloses an enthusiastic attitude: "And so after a period of observation, study, and work in the nursery school, the public health nurse is better equipped to go into a home where a preschool child is found and recognize his various needs. . . . I have been sensitized to the needs of this age group."

The student nurses' response: (From a teacher's personal file). Toward the end of a two-week period of daily participation in a hospital nursery school, a student nurse told the nursery school teacher that she had never worked so hard in her whole life to control her temper as she had during her nursery school experience. "I just want to stamp my feet at that child," indicating a certain resistant two-year old. "I have never done it" she hastened to say. "But I would have if I had been on the ward." In her last conference with the nursery school teacher, "I have never known the real meaning of self-control until I learned it from working with the nursery school children," and, in a truly scientific spirit, added: "I am just waiting to try it out on the ward."

"Since I have been assigned to the nursery school, I am beginning to feel as I used to feel before I entered nursing," a sensitive student confided. "Just getting into a dress again, rather than a uniform, is a part of the satisfaction. I have a great deal to learn about nursery school technique but the atmosphere there is so pleasant and natural that success in doing things seems but natural."

"The nursery school is no snap" was the comment made by one student to another. "One works just as much as on the ward; one reads and studies more. And, when you are assigned back to the ward after being in the nursery school, all the supervisors expect more of you."

Relating some incident about a child who, during his long stay, had become
something of a hospital pet, a student nurse remarked: "He is the best child in the ward, always so good, nice, and quiet, and such a shy little fellow—" Here she was interrupted by one in the group sitting around the radio: "Well, haven't you been taught to watch out for the good child?" And, with conviction: "Since I have been in the nursery school, I have watched the shy ones too!"

During the classroom discussion of "fear," a student nurse posed this question: "Isn't the chief cause of insecurity in nurse-child relationship due to the fact that often the nurse is afraid of the child and the child is afraid of the nurse, and, in some hospitals, the nurse is afraid of the head nurse, and the head nurse may be afraid of the supervisor, and the supervisor may be afraid of—someone else?" As the various forms of class approval died down, she continued: "In the nursery school everything is so different, everyone seems to belong together."

A graduate nurse taking a course in pediatric nursing expressed herself with regard to the many complex features of a children's hospital organization: "It seems so important for all of the hospital staff to be in sympathy with the nursery school program even if they don't understand what it is all about, for the children are so quick to sense attitudes."

"I like the nursery school," a young affiliating student said eagerly, "for it is one place where we can use the psychology we get in the classroom." Later in the conference she agreed that psychology could be used elsewhere in life, and also that the nursery school techniques were often adapted to the care of children in the ward. However, she held firmly that "it all depends on the supervisor—whether she is sold on it or not."

At the end of her first day in the nursery school, a student nurse, a recent arrival from a large hospital service for the acutely ill, complained: "I was never so miserable, I might as well have been a wooden Indian today. I was told to be, 'inconspicuous and observe the children'—well, I never felt so conspicuous in my whole life, and as for observation, twenty children observed me! I know I'll be bored to death with nothing to do all day but play around with the children." About a week later in the classroom, while learning was being discussed, this nurse volunteered: "The hardest thing for me to learn is to keep from doing everything for the children. In our hospital, we even did the talking for the children."

Chosen at random, as these cases are, they nevertheless illustrate many problems confronting pediatric nursing education in its wider aspects. If these cases also contain some evidence that nursery school contact makes a difference in the student's attitude, if she becomes more objective-minded, less docile, that is as it should be.

In conclusion, I offer these materials for your consideration, particularly to my fellow workers in this nascent movement. I submit that the nurses' response to the nursery school is an intelligent, serviceable response, and that the many problems arising in this newer phase of pediatric nursing will receive the attention that they merit.
Round Table III

Thursday, April 28, 2:30 p.m.

Presiding: Dorothy Campbell, R.N., Cook County School of Nursing, Chicago, Illinois.

Subject: student health

THE HEALTH SERVICE AT THE UNIVERSITY OF KANSAS

RALPH I. CANUTESON, M.D., Director, Health Service, University of Kansas, Lawrence, Kansas

Health services in colleges have been the outgrowth of one of two general demands: first, the request of the students for health protection; and second, the feeling of college administrators that provision should be made in the college curriculum for educating and leading the student in fundamental health habits and practices.

At the University of Kansas the health service developed from a demand, early recognized by a few administrative officers, for medical care and hospitalization during a mild epidemic of diphtheria. In 1906 the Students' Benefit Association, a voluntary membership organization, was founded. For a semester fee of fifty cents its 42 members were promised a limited amount of hospital and nursing care if they contracted a contagious disease. The University provided self-supporting students with the consultation services of a physician faculty member. In 1908 the Benefit Association was officially recognized by the Board of Regents, and the membership grew to 742 at a yearly fee of $2. This permitted extension of the hospital and nursing services and the hiring of a part-time physician. Four years later the consultation work was taken over by the director of physical education, a physician, and an assistant woman physician in the women's department of physical education. In 1928 the part-time staff was replaced by full-time physicians, and the service had then grown to provide hospital and dispensary facilities for all students.

With the change to a full-time staff, efforts were increased to carry out the aims of the service, namely, the promotion and protection of the health of all the students in the University. Towards accomplishing these aims, the hospital and dispensary facilities were enlarged and improved by installation of more complete laboratory and x-ray departments. The entrance physical examination, which had been given only to a part of the new students, was extended to reach all new students, whether freshmen or upper classmen. The examination itself was made more detailed with the aim of picking out structural and functional abnormalities. Besides the usual urinalysis, other tests were included, chief among these being the tuberculin test. When any student showed a positive reaction to the tuberculin test x-rays were taken and additional laboratory tests and observations made. As far as possible, all significant abnormalities were re-checked and the student
advised as to corrective procedures. The record system was improved and standardized, and a continuous record kept on every student.

The physical plant of the health service has gone through several changes since its origin as a contagion detention, or "pest," house. The next step was a larger house remodeled for hospital use with provision for both contagious and non-contagious cases. Later a larger house was taken, and in addition to the usual bed space, a makeshift operating room was provided, and an outpatient dispensary. In 1931 Mrs. J. B. Watkins added to her benefactions to the University and the city of Lawrence by building and presenting to the University a completely equipped 46-bed hospital. This building, architecturally beautiful, is located on the campus close to the main lines of student traffic, and contains a large outpatient dispensary, record and business offices, x-ray and laboratory rooms, a pharmacy, an operating room, kitchens, and resident physician quarters. The original 46-bed capacity has now been enlarged to 62, and there is adequate provision for both contagious and non-contagious cases. In the past year she has built and presented to the University a nurses' home adjacent to the hospital.

The health service derives the major portion of its support from health fees paid with the incidental fees by all except a few special students. This fund provides for the health service staff, maintenance of hospital equipment, partial maintenance of the building except outside repairs, surgical and medical supplies, and the multitude of other needs of a hospital and dispensary unit. For a few services, over and above the average, there are minor charges made the student. These extra services include hospitalization beyond three days, some special drugs, and the use of the operating room.

The staff of the health service consists of four full-time physicians, six graduate nurses, laboratory and x-ray technicians, pharmacist, and record clerks. If the student requires consultations or treatments by specialists or needs special nursing care he is responsible for the extra fees. The hospital is open to any qualified physician.

In promoting and maintaining students' physical welfare there are in general three major approaches: first, medical supervision including routine physical examinations, advice on correction of defects, and provision for or guidance to adequate medical care; second, instruction in the essential good health habits by means of personal consultations, by object lessons in early care of abnormalities, and by lectures; and third, provision for good living conditions including acceptable rooming houses and good food, and recreation facilities. In some universities all of these functions are united in one departmental unit. In the University of Kansas the first function and part of the second, such as teaching by personal consultation and example of modern medical care, are directly in the health service. The third function is divided between the department of physical education and other departments, with only a part of the rooming house supervision and examination of food handlers delegated to the health service.

The student makes his first contact with the health service when he is
given his appointment for the entrance physical examination at time of his registration. During one of the four days preceding the opening of classes he reports at the hospital where he is assigned a numbered record. A nurse takes his personal and family medical history in considerable detail. Next he is given a tuberculin test, then that part of the physical examination covering the vision, eye, ear, nose, and throat is made before the two sexes are separated to continue the examination through separate sets of examiners. Only women physicians are assigned to the women students. The remainder of the examination includes weight and measurements, urinalysis, complete chest and abdominal examination, orthopedic examination, and inspection of the skin. Should any significant findings appear the student may be given a later appointment for additional tests and examinations. This may include additional x-rays, blood examinations, kidney function tests, and electrocardiographic records. At the end of the examination the findings are summarized with the student and he is advised of any abnormalities of consequence, particularly if they are correctible. Later he returns for the reading of his tuberculin test and administration of a second test if the first is negative. If the test is positive he is given an x-ray examination of the chest, and perhaps added physical examinations and laboratory tests if the x-ray shows any findings suggesting secondary tuberculosis.

Subsequent contacts with the health service occur if he requires consultations because of illness or on account of problems related to his health, such as scholastic loads, outside work, worries, etc. Students who are sick enough to be in bed or who have no one to care for them at their rooming houses are admitted to the hospital. Frequently students are admitted to give them rest in an effort to readjust their schedules. The hospital endeavors to fulfill not only the role of the home but that of the parental and family physician supervisors in the many minor or serious health disturbances that afflict this age group.

A brief analysis of a year's activity would illustrate better the multiple and wide services extended. In 1936-37 there were 1,467 routine entrance physical examinations given in September and an additional 150 during the year, mostly at the beginning of the second semester. Of the 1,467 examined in the fall, 346 had positive tuberculin tests, and further examination by x-ray showed seven to have secondary tuberculous infection, of which two were active infections. Eighty-five per cent of the 4,000 students paying the health fee visited the dispensary for a total of 32,378 visits. Hospital patients numbered 1,295 for a total of 5,330 hospital days, and an average stay of 4.11 days each. X-ray examinations were made on 1,242 students.

Leading the list of causes for students coming to the dispensary are the following: respiratory diseases 5,996, examinations and re-checks on physical examinations 1,774; skin diseases 1,587; diseases of the body as a whole (including some contagion) 1,420; digestive disturbances 1,114; vaccines (smallpox, typhoid, diphtheria, hay fever, colds, etc.) 1,066; and health certificates for teaching positions, army applications, etc., 731. There were
in the hospital 108 surgical cases, half minor surgery and half major, with appendectomies predominant.

Some of the special problems may be of interest to this group. Experience has shown that the nurses who enter health service work must be particularly interested in it and fitted for it by reason of a point of view not too different from that of the group with which she must work. At the same time she must have the poise and tact necessary to control a group of active, and sometimes not too sick, student patients. We find that it is somewhat more difficult to maintain hospital discipline in this type of work than in a general hospital. The specialty of care of college students might be classed as "grown-up pediatrics" and it presents many of the problems of child care.

The work often is physically hard. This is most often due to the rapid turnover of patients and the fluctuation in hospital census. The respiratory diseases and digestive disturbances have every opportunity to occur in sudden waves or minor epidemics. The hospital may be practically empty on a Sunday afternoon and by Monday night have reached its normal patient capacity. We are still following the older system of so-called 12-hour duty, with 2 hours off each day, one half day a week and every other Sunday free. Undoubtedly an eight-hour schedule would be more satisfactory from the standpoint of the nurses and the hospital administration but in a small hospital the added cost makes such a plan prohibitive at the present time.

During the past year we have put into effect a different plan of serving meals with the complete agreement of the staff and the patients. Because so many of our cases are minor illnesses or injury cases and retain hearty appetites, the old system of serving dinner at noon and a light supper early in the evening demanded extra feedings before the patients would settle down for the night. With slight change of kitchen schedule lunch is now served at noon and dinner in the evening. This has eliminated the bedtime feedings and even the most ravenous patient is satisfied.

In a mixed medical and surgical hospital the problem of caring for contagious disease is always before us. Every year we have a few cases of the contagious diseases, other than acute respiratory infections. These cases are isolated in a separate contagious wing as much as possible, but occasionally there has been an overflow into other rooms. On the theory that a patient can be isolated anywhere by observing certain simple precautions we have concentrated on developing this technique among the hospital staff and on teaching the patient to do his part. Gowns and masks are used only when the nurse is working over the patient, when the doctor is making a close examination, or when the patient is too sick to cooperate. Otherwise the "arms length technique" is used, whereby the doctors and nurses stay a reasonable distance from the patient, do not touch him except as needed, and then only with the hands, and the patient is taught to avoid contact and droplet exposure of those in the room with him. This method has given us a clear record of cross infection; no cases of cross infection having occurred in ten years. Needless to say, thorough washing of the hands (with soap and
water) and cleansing of instruments are carried out as with any type of illness.

The type of service here described fits, with some individual variations, many schools in the United States. After a long experience in college health services we are convinced that they provide a necessary part of the educational experience of the student. They teach by consultation and by example. They substitute for the family influence and the family doctor in time of illness. Until our social order provides something which will serve the college, the student, and his family as well or better, they are destined to continue the growth they have been making in the past thirty years.

HEALTH PROGRAM AT MINNEAPOLIS GENERAL HOSPITAL

GLADYS BRATHOLT, R.N., Assistant Superintendent of Nurses, Minneapolis General Hospital, Minneapolis, Minnesota

The health program for the students in the school of nursing at the Minneapolis General Hospital has as its basis the belief that the teaching of positive health should not be delegated to a few. In an institution in which much stress is placed on the curative aspects of disease, prevention often is relegated to the background. The nurse, in teaching her patient the preventive aspects of disease, should be motivated to apply these principles to herself. The supervisor who works in immediate contact with the student can do much to encourage her to maintain good health. The health of the student should be a matter of her daily living rather than just something to be checked periodically by the physician and the health nurse. Each student's capacity for maintaining good health is essentially different. That program of health is best which best serves to motivate the individual to healthful living.

Since the Minneapolis General Hospital is a part of the University of Minnesota School of Nursing, it is necessary to describe briefly how the health programs of the two are interwoven before describing more fully that of the former.

During the three-year student’s preliminary period, when she is registered at the University and has not yet been assigned to either the University or the General Hospital, her health is under the care of the University health service. During the two and one-half years when the five-year student is on the campus, her health is also under the care of the health service, as is that of any other University student. This service has a director, eight full-time physicians, thirty-five part-time physicians, three full-time and four part-time nurses, plus twelve clerical workers. A fully equipped unit is available for hospitalization of students.

Before beginning this preliminary period, our school of nursing requests that each student have her dental work completed, be vaccinated against smallpox, and immunized against typhoid fever, diphtheria, and scarlet fever. If, for any reason, a student enters the school too late to have had her
immunizations done by her family physician, she may have them done at the health service.

Upon entering the University, the student must pass a physical examination given by the health service. This includes family history, past and present physical status, environmental factors, tastes and interests, health habits, a complete laboratory study, Schick, Dick, Mantoux, and Wassermann tests. (The records on which results are kept will be shown later). If her Mantoux test is positive, a chest x-ray is taken. At the completion of her examination she has a conference with a health service physician, who discusses with her any health problem she may have, refers her to a specialist for further study of any abnormality revealed by her examination, and to an orthopedist who advises types of shoes to be worn. If the student is assigned to the Minneapolis General Hospital at the completion of these first three months, a complete record of Mantoux tests and immunizations is sent from the health service to that hospital. A student who has not completed her immunizations is referred back to the health service.

Having been assigned to the Minneapolis General Hospital, the student finds that, in addition to herself, the following persons are responsible for her health:

1. A resident physician of the medical service in charge of the examining clinic in the out-patient department
2. A resident physician of the medical service who cares for the student if she is hospitalized
3. Various staff members when consultations are indicated
4. A member of the school of nursing office, who gives a part of her time to student and graduate health.

The resident physician in charge of the out-patient department examining clinic gives a part of his time to the examination of students who are ill, referring them to various clinics for special treatment. This clinic is open daily at 7:45 a.m. and 3:00 p.m. except Saturday afternoon and Sunday for all nurses who are ambulatory. If emergencies arise, the nurse may be seen by this physician between 7:45 a.m. and 3:00 p.m. The member of the school office responsible for student health assists the physician at the clinic held at 7:45 a.m. At 3:00 p.m. a nurse in the out-patient department is present. Emergencies which may arise before 7:45 a.m. and after 3:00 p.m. are referred to a resident physician in the receiving department. Upon the recommendation of the resident physician in the examining clinic, all nurses who are too ill to remain in their rooms are hospitalized and are then directly under the care of a resident physician of the medical service. Nurses are hospitalized in a unit on the women's medical floor. Efforts are made to hospitalize nurses who are acutely ill in two-bed rooms.

The member of the school office responsible for student health arranges for hospitalization of students and is responsible for general follow-up work and records. She also visits the health service and acquaints herself with the preliminary health record of each student assigned to the Minneapolis General Hospital, thereby obtaining knowledge of any past illness which the
student may have had. She holds a conference with each student when she arrives at the hospital and makes a brief record of information gained pertinent to her mental and physical health. The informal nature of this conference tends to make the student discuss her problems freely. A definite effort is made to assist each student to adjust herself to her new environment and to feel free in the future to discuss any problems which she may have. If the student has been under the care of a mental hygienist at the University, she is encouraged to continue under his observation. She also discusses with the student any physical condition which should have further study. A brief orientation to the health program at the hospital is given to each new group of students. Special emphasis is placed on the early reporting of minor illnesses and on prevention of the diseases most common to student nurses. A similar program is carried out for students who affiliate for a year or longer.

The student health program of the Minneapolis General Hospital, in addition to caring for the ill student, provides for:

1. A complete physical examination once a year and one one week prior to the completion of her course. Just before completion of the course, a chest x-ray is done.

2. A Schick and a Dick test once a year given by a member of the University health service staff. If either test proves positive, immunizations are given. A Mantoux test is given if previous ones have been negative.

3. Nourishment between meals for the student who has difficulty in maintaining her normal weight. The student is weighed each month. Any appreciable loss is carefully checked by the physician.

4. A Mantoux test and chest x-ray just preceding assignment to the tuberculosis service. If the student’s tests have previously been negative, a Mantoux is again done upon her completion of the service. If this test is positive, a chest x-ray is done.

5. Tonsillectomies and other operations when necessary. A written consent from the family is required for all major operations, any operation requiring a general anaesthetic, and for such minor operations as tonsillectomies and submucous resections.

6. Two week’s sick leave during the nursing course, to be used for any type of sick leave necessary (such leave to be recommended by a physician). This leave is for the purpose of promoting better health by encouraging the student to report her illness early. It may likewise be used as a leave of absence in the form of a preventive leave in an effort to assist the student in maintaining positive health. After a student has been acutely ill, she resumes her duties gradually by working half time for the first few days until her strength returns to normal. The two weeks of sick leave are allotted for the above purposes only and do not in any way affect the finishing date of the student who loses no time due to illness.

The program described could be made more effective by having one staff physician, together with a full-time nurse, responsible for the health of
students and employees. The nurse could be of valuable assistance in the field of prevention and health education. Health supervision of employees can do much to prevent students from unnecessary exposure to undiagnosed cases of tuberculosis and to carriers of various other infectious organisms. In adjusting to a new environment, students often present problems which would warrant the part-time services of a mental hygienist. At present the Minneapolis General Hospital is striving toward the attainment of such a program.

Joint Session

American Nurses’ Association
National League of Nursing Education
National Organization for Public Health Nursing
Thursday, April 28, 8:30 p.m.

Presiding: Nellie X. Hawkinson, R.N., President, National League of Nursing Education.

The invocation was given by the Reverend George P. Baity, D.D., of the Westport Presbyterian Church, Kansas City, Missouri. During the hour while the guests assembled in the auditorium, the Kansas City High School Orchestra, George Keenan, Director, played musical selections.

PERSONALITY

GEORGE WILLARD FRASIER, PH.D., President, Colorado State College of Education, Greeley, Colorado

It is dangerous to discuss anything as old, yet as new, as personality. The subject is as old as civilization and yet as new as the latest discovery in the field of endocrinology.

It is difficult to define personality, yet everybody knows what it is. The dictionary says that personality is “that which makes one human being different from another.” Yet the word “personality” is popularly used to mean many things. The radio announcer refers to a little girl as having loads of personality. Prospective employers each year ask us to rate teachers on a personality scale. A satisfactory personality is necessary in almost any position. But what is personality? Is it a matter of amount? Is it something that can be rated 1, 2, 3? What is a satisfactory personality?

If we are going to discuss personality, I suppose it will be wise to attempt to say what it is. Let us use the dictionary definition. Personality is “that which makes one human being different from another.” It is something that is peculiarly personal. It is that which is a person. Personality does not detach itself from substance. It cannot be folded up and put into a bureau drawer like Peter Pan’s shadow. It cannot parade like a ghost. Personality is not something you have; it is something you are. It is not something you find; it is something you create. It is not something you
put on and take off; it is something you live. Furthermore, personality is lived in the presence of others. So far as I am concerned, your personality is what you do to me when we come in contact. Personality contacts vary widely for the same individual. A young man may be a boisterous, blustering ego with younger boys. This same young man may be hesitant, bashful, and awkward in the presence of girls his own age. Consequently he exhibits a different personality.

Where does personality come from? Our answer must be incomplete and full of uncertainty. But I think we can safely isolate some of the factors concerned with personality.

Let us see what Dr. Richmond, an eminent mental hygienist, says in her recent book, *Personality—Its Study and Hygiene*.

Personality development is an exceedingly complex process; much, if not all of it, takes place under cover, so to speak, and it is only by deduction and inference that we discover what is happening. Indeed we might say that personality formation is never discovered while it is going on, but only after it is an accomplished fact—and then, of course, it is often impossible to know just what factors have been of most importance.¹

On the other hand, the behaviorist says that personality is a system of habits. The total habit pattern makes personality. It would follow from the behaviorist's point of view that direct teaching of personality would be of little value. If you want to affect personality, you must develop the right types of individual habits. In fact, if we are to follow the lead of the behaviorist, we will look for causes of adult action in habits that may have been developed in childhood.

We might look to the psychoanalyst for help. He will insist that all personality traits arise not from habits but from primitive impulses and the sublimation of them. Thus adult behavior is usually explained in terms of childish instincts that still persist. Gestalt psychology offers a helpful suggestion. The Gestaltist always deals with a total situation. He is interested in integration.

But let us try to see through this maze of uncertainty and conflicting evidence. I will try to reduce personality development to its most simple and fundamental factors.

In the first place, a personality must have a body in which to live. The body, however, is more than a dwelling place. Many bodily functions condition personality. The ductless glands, for example. Personality is intimately tied up with the central nervous system. It is closely related to bodily vigor. It is directly affected by disease. We must look well to the physical body if we are to understand personality. The human body helps determine personality, and yet personality is not particularly concerned with physical dimensions. Personality is not concerned with height—Napoleon was short, Lincoln was tall; or size—John Philip Sousa was small, William Howard Taft was large; or color—Booker T. Washington was black, George

¹ Richmond, Winifred V., Farrar & Rinehart, 1937.
Washington was white; or race—Kagawa is Japanese, Jesus was a Jew. Yet you will all agree that these were outstanding personalities. Evidently personality is not determined by such external factors.

What then about the physical body determines personality? The first and most important consideration should be given to the endocrine glands. The functioning of these ductless glands, located in various parts of the body, affects the development of personality. We have learned much about the functions of these glands in recent years. We know now, for example, that the thyroid gland conditions personality. The thyroid gland may function abnormally in two ways. It may produce too much thyroxin; or it may produce too little. In the first case the individual loses weight and is nervous, sleepless, restless, and easily irritated. The opposite effect comes from the other condition. The individual becomes slow, phlegmatic, sleepy, and his mental processes are much slowed up. The functioning of the thyroid gland plays a significant part in the making of human personality. We know less about the other ductless glands, but we know that they play an important part in the making of personality.

Another physical factor that conditions the formation of personality is general health. A person who is suffering from anemia, tuberculosis, or diabetes shows their effects in the development of personality. Modern medicine has discovered how such diseases may be controlled and in many cases personalities have been almost completely changed after the body has been freed from disease. Health, bodily vigor, enthusiasm are all important considerations in the study of personality. Furthermore, there are a large number of specific defects that may interfere with personality development. Probably the most common one is speech defect. The person who is tongue-tied, who stutters or stammers, who finds it difficult to express an idea, oftentimes damages an otherwise satisfactory personality.

Furthermore, personality is intimately bound up with the mental processes. Native intelligence is important. The ability to project, to plan, to think ahead is significant. The ability to review action is important. The ability to integrate is basic. Personality is closely tied up with the mental life. It is also concerned with the relationship between mental and physical life.

Furthermore, general intelligence largely determines whether a person is slow, infantile, brilliant, or unintelligent in his thinking. It is very difficult to change those aspects of personality that depend on intelligence. It is much more important to understand them. It is also extremely important that the individual understand his own possibilities and limitations if he is to have the most satisfactory life possible.

Consideration must also be given to the emotions. Love, hate, rage, fear, and other emotional states affect personality. Emotions play such an important part in personality that we often refer to a person as loving, hateful, or bashful. Emotions often determine the dominant characteristic of a personality. Emotions also help to form personality. Emotions sometimes com-
pletely dominate a personality. Many individuals are emotionally unbalanced. The man who is quarrelsome, the woman who is moody, the girl who is friendly, the person who lives in a surging series of ups and down, the one who is afraid to live, are all possessed of emotionally controlled personalities.

Personality is also concerned with social and environmental factors. It is concerned with relationships that we refer to as character. I shall not define character; I shall assume you know what it means. We often associate personality intimately with character—a dissipated man, a wayward youth, a gluttonous fellow, an upright woman—these expressions denote character, but they also point to personality. As a matter of fact, relationship to others is one of the most important things to consider when we study personality. In France and Japan and many other countries, manners and morals are taught together in school because they are both related to social environment. He who is kind to an old lady, considerate in helping a blind man across the street, or who wipes the tears from the eyes of a youngster who has fallen down, may be exercising faultless manners or demonstrating a moral code. Whichever it is, it is positively related to personality. A person has as many personalities as he has social contacts. Each contact may call forth a different reaction and show a different personality. A nurse may show one personality to a patient, another to the doctor in charge, and still another to friends at lunch time.

Can personality be improved? The answer is yes. If it were not possible to improve personality, there would be no point to this discussion. It would not be important to understand the factors that make personality if we could not manipulate those factors to improve personality. We shall discuss the improvement of personality under the same four heads that we used in discussing the development of personality.

We shall approach it first from the standpoint of the physical body. If you would improve your personality, here are some things for you to do.

Keep your body free from disease. Research in the field of science and medicine during the past hundred years has taught us how to control most diseases. You should make use of this information. It is no longer necessary for diabetes to disintegrate a personality, because of the development and use of insulin. It is no longer necessary for anemia to fade and destroy a personality, because anemia can be controlled. It is no longer necessary to have an abnormal personality because of the overreaction or underaction of the thyroid glands. Thyroid glands may be removed or controlled. They can be made to function normally. It is no longer necessary to have a body driven by excess metabolism or slowed up by the lack of proper metabolism, because metabolic rate can be controlled. It is possible to a large extent to keep the body free from disease. This improves bodily vigor. A healthful body reacts on the nervous system and the emotions. When you have a healthful body, you have gone far in the solution of many other problems of personality.
Then there are some more or less trivial things that to a certain extent affect personality. I refer to overweight and underweight. They do affect personality. You will remember from your Shakespeare, "Yon Cassius has a lean and hungry look." We might also mention such things as posture. We might mention (although we do not care to give it too much importance) the matter of clothing. Clothes do not make the man, but they add to personality. We might throw in for good measure such things as personal attractiveness, and the ability to choose clothing wisely.

The second factor that conditions the improvement of personality is intelligence. But, you say, intelligence cannot be improved. Probably not—at least it cannot be changed very much. It is impossible to change an idiot into a normal person, or a normal person into a genius; but if you would develop the best possible personality, you must understand first of all that there are different types of intelligence. Some are gifted with abstract mathematical intelligence; others have artistic intelligence; while others may be endowed with social intelligence. It is well to understand the type of intelligence that you have. Furthermore, it is important that you set for yourself tasks that are within the realm of achievement. If I should set for myself the task of learning to play the violin, I might worry myself and damage my personality because it would not be an intelligent goal for me. The most important thing so far as mental life is concerned is that you understand your own possibilities and limitations.

"How can I get the most from my mental equipment?" you ask. In the first place, it is important to plan ahead. Always know where you are going. This matter of thinking straight, planning, and attempting to achieve a goal, is basic in personality improvement. Always differentiate between day-dreaming and planning. Day-dreaming and wishful thinking use up much energy and deteriorate personality. Intelligent planning uses up energy, but it is of positive value in personality improvement. The most important thing in life is to learn your limitations and plan your life accordingly. I cannot play the piano; my musical education was a total and complete failure. I tried once for many months to learn to play a banjo. I could read notes and find the correct spot on the string; I could count time; but never could I get to a place where I could tuck a banjo under my arm and make something sound like "Old Black Joe." I cannot speak French or Italian or German; in fact I must go through life with only one language. I have tried for years to play golf, but I know I can never be anything but a "dub." However, I don't go through life moaning to myself, "I can't play the piano, or speak French, or break a hundred in golf, what shall I do?" I have learned to accept my limitations. I think this point of view is sensible in the development of wholesome and intelligent personalities.

A complete personality can be developed in spite of physical and mental handicaps, if you understand your limitations. We have mentioned those who are handicapped by serious speech defects. Of course, many defects
can be removed, and they need not interfere with the development of a total personality. However, some of them remain for a lifetime. There was a time when we believed that it was unwise to talk to people about disabilities. But in the development of personality this is exactly what should be done. The individual who says, "I stammer and stutter when I get excited, but don't worry about me, I will get through all right," will not suffer personality deterioration because of a speech defect. The same thing is true of physical deformity. Steinmetz developed an interesting and valuable personality though undersized, hunchbacked, and deformed. It is not the deformities of life that destroy personality; it is the attitude of the individual toward such deformities.

We shall next turn to emotions. Emotions are important in the development of a better personality. We are living in a highly organized society. We are living in a civilization that tends to curb all emotional responses. Our more remote ancestors could kill, strike, fight, roar with laughter, scream with pain, or yell with glee. It was all a part of life. But modern society constantly says, "Thou shalt not," to almost every emotional outlet. Of course we should keep emotions well under control; but we should have more emotional experiences than we do. In other words we should use emotions; we should color life with emotional experiences if we are to have well-balanced personalities. Some children must "blow off steam"; some adults should do the same. For example, a man goes to a baseball game; he screams until he is hoarse; he slaps the man next to him on the back. He yells, "Kill the umpire," and at the end of an hour and a half he goes away exhausted; but from the standpoint of emotional life, it has been excellent experience. It is wise sometimes to lose yourselves in emotional reactions. Perhaps girls do not like baseball; they must get their outlet some other way. Some people swim; others walk for miles; others dance; others bang the piano; while others write long letters and then tear them up. These are some emotional outlets, and most normal individuals need them.

Furthermore, emotional balance is important. If you live in the realm of gloom or an atmosphere of continuous hilarity, there is danger that life will become one-sided. Some people do little but play bridge; others live a life that centers around golf or racetracks. Some people read constantly. Some live a "job" twenty-four hours a day; others go to movies every night. Too much of anything throws life out of balance and brings many of the nervous breakdowns that are so common today. I am told by those who know, that a great many wives of farmers, in isolated dry-land districts, are now in the mental hospital because life was too much the same day by day. Variety is important. Balance is essential. Integration is the most important word in personality building.

We turn finally to social and environmental factors in the improvement of personality. Can we improve personality by improving social environment? Yes, both are susceptible to change and improvement. Every time you build a new ideal, which is an emotionalized idea, you are forming
personality. It is a slow process. New ideals make for new relationships. New relationships change personality. Manners and morals are social concepts that are often confused. Both are related to personality. If you would better your personality, look well to your morals and manners. The little niceties of life, demanded by a polite society, are what make for a more satisfactory personality. It pays to be socially acceptable. Usually those who have a high degree of development in both morals and manners have a more complete and satisfactory personality.

Harry Emerson Fosdick, in a recent article, analyzed personality and its development. He recognizes three factors that enter into the achievement of a fine personality. He lists first imagination. He cites many cases of great personalities, each one endowed with unusual imagination. He says it is necessary to picture to yourself the things you want to do and where you want to go. Picture this to yourself vividly; assume yourself as winning, and this will contribute immeasurably to success. He also suggests that if you do not use imagination, do not picture the future, you will drift like a derelict.

The second factor recognized by Fosdick is common sense. By common sense he means ability to analyze a situation and select the goal that is within your possibility. If you select a goal that you cannot achieve, you do not create personality but destroy it. So it is necessary to study yourself, study your mental possibilities, and picture your goal. This takes wisdom or common sense.

The third factor he recognizes is courage. Even though you have imagination and common sense that leads you to picture an intelligent goal, that personality will not be achieved unless you have the courage to go ahead and do that which is necessary to achieve your goal. Vision plus common sense, plus valor, is important.

Up to this time, we have been largely interested in the development of your own personality. I wish now to urge upon you the necessity of exercising the greatest care in dealing with other developing personalities.

Regard for human personality is peculiar to our civilization. You do not have to go back far in history to find records of those who tortured the bodies of their enemies; who sacrificed babies to angry gods; who misused women; and destroyed the rights of children. But you say such things are still done. Yes, there are still some uncivilized places in the world, some uncivilized people in our midst, and some nations that have reverted to savagery. Such examples as these show a complete disregard for human personality.

Regard for human personality is basic in modern education. It is the fundamental philosophy upon which progressive education is based. It is the theory back of the child-centered school. It is regard for human personality that keeps us from assigning children tasks that they cannot do. An ugly word from a parent or a careless statement from a teacher may change a life and condition a personality. A short time ago there appeared
in the press of the country a story from a village in New York. According to this story, the principal of the high school, in his attempt to discipline two high school girls, insisted that they should write, "I won't laugh out loud again in class," not once but a thousand times. These two fourteen-year-old girls said that such punishment was beneath their dignity, and they walked out of school. Their classmates walked out with them. The principal of the high school insisted that before they be readmitted they should not only fulfill the requirements of discipline already imposed, but that they should write, "I won't go on a strike again," not a thousand times but two thousand times. "It is a silly, ancient, barbaric custom," said the girls. The president of the school board backed the principal to the limit. He is quoted as saying, "I had to do it; my father had to do it; and there isn't any reason why kids nowadays should not be punished in the same way. Anyway, they have too many fresh ideas."

I have no idea how the strike ended, but I am telling the story here as an example of a school that violated the inalienable right of human personality. I am quoting it because it illustrates the fact that many people today believe that because human personalities were violated in the last two or three generations, we should continue to do it. I could multiply this example innumerable times. It is not difficult to discover cases where school authorities have had no regard for human personality. Our whole system of promotions and failures is based on a wholesale disregard for personality development. Children are constantly asked to do those things they cannot do. Then they are unjustly punished, demoted, or failed because they cannot do the work.

Fred C. Kelly recently said, after making an expansive study of criminals of one large city, "It is evident that nearly all criminal careers start with emotional maladjustments, at home or school, so slight that they might be remedied if detected early."

The great religions of the world have had much to say about human personality and the regard for its development in children. Probably the most quoted expression attributed to Jesus is his statement, "But whoso shall offend one of these little ones, which believe in me, it were better for him that a millstone were hanged about his neck, and that he were drowned in the depth of the sea." This is a vivid statement of the necessity of a regard for the personalities of children.

The aim of every individual should be the development of a whole, well-balanced, integrated personality. Such a personality contributes to the happiness of life, to the enjoyment of others, and to the development of a satisfying existence.
THE FLORENCE NIGHTINGALE INTERNATIONAL FOUNDATION

LULU K. WOLF, R.N., Past American International Scholar, Florence Nightingale International Foundation

It is my privilege to give a brief account of the year’s experiences of an American student in the Florence Nightingale International Foundation. To choose the best and most valuable opportunities and activities of that eventful year, and to relate them briefly is rather difficult. However, I hope to be able to give, more by overtones than by details, some of the atmosphere and flavor of those twelve months in Europe as the representative nurse for the United States.

Go with me, if you will, to the lovely old English house at 15 Manchester Square in London, where eighteen students from thirteen countries live together, eat together, play together and at times, even “irritate” together. Each girl lives in a room bearing the name of her own country, and upon entering this room she finds the essence and decorations in harmony with those of her respective homeland. It is her problem to create, through her personality, the appropriate atmosphere. What a challenge this is! Try as one will, it is almost impossible to shake off the idea that what one does reflects upon one’s entire country—a responsibility, of course, but a delightfully stimulating and leveling one for us all.

Fifteen Manchester Square plays a major rôle in the learning process of the student. It is in the library of this house that most of the studying, writing of essays, and open discussions take place. Here, in the intimacy of a small group, it is possible to discuss informally, pool ideas, weed out prejudices in a way quite unbelievable to a student who has studied only in her own country. Here, by the open fire in the late evening the lectures of the day at Bedford College and the College of Nursing are reworded, explained in different languages, discussed, debated, and finally digested and assimilated. All sorts of questions arise at these unusual lively get-togethers about industrial conditions, ethical principles, psychology, nutrition, social administration, methods of government, mores and customs—all, in turn, are discussed and criticized, sometimes quietly, sometimes heatedly; but always comprehensively. Preconceived ideas are scrapped; new meanings are injected into old thought processes; deeper understanding of boundary-line tensions is ingrained, and a finer appreciation of each country’s social structure evolves. As a result, one must gain a richer background upon which her professional education is subsequently placed.

The international student has a choice of four major courses: public health nursing, teaching, or administration, and social work. In any of these courses the curriculum requires the nurse to spend six weeks observing in hospitals, clinics, or health centers in London or its vicinity. My six weeks were spent in four famous old interesting London hospitals: Saint Charles’, Guy’s, Saint Bartholomew’s and Saint Thomas’s. During this time I lived in their respective nurses’ homes. This experience was invaluable;
I was seeing bedside care, nursing technic, ward management, food service, hospital and nursing school administration in an entirely new social setting, and in a totally different situation. I found myself surprised, wondering, shocked, amused, delighted, as I reacted, first with an American viewpoint, and then, with that of the English nurse. Why had I never thought of all these angles before? How could they all be dovetailed into a still better thing? These, and countless other thoughts kept me constantly in a mental whirl. Stimulating, enervating, exhausting.

At the end of each day, as I reviewed and translated my experiences to my Austrian companion, her questions, comments, and comparisons with her own country would send me off to reexplore and redirect my thought once again.

Returning each week-end to Manchester Square, we would have group discussions, in which we learned of each other's experiences, and heard comparisons of nursing methods until the wee sma' hours of dawn. It is difficult for one to imagine such spirit, frankness, and emotionalized thinking as was expressed in these early weeks of observation. Like all youngsters we were at first violent, but by the end of the first semester we had calmed down to the point where tolerance, understanding, and critical thinking were replacing emotional blindness and prejudice.

During the Christmas holiday field experience and professional observations are not encouraged, due to the strain and fatigue occasioned by the first few months of the course. The period is given over to picnics, holly picking, dinner parties, hospital festivities, travel, and rest.

At Easter tide five weeks are available for observation of nursing in Great Britain, Scandinavia, or the Continent—the choice is left entirely to the student. In this period I visited seven countries: Norway, Sweden, Finland, Poland, Hungary, Austria, and Germany. Brevity of time forbade any intensive study of nursing in any of these countries, but I spent from three to five days observing hospital or public health nursing in each country; I had the advantage of having as guides and hostesses nurses who had been international scholars in either England or the United States. They knew the bases for comparison of nursing practices, and from them I learned much in a short time under such optimum conditions. Nursing history, formerly learned from books, assumed a new importance as one chatted till late evening with a former "International" in the famous old wine cellar in Warsaw, in a snow-clad mountain resort in Norway, or between acts of the opera in Vienna.

Would that I could tell you more of the flavor of that glorious year! The final exercises, the boat trips on the Thames, the hedgerows and the gardens, the military tattoo, the international champions at Wimbledon, the derby, the coronation, and other new and unusually stimulating experiences, which were mine last year, and which will be yours if you are awarded the scholarship.

You can always go to school at home, but the crucial test comes only when you study in a country where everything—even to the air you breathe—is
different from that of the homeland. You'll learn unique and different ways to handle old problems; you'll see your own country and her nursing practices from the healthy viewpoint of an outsider; and, you'll come home a wiser, more liberal, and more tolerant nurse than you ever were before. I wish this grand adventure for you all.

**The Spiritual Values in the Profession of Nursing**

RABBI ABBA HILLEL SILVER, D.D.

*The Temple, Cleveland, Ohio*

It is not difficult to define the spiritual elements in the profession of nursing. Nursing like medicine, like so many other essential enterprises of man, stems directly out of the religious sentiments and convictions of the human race. The healer among earliest peoples was the priest. The first healing centers among the ancients were connected with temples and shrines. The first hospitals were built by religious organizations. The first nurses were religionists. The first scientific training of nurses which was inaugurated a little over a century ago was also at the outset on a semi-religious basis.

Inherent in the care of the sick, the protection and the safeguarding of health, are certain basic religious tenets which both motivate and explain them. These tenets, as far as the Western World is concerned, derive mainly from the Jewish-Christian tradition, the source of which are the mighty ethical principles and codes of the Old and New Testaments. In a real sense, the ethical teachings of Judaism and Christianity in the early centuries were a direct and deliberate challenge to the moral callousness, the insensate attitude to human need and suffering, and the indifference to human life which characterize so much of what we call paganism.

In a world which found its enjoyment and sport in the blood-soaked arena where man killed man or beasts tore human beings for the delection of a holiday crowd, the religions of Moses and Jesus proclaimed aloud the sanctity and the inviolability of human life and the horror of shedding innocent blood. In a world where the poor man was despised and hated, where, as Seneca says, most Romans regarded the chance meeting with a poor man as an evil omen, and when a man would not touch a beggar but would throw the pitance to him; where Virgil proclaimed that the "ideal man knows naught of the pang of pity for the poor"; and where Quintillian, another Roman declared, "How can a man lower himself—and not drive the poor man away, as a despised creature?" our religions called not only for compassion and pity for the poor, but for respect and brotherliness. Both home and heart must be open to them. Poverty was at times even extolled, perhaps excessively, as the one classic way to salvation.

At the heart of your profession are some of these mighty religious and spiritual postulates and attitudes which civilization has come to identify with the Jewish-Christian tradition.
Your profession believes that human life is a reflex of divine life, that it possesses a sovereign, inherent significance and nobility, and that it is therefore deserving of the utmost solicitude and the most painstaking care. It furthermore believes that every individual life is similarly significant, for every life is fashioned in the image of God—not merely the lives of the great but also of the humble, the weak, the unknown. There is beauty and promise and the hunger for fulfilment also in the unheralded and unnoticed lives. All who belong to the great and motley communion of saints and sinners, which is the world of men as we know it, have the seal and imprint of God upon them and have a claim upon the pity, love, and tenderness which is the image of God in us.

The significance of the individual—that is one of the characteristic axioms of your profession. You deal with individual human beings. Always your service is directed to one man or one woman or one child. It is a distinct, separate, and self-contained entity, an end in itself, that you are called upon to tend, to observe, to help, to comfort.

In our age, unfortunately, the individual is being dwarfed. He is being merged or submerged more and more in the mass. He is being coordinated. The totalitarian state, for example, reckons little with the individual per se and the requirements of his unique personality. It forces him into pre-arranged molds. It deals with him as with an indistinguishable item in a statistical table.

But, in the religious tradition, the individual is paramount. The salvation of his soul—that is the supreme drama of human destiny. The Bible begins with the story of the creation of one man and closes with the story of the death of one man who saw God face to face. Commenting upon the phrase in the early chapters of the book of Genesis, "this is the generation of man," where man is mentioned in the singular and not in the plural, one of the ancient rabbis stated that the reason for the use of the singular is to indicate that at all times every single human individual has the right to say, "for my own sake was the whole world created."

Your profession, in so far as it is built around personal service to the individual—his care, his physical salvation, his peace of mind—is closest today to that classic religious tradition which unfortunately is being eclipsed in our world today—we hope only temporarily.

Your profession renders not only personal service to individuals but personality service. I cannot conceive of any profession wherein the moral and spiritual personality of the servor is of such importance as in the profession of nursing. Sound moral qualities are the foundations of true success in every profession. They are the strong arms which sustain men and women in all their ways. But nowhere are they so much a part of the actual professional routine and procedure as they are in the nursing profession. Without them the work of the nurse is just not possible. Reliability, trustworthiness, steadiness, loyalty, kindness, tact and unselfishness—these
are the indispensable ingredients of the service of nursing which alone define its success. They are its inescapable criteria and standards.

This is not to suggest that scientific skill, training, and experience are non-essentials in this profession. Quite the contrary. The unique appeal of this profession is its remarkable blending of the two—the scientific and human. Good will and the best of intentions are not enough in this or in any other profession. There must be knowledge, technic, training, skill. All the facilities and instrumentalities which science has made available and which serve to increase the efficiency of a human service must be exploited in this profession as in every other profession to the utmost. Science has bestowed a great gift upon the modern world. It has trained mankind to take the greatest care in order to insure accuracy, efficiency, and dependability—to eliminate as far as possible, chance or variability or the element of surprise, to provide for every conceivable contingency. Science is training mankind to reduce the coincidence of chance and accident to a minimum.

A few days ago I flew some seven thousand miles across this country. Thirty-five years ago, there was no heavier-than-air plane. The whole science of aeronautics did not exist. Within thirty-five years, approximately in half a man’s lifetime, the great new science was developed, together with new machinery, and new implements. An elaborate organization, an elaborate technic and a trained personnel of plane builders, engineers, mechanics, and pilots were developed—and one travels today thousands of feet in the air, in rain or snow, by day and by night, in a shell of a plane at a terrific speed, in comfort and in peace of mind. Why? Because one has confidence in the mind, in the scientific mind which built the machine, in the scientific skill which went into the construction of that machine. One has confidence in the dependability, in the reliability of the implements which aid pilots in the navigation of the ship. One has confidence in the radio telephone by which the pilot keeps in communication with the ground and receives his weather reports. One has confidence in the radio signals which enable the pilots to keep on a straight course and not to deviate. One has confidence in the two-million candlepower revolving beacons which one sees every twenty miles, which illuminate the path across the country, and which tell the traveler that he is being conveyed by an unfailing human vigilance, by a dependable organization, by a science which has made provisions for nigh every contingency.

But science, in spite of its great and indispensable contributions to every human profession, is not enough. Especially in your profession, it is not enough. There must also be human sympathy and gentleness of attitude. And there must be spiritual sensitiveness.

There must be wisdom which transcends knowledge and an eagerness to help which supplements the ability to help. There must be ideals which replenish the reservoirs of purpose and determination.

My friends, mankind is reaching out everywhere today for security—political security, economic security. Nations are arming themselves to the teeth to make themselves secure against war and invasion. Desperate struggles
are being waged all over the world today to bring about a more secure and stable economic order. In some countries, bitter civil war, bloody purges and liquidations are resorted to in an effort to achieve such security. It is very doubtful whether the means which are now employed will ever bring about the desired end.

But there is another essential security of which mankind is in daily and real need—the security of health, protection against the ever present threat of plagues, epidemics, and communicable disease which have in the past ravaged whole nations and continents and which still lurk like an ever present menace close to every civilized community. The slightest relaxation of medical vigilance, the slightest carelessness in public health service, the slightest let-down in discipline and organization—and the foe strikes with blind, remorseless fury and destroys myriads of men, women, and children.

There are also the unpredictable disasters of wars, floods, tornadoes, and fires which bring misery and suffering to untold numbers. It is the medical and the nursing professions and their allied services, indefatigably on guard in every home, school, office, factory in the land which stand between man and his age-old implacable foes of disease and disaster—the dread Horsemen of the Apocalypse. They give to man’s life that element of security and confidence which alone makes possible a planned and orderly existence and a steady progress in all the avenues of man’s quest and development. They have banished from our lives that fateful dread and fear which hung like a pall over the lives of men and nations in other ages.

And in the struggle for this form of security, be it noted, the weapons employed are not blood and terror and force and dictatorship—primitive, futile and tragic weapons—but the moral and spiritual weapons of knowledge, research, education, love, service, and the spirit of self-sacrifice.

And be it noted, also, that because of the moral means which are employed, this form of human security is about the only one wherein real progress has been registered.

Joint Session
American Nurses’ Association
National League of Nursing Education
National Organization for Public Health Nursing
Friday, April 29, 8:15 a.m.

Presiding: Susan C. Francis, R.N., President, American Nurses’ Association

REPORT OF THE JOINT COMMITTEE ON COMMUNITY NURSING SERVICE
(Three National Nursing Organizations)

During the two years which have elapsed since the 1936 Biennial Convention, there have been the following changes in the membership of the Joint Committee on Community Nursing Service. Mrs. Chester C. Bolton and Mrs. George Oliver Carpenter have resigned in order to allow their
places to be filled by persons who are more likely to be able to attend committee meetings. Mrs. Carpenter's place has been filled by Mrs. Chester K. Brooks of Cleveland, Ohio. To date Mrs. Bolton's place has not been filled. Nellie X. Hawkins has replaced Effie J. Taylor as an ex officio member by virtue of her position as president of the National League of Nursing Education. Anna D. Wolf resigned and her place has been filled by Grace Warmen who is an ex officio member representing the Committee on Lay Participation of the National League of Nursing Education. Mrs. Frederick S. Dellenbaugh is an ex officio member representing the Board and Committee Members' Section of the National Organization for Public Health Nursing. Sophie C. Nelson served as chairman until January 1938, when she asked to be relieved of the responsibility. Following her resignation as chairman of the committee, Miss Nelson was appointed an ANA representative on the committee and is now serving in this capacity.

A group of ten men representing practicing physicians' groups, hospitals and the public health field in different parts of the country have been invited to act as consultants to this committee. They will receive material and reports from the committee; their advice will be sought by members of the committee, and by the executive secretary when in the area in which they are located. Their point of view will be helpful in getting a broader perspective of community problems in relation to nursing the public.

The work of the committee is carried forward by an executive secretary, Lulu St. Clair. The Headquarters office is located at 50 West 50th Street, New York, N. Y. The committee has held the following meetings: February 25, 1937; December 4, 1937; and February 18, 1938.

For the purpose of review in regard to the function of the Joint Committee on Community Nursing Service the objectives are herewith presented:

1. To analyze the existing needs for more satisfactory nursing service throughout the country
2. To consider, through study and possible experimentation, new means for meeting these needs

The tentative general principles on which the work of this committee is based are:

1. That a responsible group representing the nursing profession, the lay public, and the medical profession work out plans in each community for a community nursing program
2. Analyzing community nursing problems includes
   a. How much nursing care is needed for different types of situations
   b. What are the present facilities
   c. What are the gaps and complications as shown by (a) and (b)
3. Meeting community needs involves
   a. An understood relationship and division of responsibility
   b. A concerted effort to fill in gaps and eliminate duplication

In order to facilitate the work of the committee an executive subcommittee has been appointed to serve as an ad interim committee to which the chairman and secretary may refer questions for decision in order that the work of the committee may proceed without delay.
Due to the urgency of requests from the field for specific types of help and the desire for material representing group thinking, the following working subcommittees were appointed after the meeting of the Joint Committee on Community Nursing Service, February 25, 1937:

I. Subcommittee to formulate a guide for the organization of a council on community nursing service. This subcommittee has had one meeting.

Many requests for assistance in the formation of councils on community nursing have been received. The purpose of such a council is to provide the best possible nursing service to the community. The following objectives\(^1\) may be pursued to accomplish this purpose:

1. To provide a meeting ground, through broad representation, for the discussion of matters affecting nursing service from the point of view of the public served as well as that of the nurse giving the service

2. To give opportunity to study various problems from the point of view of all concerned, rather than from the viewpoint of isolated organizations’ needs

3. To serve as a connecting link between the community, the agencies that provide nursing service and the nurse who gives the service, and thereby establish sound public relations

4. To encourage the setting up of proper machinery to coordinate and distribute nursing service in a community so that there will be minimum waste

5. To sponsor new types of programs of nursing service

6. To interpret nursing to the community

7. To interpret community needs for nursing service to
   (a) schools of nursing
   (b) agencies distributing nursing service
   (c) individual nurses rendering such service

8. To ensure adequate preparation for nurses for community service

9. To stimulate the feeling of responsibility
   (a) on the part of the community for
      (1) supplying nursing service to the community
      (2) education of nurses to render the service
   (b) on the part of the individual nurse for the quality of service that is given

10. To stimulate interest and provide ways and means for research on mutual problems

11. To furnish a means of education for various groups concerned

These objectives are included in the Tentative Guide for the Formation of Councils on Community Nursing which was outlined by this subcommittee. This guide was approved by the members of the Joint Committee on Community Nursing Service and approved by the Joint Board of Directors as a tentative guide, and it was published as part of an article by Grace Reid in the January, 1938, issues of the *American Journal of Nursing* and *Public Health Nursing*. It has been released and is available for use.

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It might be interesting to note the following information regarding councils on community nursing:

Number of councils existing previous to 1936 ........................................... 6
Number of councils organized to date—1938 ................................................... 11
Number of communities where some steps have been taken toward the formation of councils .......................................................... 10
Number of guides for formation of councils sent upon request to 19 different states and two provinces in Canada ........................................... 125

II. Subcommittee to formulate an outline to be used in making a survey of community nursing resources. This subcommittee has had four meetings.

It has prepared a tentative survey outline to be used in surveying the community resources for nursing service. This has been done because so many requests for assistance in surveying community nursing needs and resources by local groups themselves have been received. The purpose of this survey outline is to get a general picture of a community's nursing service resources in an attempt to find if and where there are duplications and gaps in meeting community needs for nursing service. It is expected that where agencies want to be studied on an individual basis they will be referred to the national agency which does such studies, for example, studies of registry service to the American Nurses' Association, hospital nursing service to the National League of Nursing Education, and public health nursing service to the National Organization for Public Health Nursing. The survey outline prepared by this subcommittee was used by the executive secretary of the Joint Committee on Community Nursing Service in making surveys of nursing services in four communities in the Middle West in October and November, 1937. These communities varied in size, type and population. There were cities of about 100,000 population differing greatly in the resources available to render nursing service in the community. One was a rural county with the largest town having about 3,500 population. The other was a county with a city of 50,000 population plus a surrounding rural area. In the light of these recent experiences and in line with comments received from various experts in community work this survey outline has been revised. Approval for its release as tentative material for experimental use has been granted by the Joint Board of Directors of the three National Nursing Organizations. It is now available for use in selected communities. A guide to be used to assist in the evaluation of the information has been compiled and may also be obtained from the office of the Joint Committee on Community Nursing Service.

III. Subcommittee to outline plans for community nursing service.

This subcommittee has formulated certain general principles upon which all community nursing service should be based. Upon the information supplied regarding nursing resources in four types of communities, more or less ideal plans have been tentatively outlined with a view to experimenting to determine how applicable they may be to similar communities elsewhere. It is recognized that communities differ as to nursing resources and needs, and it would be impossible to outline a plan for a program which would fit every community. Probably more requests for a guide to assist in community planning have been received than any other type. Certain general principles as a basis for planning for community nursing are offered:

1. The chief objective in any plan for community nursing service is to furnish the best possible nursing service to the community.
2. Complete up-to-date information of the community's needs and facilities for meeting these needs should be possessed by those planning for the nursing service to the community.

3. Community participation is essential. The plan evolved should grow out of the realization of the needs and the joint planning of representatives of the governing bodies of the agencies rendering the services, the public who consume the services, and nurses responsible for rendering the service.

4. The amounts of each kind of nursing service needed may vary in different communities but all the types of nursing services are used to some degree in all communities.

The use of the term "tentative plan" indicates that these materials are not to be considered as final. It is expected that they will be revised from time to time in the light of further study and experimentation.

The Joint Committee on Community Nursing Service, early in 1936, suggested plans and procedures for the work of the secretary. These included:

1. Review of studies which have been made in certain communities
2. Analysis of existing councils on community nursing
3. Restatement of the functions of nursing councils and suggestions for outline of such councils
4. Consideration of some machinery to be set up for a clearing house of community studies of various kinds which have been made by various groups
5. Consultation service in the field in regard to forming nursing councils and studying nursing resources
6. Stimulation of interest in experimenting with new machinery for distribution of nursing service

Activities of the secretary have included:

1. Speeches at meetings such as medical societies, State Nurses' Associations, state hospital associations, and local community groups
2. Assembling information on all nursing councils and compiling a bibliography of material to be used in stimulating interest in community nursing service
3. Surveys of community nursing resources
4. Compiling a bibliography of available standards for evaluating nursing service
5. Consultation service in the field which has included meetings and conferences with all kinds of community groups
6. Supplying information on phases of community nursing service
7. Gathering information which might be of assistance to the committee
8. Sending tentative guides upon request and answering questions in regard to the use of same
9. Compiling a bibliography of studies or surveys with nursing implications done by national agencies
10. Giving assistance to communities wishing to form councils on community nursing

The following is representative of the kind of requests which have been received:

1. Information on procedures to form councils on community nursing
2. Assistance in making survey of community nursing service
3. Consultation service in field on formation of councils
4. Speeches at meetings such as medical societies, State Nurses' Associations, local councils of social agencies
5. Information on various phases of community nursing service
6. Information on cost of coordinated nursing service
7. Standards to be used in evaluating community nursing service
8. Assistance to a community planning a program with new machinery for the distribution of nursing service

In addition to publicity obtained through talks at state meetings and before other groups, the following articles have been published:

Joint Committee on Community Nursing Service, in the October, 1936, issue of Public Health Nursing
Community Nursing Service, in the March, 1937, issues of the American Journal of Nursing and Public Health Nursing
Councils on Community Nursing—A step toward better community nursing service, by Grace L. Reid in the January, 1938, issues of the American Journal of Nursing and Public Health Nursing
How Doctors and Nurses May Cooperate to Secure Better Nursing Service in the Community," in the August, 1936, issue of the New York Journal of Medicine

Requests for assistance are being received with increasing frequency which shows that there is more interest prevailing throughout the country than ever before.

The Joint Committee on Community Nursing Service would like information about communities which are starting councils or planning any machinery for better coordination of nursing activities, or any joint activities that affect the community as a whole.

On every hand there seems to be the need for information on what is adequate nursing service, how it should be distributed, how much it will cost and how it will be paid for. It is believed that these questions will not be answered to any great degree of satisfaction until some actual experimentation is carried on to demonstrate them effectively. Many communities have been encouraged to undertake such projects. So far there are three communities which have gone further than others in an attempt to meet community needs. One especially has progressed quite far. It is hoped that information regarding this project may be released through the professional journals in the near future.

Respectfully submitted,

ELSBETH H. VAUGHAN, Chairman

REPORT OF THE JOINT COMMITTEE TO OUTLINE PRINCIPLES AND POLICIES FOR THE CONTROL OF SUBSIDIARY WORKERS IN THE CARE OF THE SICK

(Three National Nursing Organizations)

The problem of subsidiary workers is a pressing one. The staffs at Headquarters of the three National Nursing Organizations realize its magnitude, since they are called upon to answer the inquiries which come to them from all over the United States. These are increasing in number and courses for
subsidiary workers are springing up like mushrooms in various sections of the country.

A Joint Committee of the American Nurses' Association, National League of Nursing Education, and National Organization for Public Health Nursing to study the problem of subsidiary workers was appointed in 1936. This replaced the committee of the National League of Nursing Education which had been appointed to study this same problem in 1933. Claribel Wheeler was appointed as temporary chairman of the Joint Committee in January, 1936.

It was believed early in 1936 that there was a need for some pronouncement on the part of the three National Nursing Organizations on the preparation and control through legislation of subsidiary workers in nursing services, such as so-called practical nurses, attendants, or others who are at present engaged in giving bedside care to the sick. The Headquarters' representatives are constantly being besieged with the requests for some policy in regard to this important legislative question.

In consequence, the following issues were placed before the Joint Board of Directors of the three National Nursing Organizations for consideration at a meeting held in June 1936 during the Biennial Convention in Los Angeles, California:

1. Should the nursing profession assume the responsibility for the nursing care of all sick persons
2. Do the three National Nursing Organizations recognize a need for subsidiary workers in any of their nursing services
3. If they do recognize a need for a subsidiary group, shall the three National Nursing Organizations:
   a. Define their duties
   b. Assume responsibility for their preparation through properly conducted courses
   c. Make provision for state licensing in nurse practice acts

The Joint Board of Directors of the three National Nursing Organizations went on record at this time as believing that it is the responsibility of the nursing profession to outline the principles and policies for the control of subsidiary workers in the care of the sick.

Alta Elizabeth Dines was then appointed chairman of the Joint Committee representing the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing.

A meeting of the committee was held on June 24, 1936 in Los Angeles, California, and on November 12, 1936 in New York. At the November 12th meeting, a conclusion was drawn that, since the nursing profession is vitally interested in the care of all sick and weak persons unable to care for themselves and since the nursing profession fully realizes that the professional nurse does not and will not provide for all the care that is needed, it seems appropriate as well as important for the three National Nursing Organizations to inform themselves of the need for and the use of the subsidiary
worker, whether she be called "attendant," "nursing aide," "hospital aide," "hospital helper," "nurse's aide," "practical" or "domestic nurse."

It seems right and logical that professional nursing organizations be ready for unselfish participation in the preparation, supervision, and protection of this much needed worker, as well as in the legal control of her practice.

The committee divided the work into three projects:

1. The National League of Nursing Education was to send a letter or questionnaire to each State Board of Nurse Examiners, asking for information regarding all courses for subsidiary workers.

2. The American Nurses' Association was to forward a letter to the president of each State Nurses' Association asking that a committee be appointed representing not only the State Nurses' Association, but the State League of Nursing Education, and the State Organization for Public Health Nursing, if one exists, to study the question of control of subsidiary workers.

3. The National Organization for Public Health Nursing was to request from all directors of public health nursing organizations facts regarding the use of subsidiary workers in connection with the care of the sick in their homes.

This work was accomplished.

Florida, Georgia, Indiana, Maryland, Michigan, Mississippi, New York, Pennsylvania, and Virginia have laws governing the practice of attendants and subsidiary workers.

There were 1,251 licensed attendants in the four States of Michigan, New York, Pennsylvania, and Virginia in 1933.

Since the YWCA assumes responsibility for conducting courses to develop "practical nurses," a letter was sent to learn their reason for the establishment of such courses, the content of courses, by whom they were given, how many persons graduated each year, length of course, number of hours in theory and in practical work, and the educational requirements for applicants.

Professional registries are reporting a demand for such workers and indicate that they are competing with graduate nurses as placed by professional registries.

Also in January 1937, the National Organization for Public Health Nursing withdrew as an organization from the activities of the committee. However, in January 1938, the National Organization for Public Health Nursing voted to resume participation in the work of this joint committee.

In January 1937, recommendations were sent to the various State Nurses' Associations to appoint a committee in each state to study the problem of the subsidiary worker in that state.

The following State Nurses' Associations have reported such committees as having been formed:

- Alabama
- Colorado
- Connecticut
- Georgia
- Florida
- Illinois
- Indiana
- Kansas
- Louisiana
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- New Jersey
- New York
- Rhode Island
- South Dakota
- Vermont
- Washington
- Wisconsin
- North Carolina
In May 1937, the meeting of the Joint Committee of the American Nurses’ Association and the National League of Nursing Education to Outline the Principles and Policies for the Control of the Subsidiary Workers in the Care of the Sick, was held in New York with six members present.

Three subcommittees were appointed:

1. The first subcommittee—To outline the duties for ward helpers and orderlies based on the proposals in Manual of the Essentials of Good Hospital Nursing Service, published by the National League of Nursing Education, with Elizabeth C. Burgess as chairman.

2. The second subcommittee—To outline the duties and type of supervision needed in private duty or free lance field, with Mary E. G. Bliss as chairman.

3. The third subcommittee—To outline the duties and type of supervision of subsidiary workers in homes when such workers are employed by or through public health nursing agencies, with Geneva Hollien as chairman.

It was voted to invite the American Home Economics Association to participate and cooperate with the ANA and the NLNE on this problem in an advisory capacity.

Data concerning schools and hospitals conducting non-accredited courses have been compiled by the National League of Nursing Education. The Boards of Nurse Examiners reporting on such schools gave figures as low as three schools in certain states, whereas from these same states the American Medical Association had as many as thirty-eight non-accredited schools of nursing listed.

Due to absence from New York City, Alta E. Dines was unable to continue as chairman of the committee in the Fall of 1937. In January 1938, Ella Hasenjaeger was appointed to serve in this capacity.

On February 19, 1938 a meeting of this committee was called and ten members were present. Communications received by the National League of Nursing Education were presented.

The Housekeeping Aide Projects as set up by some of the State Works Progress Administrations have been giving the committee some concern, since some of the WPA workers have indicated they are prepared for nursing.

Mrs. Ellen S. Woodward, Assistant Administrator of the Federal Works Progress Administration, Washington, D. C., is cooperating to control any erroneous impressions which these workers may hold in regard to their work and preparation for it. The course is definitely to develop the worker for housekeeping and simple home care of the sick, such as making closed beds, how to strip and air a bed, how to ventilate and clean the patient’s room, et cetera.

A progress report of the Subcommittee to Outline Duties for Subsidiary Workers in the Employ of Hospitals, with Elizabeth C. Burgess as chairman, consisted of a list of duties now being performed by such workers and included the duties as compiled by a committee of the Department of Hospitals in New York, whose purpose it was to study the need for and the available facilities, together with educational requirements for a school for “Nursing Aides” or “Attendants.”
A progress report of the Subcommittee to Outline Duties for Subsidiary Workers in Private Practice, Mary E. G. Bliss, chairman, promoted much discussion. The report called attention to the importance of and necessity for publicity regarding the services of registered nurses. This subcommittee did not outline the duties which might be safely assumed by a subsidiary worker in private practice, since there is no assurance that such a worker would be properly assigned to her duties or adequately supervised.

Geneva Hoilien, chairman of the Subcommittee to Outline the Duties of Subsidiary Workers in Public Health Agencies, gave a tentative report and a suggested list of duties of these workers. This list appeared to be very satisfactorily prepared. With regard to supervision of the subsidiary workers to be placed through public health nursing agencies, if they are placed by such agencies, it was agreed that they should receive instruction as to the policies of such agencies.

A report of the study which was made in New Jersey in 1937 was presented by Miss Hasenjaeger, chairman of the Subcommittee to Make Recommendations to State Nursing Organizations to Study their Local Problems.

The outline used for the collection of the data necessary to clarify the understanding of the subsidiary worker in New Jersey and the questionnaires used in the collection of these data were presented to the Joint Committee for its consideration.

Motions were made to recommend that two lay members be invited to become members of the committee, also a private duty nurse, a physician, and a member of the American Home Economics Association.

The committee went on record as believing that all of those who nurse for hire should be licensed.

Respectfully submitted,

Ella Hasenjaeger, Chairman

General Session

Friday, April 29, 9:00 a.m.

Presiding: C. Ruth Bower, R.N., Vice President

Subject: GUIDANCE

Some Underlying Principles of Guidance

Grace Wilkie, Dean of Women, Municipal University of Wichita, Kansas

Because of changing conditions and the complexity of our modern life and because we believe in assisting each individual through his own efforts to “increase in wisdom and stature and in favor with God and man,” organized guidance has become a necessity of every educational program, whatever the type of institution may be. "Guidance involves personal help that is designed to assist an individual to go somewhere or to do some-
thing.”¹ In college, this guidance is generally spoken of as personnel work; sometimes, as social education. The term guidance was first applied to vocational guidance, but as the concept of guidance expanded it included both vocational and educational guidance. It is interesting to note that in Brewer’s Education as Guidance,² the term is expanded to include guidance for home relations, for citizenship, for health, for leisure and recreation, for personal well-being, for religion, for right-doing, for wholesome and cultural action, and for thoughtfulness and cooperation. In other words, guidance is concerned with the development of the whole personality. “The student cannot send his mind to college, and leave his physical, moral, and emotional needs at home.”³ Therefore, wherever young people are being educated, some kind of guidance is going on. This guidance service must be provided, responsibility centralized, a clear understanding of objectives agreed upon, and the duties of various members of the staff integrated so that the students have the kind of guidance that they have a right to expect. The modern demand for all-roundness in guidance is illustrated by the following statement, perhaps somewhat exaggerated: “An individual lives in physical, social, ethical, moral, civic, emotional, and spiritual relationships as well as in mental, and without suitable training in all of these he is as incomplete, useless, and ludicrous as an automobile with important parts missing. Moreover, a development in one direction does not guarantee a satisfactory development in the others. For instance, it is possible for the valedictorian of the senior class (the ‘best member’ of the class?) to have the honor of possessing the finest array of marks (only fairly intelligent guesses) and still be offensive personally, dumb socially, vicious morally, weak spiritually, a grafter politically, a misfit vocationally, and a wreck physically. Is he educated? Hardly.”⁴

No two institutions will have or perhaps require the same guidance program, but, I repeat, the personnel work must not be left to chance or to some convenient person who “just loves girls.” The person or persons in charge of guidance should be interested, trained, experienced, and have some natural inclinations for this type of service. In a school of nursing the different professional status of doctor, supervisor, registered nurse, and nurse in training will require a somewhat different provision for guidance than that made by a college, but this is for the local administration to determine in light of its needs, resources, and staff. Elaborate set-ups are not only expensive to provide but require abundant funds for office assistants and general operation. Necessary space or quarters and a simple record system, gradually expanded as need dictates, make for much greater permanency, effectiveness, and usefulness. An elaborate record system which is not or cannot be kept up because of expense is futile. “While the methods vary in many specific details, depending on the training and experience of

the individual, the general approach is that of the interview, the amassing and coordinating of all available data, and the employment of the greatest common sense in the recommendation made. Information is obtained from the student, his friends, or campus associates, his instructors, his student and faculty advisers or counsellors, the administrative staff, and a varying group of specialists in medicine, psychology, and education. Such a mass of data is sometimes coordinated by an individual worker, a committee, or a staff group with discussion following the clinical case method. But the ultimate use of the material in the life of the student is dependent upon the individual accepting responsibility for the direction of the same, namely, the guidance worker, whatever his or her title may be."

The general trend towards guidance replacing discipline is another progressive step and makes for a much happier relationship between student and counsellor. Someone has said "a discipline case is a student in trouble, a student who has stumbled against some social or moral code, and guidance of the finest type is needed." It must be made apparent to the student that the counsellor wishes to do something for her rather than to her, and that confidential matters are held in strict confidence. By all means must the door always be left open for the student to come back! It requires sympathy, understanding, warm-heartedness, good common sense, and fair-mindedness to give this impression to youth. In addition, three significant psychological principles of guidance must constantly be kept in mind in all relations with the student: (1) individuals differ in intellectual and physical capacity, interests, and other respects, (2) individuals' conduct and interests can be modified and it is the function of guidance to promote desirable changes in personality, and (3) modification of behavior takes place through reactions in which the element of satisfaction or dissatisfaction usually enters. The personnel worker, therefore, should know the student in his environment. Often some adjustment in study habits, social or recreational opportunities, companions, or roommates, perhaps, will produce more desirable behavior.

May I comment here, to caution about any written records made of a so-called discipline case. Understatement should be the rule, and great care be taken as to what is written, if anything at all, on the permanent record. Sometimes a code or symbol is wisely used or a temporary record made which is later destroyed. The reason is obvious.

In the November 1935 issue of Occupations there appears a very interesting article on Why Men Fail—Or Succeed. It applies equally well to women, I think, and I recommend it to you for its valuable suggestions. Professor Hoopingarner describes in Personality Improvement and Vocational Orientation a credit course which he has offered for the past five years in the School of Commerce, New York University. I quote somewhat at length in regard to this course because its general content and purpose have im-

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8 LEONARD, op. cit.
pressed me. "The course was undertaken as an experiment to try to work out a practical means of giving the student definite help in developing his personal qualities and in making a more satisfactory adjustment to life. The course is in reality a 'laboratory' in which the student analyzes and studies, under supervision, his own abilities in relation to different types of occupations and professions; and in which he not only is helped to decide more intelligently what to undertake for his life work, but is guided also in how to go about planning to develop himself—his personality—so as to assure himself of a reasonable chance of success in the field of his choice.

"The general method followed in giving the course is as follows:

"1. Lecture and discussion each class period dealing with personality, personality improvement, traits, development of the right attitude, courtesy and conduct, methods of study and work, how to use the library, concrete cases of successful performance in business and professions, etc., etc.

"2. An analysis of the student's personality, including interests and aptitudes, as a basis for recommendations for a program for improvement.

"3. Moving pictures and voice record of each student, so that he may see for himself any peculiarities or mannerisms which might unfavorably affect his dealings with other persons.

"4. Personal conference with each student to discuss the results of the analysis and to make recommendations.

"5. Assigned readings.

"6. A term paper on the topic, My Vocational Aim and Program for Continuous Personality Improvement, required of each student as a major project of the course, in order to crystallize the results of the study. Plans for at least five years in advance must be made.

"If the course did nothing more than bring the student to a consciousness of his need of personal improvement and interest him seriously in getting a more definite aim in life, I believe it would justify itself. The fact that he is given something in the way of a method, point of view, and attitude, and that he has more clearly 'objectified' his goal, is in itself of positive value.

"The procedure assumes that everyone has 'personality'—not meaning by this word the possession of peculiar or charming traits, nor referring to something metaphysical and intangible—and it assumes that if everyone has a personality, it can be evaluated with some degree of accuracy.

"The procedure admits that personality undergoes continuous adjustment and continuous improvement—or the opposite; that one's personality is not a final matter and that in controlling its development, if one cannot add to innate capacities, one can at least modify the goal to one within possible reach, and change habits of response.

"It recognizes that the majority of persons seeking advice are neither abnormal nor pathological, and so it does not emphasize the discovery of such traits. In fact, it carefully avoids the suggestion of anything pathological.
Not only objective tests of mental ability and subjective tests, but also surveys of experience, skill, and interests are incorporated.

"The twelve personality traits taken into consideration are tested as follows:

"1. Impressionness, 'the combination of personal and physical qualities which influence favorably those with whom one comes in contact,' including physique, energy, personal appearance, manner, and presence, is tested by 30 questions, most of them indicating behavior patterns.

"2 Initiative, 'a combination of originality, determination, perseverance, and enthusiasm . . . having ideas and getting things done,' is tested by 24 questions.

"3. Thoroughness, 'involving accuracy and dependability in performing any task—not taking things for granted—and reliability in the assumption of any duty' is judged by two timed tests which require thoroughness, and a question test about one's habits of thoroughness.

"4. Observation, 'involving both memory and perception,' is tested by the ability to see and to remember details of a picture which is observed for a definite length of time.

"5. Concentration, 'the ability to disregard other problems and to focus attention on the particular task at hand,' is tested by two timed tests which, while easy to understand, require close attention.

"6. Constructive imagination, 'the ability to apply present knowledge and experience toward the solution of new problems . . . the ability to see the relationship of what you already know to new situations, which is the basis of originality,' is judged by a test which demands the recall and use of data already known, as well as the definite statement of the subject's goal and his plans to reach it.

"7. Decision, 'involving quickness of comprehension, the ability to think through a situation and to arrive at a conclusion, and the ability to put a problem aside and to go on to the next, once a line of action has been decided upon,' includes, in the test of this trait, questions about habits of decision; also the matching under a time limit of proverbs which have similar meanings, the ability to do which promptly is differential of ability to come to a decision quickly and efficiently.

"8. Adaptability, 'the inherent ability to adapt oneself to new problems easily and quickly, which involves mental alertness, speed of thinking, and facility in changing mental set,' is measured by short timed tests which require abstract intelligence and by questions about habits which are associated with ability to adapt well. Both social and mental adaptability are here given consideration.

"9. Leadership, 'the ability to get others to do willingly what you want them to do, to get results from men rather than from tools and machinery,' is measured by questions which furnish indications of mastery, control, fairness, and tact.
"10. Organizing ability, 'the ability to see the elements of a problem and to keep them in their proper relationship, and to be resourceful in planning methods for their solution,' is measured by timed tests which require ability to analyze and synthesize data.

"11. Expression, 'the ability to think clearly and to convey one's ideas to others—to know and let others know you know,' is measured by an antonym-synonym test and by questions about ease of expression, tact in arguments, etc.

"12. Knowledge, 'knowing facts and having ability to use them, that is, to recall them when wanted,' is measured by two tests—one on general knowledge and the other requiring knowledge of business.

"In summary, these are some of the conclusions growing out of giving this course over a period of eleven years:

"1. Inability to get along with and deal effectively with people is one of the greatest obstacles not only to success but also to happiness.

"2. There is a positive relationship between life planning and success, and the converse, lack of planning and failure.

"3. Continuous personality improvement should be looked upon as a life process for every normal person. The need for vocational adjustment is related, but secondary, to the need for continuous improvement in one's personality.

"4. In all practical clinical or advisory procedure, tests and other data, even the most carefully standardized, are only aids to diagnosis. Trained practitioners, capable of interpreting results and making sound inferences, are essential."

I am not advocating this course as "the recipe" for every school for a part of its guidance program, but certainly there are phases interesting and useful for all of us, and it stimulates us to evaluate our own efforts.

This course also indicates the contribution that carefully applied psychology is making in meeting and understanding the problem of personality development.

From some years of experience in personnel work may I make a few observations or give a little guidance?

"Never play the part of Providence in the life of any student." This was said by the late President Pendleton of Wellesley when addressing a meeting of deans of women, and I have found it very excellent advice. You see, guidance, as explained by Arthur J. Jones in his excellent book on The Principles of Guidance, is concerned with crises, with times of choice, times when the ways diverge, with times of needed adjustment. From the preceding description, it is clear that the help given may be direct or indirect, the one guided may be conscious of the help given or may be entirely unconscious of it. The guidance may be given at the time of a crisis or long before it occurs. Indeed, the best guidance is usually that given long before the need for choice occurs. It consists in assisting the individual in the gradual accumulation of facts and experiences that will, when the time comes, enable her to decide wisely. Guidance is thus seen to be an
essential and a fundamental aspect of education. Notice, the student, after analyzing the situation, makes the choice; it is her responsibility. Thus guidance becomes self-guidance which is the objective of all personnel work.

Another point that needs watching is to see large things large, and small things small. Often too much notice is taken of an insignificant matter and if this become a habit, the student no longer seeks our counsel because she has lost faith and confidence in our sense of values. Unfortunately, sometimes, records assume more importance than human contacts.

Never be shocked (or show you are shocked) at what a young person may confide in you. Shock at once becomes a barrier, an inhibitor to further confidence. As a rule the more shocking the incident related, the more guidance the student needs!

Will I succeed? Some quite reliable tests for some vocations are available but in general—success where you are is the best guarantee of future success. A good habit to form is—"Do a present duty well."

Discussion of the details of the various techniques developed and used in guidance cannot be given now. The personnel worker must ever be alert to development of methods and improvement of self if she would guide others. Hers is a vocation in human engineering. It is enriched living that is desired for every student, that ability to see life steadily and to see it whole, that conservation of human resources, that all-roundness for which personnel work exists.

In closing: "Personnel work in a college or university is the systematic bringing to bear on the individual student of all those influences, of whatever nature, which will stimulate him and assist him, through his own efforts, to develop in body, mind, and character to the limit of his individual capacity for growth, and helping him to apply his powers so developed most effectively to the work of the world."

Streamlining is the vogue of the day—it gives beauty, decreases resistance and friction, insures greater efficiency, releases greater power, and, therefore, results in a much better developed and delicately adjusted mechanism which demands most careful control—an expert at the wheel. What streamlining has done for the automobile, guidance should do for the individual in developing personality.

PRACTICAL APPLICATION OF GUIDANCE PRINCIPLES IN A SCHOOL OF NURSING

DOROTHY ROOD, R.N., Associate Professor of Public Health Nursing, Ohio State University, Columbus, Ohio

The original plan of the program committee was for Dean Wilkie to give her talk on the principles of guidance and then for me to apply those principles to a particular situation. Limitation of time made it impossible for me to know what Dean Wilkie was going to say before deciding upon

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7 Strang, op. cit.
my own message to you. Fortunately, however, what I say will follow closely what you have just heard.

I have been undecided as to whether or not I should try to make my remarks apply to that hypothetical institution—the typical school of nursing. The difficulty with that procedure is that schools of nursing are so diverse in character, purpose, plan, and facilities that I would not recognize the typical school if I saw it.

I have therefore decided, at the risk of limited application, to use only the situation with which I am familiar and tell you what we do. In this I must warn you that we are experimenting and no two of us can or probably should do things in the same way. I hope, therefore, that you will pardon a great deal of personal opinion and a very free use of the first person singular pronoun. Perhaps you will also pardon a mention of what we hope to do, because this guidance program is so very new and experimental that we dream before we can carry out new ideas.

It will be easier to explain our program if I tell you first a little about our school so you may envisage the problems better in their true setting.

The Ohio State University School of Nursing is an integral part of the College of Education. We have very close relations with the College of Medicine, sharing the University Hospital as a laboratory for both medical and nursing students and receiving much assistance from the medical faculty in both formal and informal teaching. But students are admitted according to the requirements of the College of Education and the school of nursing faculty have the privilege of close association with the Education faculty. This close connection helps us to build progressive education ideas into the conduct of the school of nursing. On the other hand, as the faculty plans and schemes to get first-hand experience with children into the early preparation of elementary and secondary school teachers they frequently remark: "You nurses have already done that," or "You don't have to worry about how to do this, you are doing it now." Let us never forget for a minute that however many other educational devices we may utilize, the process of learning by doing is a very precious part of nursing education and we are all trying to develop, first and foremost, good bedside nurses. That certainly does not mean an unthinking automaton.

All who attended the general meeting last evening will agree that a nurse should be an intelligent, understanding, tactful, well-adjusted individual. She must enjoy her work and be happy in it so that she may put forth a sincere cheerfulness in her bedside manner. She must be healthy in mind and body so that the fatigue of her work and the necessarily unpleasant incidents will not upset her calm serenity. She cannot achieve this ideal personality adjustment if she is overworked, fearful, worrying, or resentful about circumstances or conditions with which she is confronted.

Theoretically, every member of the faculty, including head nurses and supervisors, should be alert to detect symptoms of misunderstanding or maladjustment. Actually, we may all be so busy that only the major in-
fringements against rules of propriety, or conduct which interfere with our own routines or prerogatives have sufficient force to penetrate our pre-occupation. A reserved student may give no external indications of a seething caldron within. To meet this sort of difficulty we have developed a system of counseling. Each student is assigned to a member of the faculty who acts as her adviser and confidant. We began with one class and one or two counselors, gradually increasing until now all of our full-time faculty members participate in this program.

We have had many discussions in faculty meetings as to the best method of determining to which members of the faculty given students shall be assigned. Ideally, a student should be allowed to select her adviser. Practically, that doesn’t work. On the one hand new students do not know whom to select. On the other, this method may make for very unequal distribution of the load. Most of our instructors feel that they would prefer not to act as counselors for the students in their ward sections. They believe that when a student feels herself unjustly treated by a supervisor she should have a neutral person with whom to talk it over. This is very true, but with students rotating through the various services, they would have to change counselors very frequently to avoid having the one in charge of the service on which they are working. Frequent changes of counselor are very undesirable. We have all found that students do not tell us intimate troubles on their first interview. Two or three talks are necessary to establish desirable rapport. Continuity of guidance demands long-time contact with the student. On the other hand, we try to leave the way open for students to request a change of counselor if they so desire. Interviews with other members of the faculty are always possible and are encouraged when advice is needed in a field in which another person is better prepared.

Junior Dean Love of our college is particularly interested in this problem. He says that counseling programs, when they have failed, have done so because of unwise selection of counselors. Since we have to use all of our faculty, we cannot select. Another alternative is in-service training. Dean Love has been working on this. He has an experimental group of 150 freshmen (not nurses). Ten of the Education faculty have each taken 15 of this group for counseling. The ten counselors have had frequent meetings at which they have discussed their mutual problems. Dean Love tells me that he has been very much pleased at the growth in objectivity among the counselors and with the progress they are making. We hope to utilize these results in the school of nursing at some future time. Meanwhile, we bring up problems in our school faculty meetings and informally among ourselves. We find it very helpful to know when we have been misunderstood. We tell each other frankly when such instances come to our attention. We are thus able to avoid similar mistakes next time. Getting both sides of a disagreement helps us to realize that there are always at least two sides to every problem and we learn not to form an opinion until we have heard the other side. Talking things over together helps us to have
confidence in our fellow faculty members and to try to interpret to the student how her conduct may have appeared to another even though her intentions were excellent.

There remains a third angle of the adviser problem. Is not counseling an integral part of the teaching process? If so, should not all teachers be selected and trained with a view to being able to carry out this function? In Ohio State University, and I presume generally throughout the country, there are two points of view. One seems to be prevalent in science and arts colleges—that a person who knows a subject thoroughly can teach it. At a recent committee meeting a discussion was underway of the preparation of high school biology teachers. A biologist presented a list of courses representing 160 quarter hours of work in biology alone, which he felt should be required of such high school teachers. As this represents roughly three-fourths of the time allotment of a four-year college course there is obviously little time left to know other aspects of the world in which we live, for acquaintance with the developing child to be taught, or for the broader outlook needed for a well-adjusted individual. The other point of view, generally taken by teacher-training institutions, is almost opposite to this. They feel that the development of the personality and techniques of the teacher are nearly, if not quite so important as subject matter, or, at least, that they may require a larger share of the allotted time for teacher preparation.

I believe that nursing education in general has not put enough emphasis on the preparation of teachers, including head nurses and all who have to do with the education of the student, and that this should be a major concern of the League in the future. Meanwhile, I feel that with our present faculty much can be done toward a good guidance program for our schools.

Before beginning on the student problems in the guidance program I must tell you a bit more about our school. We have two groups of students. The first is that group who enter as freshmen and take the entire five-year course leading to a B.S. degree and a diploma in nursing. A second group are already graduate nurses and come to work for their B.S. degrees. They enter with advanced standing and most of them are aiming toward public health nursing or teaching in schools of nursing.

Our first contact may be when the prospective student, perhaps accompanied by one or both parents, comes to see the school, possibly months before time to register. Whatever member of the faculty is most easily available usually sees her, answers her questions, shows her around the hospital if she desires, and directs her to other parts of the campus she wishes to see. If she has questions about special curricula she may be referred to other members of the faculty for interview.

Freshmen and all other new students have an orientation program during what we call Freshmen Week before the regular program begins. They learn their way around the campus, decide on their program of studies, register,
pay fees, and begin their numerous tests, including intelligence, English placement, and medical and physical examinations.

All of our students live in dormitories with other students, in sorority houses, or in private homes approved by the University dean of women. They are governed by the same rules as are all other women students in the University. We believe that this living arrangement tends to broaden the outlook and point of view of the nurses and it also tends to overcome some of the prejudices held by other groups with regard to members of the nursing profession. I have heard that one university has given up this arrangement because it involved so many problems. Of course it does, but I believe the advantages outweigh the disadvantages.

Smoking is one of these problems. No smoking is allowed in class rooms on campus, but members of the faculty smoke in their offices and when small groups of students meet with them in their offices they permit smoking. Nurses are not allowed to smoke in the hospital or in uniform. When they come on duty smelling of tobacco it is a matter for individual counseling. They are informed that no nurse is successful who makes herself obnoxious to her patients. If smoking is more important to them than success in nursing they are advised to transfer to another department of the university. There are very few with whom a straight talk along these lines does not settle the question.

Then there is the problem of uniforms. We have a rule that uniforms are not to be worn to any but nursing classes. They realize that the purpose of the rule is that they may not be branded as different from the other coeds and to prevent carrying infection to the patients. They approve this purpose and accept the rule.

It is a little harder to control their going to restaurants. We make one exception for the benefit of those who do not get their meals at the hospital. If they have to be in uniform again after lunch, they do not have time to change twice and they are permitted to eat lunch at one restaurant which is the nearest to the hospital.

Nail polish is another important problem. We have said none darker than natural may be used, but I'm afraid nature wouldn't recognize all the shades attributed to her. We have equipped the operating and delivery rooms with polish remover. One young girl remarked how fine that was and added, "Now if they'd only keep a bottle of polish to put back on afterwards, it would be complete."

I have tried to persuade them against the fearful orange or cerise shades of rouge and lipstick by pointing out how awful it looks when they blush or otherwise develop natural color. Sometimes that has a good effect.

In all these things it seems to me better to develop taste and self-restraint than to make too strict rules and then have them know no bounds when they leave school. The newer idea in education—that of guiding the child and young person to make progressively more important decisions—is wise. Too much restraint suddenly removed is the cause of most explosions.
The next step in the guidance program is the counseling interview. My own group of counselees are at present those majoring in public health. When I had a more mixed group I found that I was continually sending them to another member of the faculty for vocational advice and that the public health majors were coming to me even though assigned to another counselor.

In my interviews I have developed certain routines and principles that seem to work best. I send a note via campus mail reminding each of my counselees that I should like an interview and calling their attention to a list of appointment hours posted on the bulletin board with a space to sign opposite the time selected. I would like to have an hour for each interview but I find this impossible, so I allow one-half hour and arrange for more time later if something needing it develops.

Before the student comes I get out her folder from the files and look it over for clues that will help me to guide her best. In this folder are stenographic reports for each quarter's work in the hospital, one written by the instructor and one by the head nurse. These are prepared with the understanding that the student is to read them. She does so at the time of the interview, if not before. We also have her percentile rating in the Ohio State University intelligence tests and her grades for each quarter of attendance.

I have an office of my own which offers a good place for interviews. Quiet and lack of interruptions are essential. I try to put the student at ease by a pleasant, casual, or even joking remark. I have no set rule. Sometimes I say, "Well, how have things been going lately?" The answer may be "Just fine," and then I must find another approach to problems, if any. Or perhaps the answer is, "Not so very well, I'm afraid." To my "Don't you want to tell me about it?" the story usually pours forth and the talk is launched. Sometimes I begin with suggesting they will want to read the ward reports. Something therein may start off the interview. Recently, one of my older counselees came in with a jotted-down list of five things she wanted to talk to me about. She knew from experience that when we got to talking she might forget. The device saved her time and mine, and I have adopted the suggestion.

I try never to be in the least shocked at anything they tell me. I like people so much that I feel a kinship in all their escapades. I can usually look back to a time when I should have liked to do what they have done or, in the case of a mistake, when I might have done it too if circumstances had been slightly different. If I can sigh and regretfully point out the dangers of such a line of conduct, they are much more apt to listen and heed than if I acted "Holier than thou." They feel that genuine liking and interest in them. I believe no counselor will succeed who does not have that sort of interest, but I think if you have that liking for people you can grow to understand them and learn how to help. A real effort to understand and a belief in the underlying good intentions of everyone smooths the way.
You will probably be interested in some of the common problems that arise. One of the most frequent underlying causes of difficulty is a lack of objectivity on the part of the student. She may find it difficult to accept criticism. It sometimes helps to point out the basis of judgment. Let her see that it isn’t an easy task to write those reports. A criticism may be based on one incident and yet take up half the report. The student may be assisted to discover ways in which she can help to give that head nurse a different impression of her work. This probably means the nurse will be doing better work, too.

The oversensitive student may need to be helped to develop a desirable amount of indifference. She should learn to be true to her highest ideals no matter what is said of her. This attitude is especially important when you know the other person concerned is a bit biased. It helps the student if she can understand the basis of that bias.

Another difficulty needing greater objectivity is the conscientious student getting “C” grades, after always having better grades at her school of nursing and in high school. Coming to a large university, made up, for the most part, of students doing good work in their high schools, the competition is keener and “average” grades are not an occasion for loss of self-esteem. But the student needs help to realize this.

Sometimes change of method causes the trouble. Many of our classes are conducted on the seminar basis in which the students select a problem and work it out together by group thinking. The timid soul who does all her reference reading but merely sits and listens in the class hour has to be made to understand that contribution to the group thinking is expected of her. Failure to contribute results in poor grades.

Recreation is another problem. Those who do not seek it intelligently need to realize that in a university recreation can be scheduled just as class hours are scheduled. If she picks an activity she likes, she makes new friends among those engaged in the same form of recreation. Swimming around the tank with a girl in the department of ceramics may open up a new interest that the nurse has never heard of before.

Choosing elective courses is another field where guidance is needed. Some students stick narrowly to nursing and allied courses. I always like to have these go far afield and take a course in music or art appreciation or join a chorus. Extra English courses, history, or philosophy all help to develop cultural background. This broadening of the curriculum seems to me preferable to trying to complete the work for two or three majors because the student fears she may not get a position if she is prepared in one field only. Some students study the bulletins, talk to other students, and know just what they want. Others come at registration time without a single idea as to what they need or want. These latter need a great deal of help in developing initiative.

Another very frequent desire is to take as much work as they can possibly manage so as to finish more quickly. I try to make these girls see that
college life is one of the delightful periods of our earthly sojourn and they should enjoy it as they go along. They should take light enough programs to have time for extracurricular activities and making friendships. Often on the campus there are persons with world-wide reputations that it will always mean something to us to have met. Again, famous people come for single lectures. If their programs are too crowded, they cannot take time to attend. If they miss all these opportunities they will be sorry later.

Mistakes, difficulties with fellow students, heartaches of various kinds come into the picture at these interviews. If they are going to continue to come, one fundamental principle must be observed. A confidence must never be betrayed. Sometimes queer situations arise. One time one of my students reported to me some difficulty with another student. I thought she was being misjudged but I could do nothing about it without talking to another member of our faculty. I asked her permission to do this but she preferred not, so I agreed to remain silent. The next week I heard about the affair from the other student’s point of view—quite a different story—but being bound by my promise I did not let the other know that I had previously heard anything about it. The affair blew over with no real damage. Had I thoughtlessly betrayed the confidence placed in me, I would have lost something far more valuable, my reputation as a safe confidant.

On other occasions I have asked and obtained permission to speak to someone else and have been able to adjust misunderstandings.

Social intelligence is another quality often lacking. One must be on the alert to catch this deficiency unless special attention is given to it. Social activities of the school or college offer excellent opportunities to notice awkwardness in social situations or ignorance of social usage. Sororities, social clubs, and school functions offer a training ground for those students who need it. The experience of working with other students who know how, may be all they need.

Another phase of guidance concerns future employment. Some students know clearly what they want to do almost as soon as they enter, a few do not know during their last quarter in the University. These problems may be brought up during interviews at any time. The counselor can make use of any and all vocational information that she can gather. Guidance in selection of a first position is to me one of the most important duties that devolves upon us. In the present shortage of public health nurses and qualified instructors, our graduates are offered positions for which they are totally unprepared. I try to make them see the dangers of failing in their first position and the handicap this will be to their future progress. The best qualified nurses see this and select a position where they will be under guidance. Those most in need of guidance accept positions where they will not have sufficient supervision. I do not know what we can do about this. We all know the executives, nurses as well as doctors and laymen, who hire a nurse without going back to her school for a credential, and then criticize the school for her failure to make good. This is not a nursing problem only
nor is it a new one. I met it when I taught commercial subjects in high school before studying nursing. However, it is a serious problem in guidance work and we need to try to educate employers to work with us.

Occasionally we find problems beyond the skill of the counselor to handle. At Ohio State University many campus services are available. The student health service gives full medical diagnosis. We have also psychiatric and clinical psychological service. A student loan fund is available for financial difficulties. Remedial courses are offered in many departments. The counselor should know how to use all these services and should have a pretty good knowledge of extracurricular activities available.

The biggest problem as yet unsolved is that of knowing the students better. We need a more thorough diagnosis of each entering student. A whole battery of tests could profitably be administered, such as intelligence, current affairs, general culture, attitudes, reading ability, and special aptitudes. A social or family history should be obtained. A study should be made of the factors that go to make up competency in nurses, including the personality traits and skills that are needed. Then all that is known about the student should be summed up and compared with this list of traits and skills so that what the student lacks can be determined and plans made to supply it during her period in the school. By this method, also, we would prevent wasting time on the attitudes and skills she already possesses. I believe this scheme can be worked out. We have shied from accepting lists of personality traits that have already been compiled because they seemed so ideal, but if we found out all we could about each entering student and then tried to guide that student through the experiences of nursing toward the ideals of personality and skill set-up, I believe we might find this guidance program a new tool in the production of that for which we are all working—ever better and better nurses.

General Session

Friday, April 29, 10:45 a.m.

Presiding: Sister M. Olivia Gowan, R.N., Dean, School of Nursing, Catholic University of America, Washington, D.C.

Subject: COLLEGIATE SCHOOLS OF NURSING

BUILDING THE UNIVERSITY SCHOOL

ELIZABETH S. SOULE, R.N., Director, School of Nursing Education, University of Washington, Seattle, Washington

The growth of schools of nursing in universities and colleges has been one of the outstanding developments of professional education in this country in the last few decades. It is more than twenty years since the combined academic and nursing curriculum was started in colleges and universities, and within the last ten years there has been a rapid increase in the number and diversity of curriculum patterns. Realization of this growth and its re-
sultant problems was a factor in the organization of the Association of Collegiate Schools of Nursing.

At present, according to a study published in 1937 by Lucile Petry, there are sixty-four schools of nursing in universities, offering seventy degree programs. In general, they fall into the following groups:

1. Master's degree in basic nursing.
2. Separate block of university and professional work, usually on the basis of two years' academic work, two years' professional work, and a fifth year for specialization, sometimes called the five-year course.
3. A program with the general and professional work integrated throughout the course with emphasis on professional subjects and sciences directly related to nursing.
4. Curricula for the graduate nurse leading to a bachelor's or master's degree, certificate in public health nursing or teaching supervision.

Some schools of nursing are an integral part of the university; others seem to be university in name only. Due to present social, economic, and educational factors, it is not desirable to have one standard pattern for a university school. For the present, at least, no one feels that we have yet reached a perfect plan which can be recommended to all. Nevertheless, it does seem desirable to set up certain principles, standards, and methods which may serve as guides to those interested in establishing or in reorganizing university schools of nursing.

The Committee on the Grading of Nursing Schools, in 1934, set up certain standards below which no school should operate. The activity analysis recently made of the work of the graduate nurse has led to definite statements on the part of the National League of Nursing Education as to what the professional nurse should know and be able to do. Therefore, any school organized today should have these in mind and should set up clearly defined objectives.

If we accept the philosophy of the new curriculum, these objectives should be (1) to prepare the nurse by giving her a wider scientific, social, and technical background for meeting the needs of the community and (2) to give the nurse, through better education, satisfaction from her work, security, and the ability to live more fully.

Since my special task in this paper is to give you the steps in building a university school I shall try to take each step in order.

THE PLAN OF THE SCHOOL IN THE UNIVERSITY ORGANIZATION

The impetus for starting a university school should come from within the university itself, because unless a small nucleus of the faculty understand and appreciate the aim of a school of nursing the school is not likely to succeed. Many times this interest must be stimulated by nurses from the outside, but the organization should be from within the university. It should be developed as an individual school or department, according to the university set-up.

CONVENTION PROCEEDINGS

It is essential that the nurse educator in charge have direct access to the administration in order properly to interpret and set out the needs of her school. It stands to reason that these needs could not be clearly understood or interpreted by someone other than a nurse educator, despite his interest and good will, if the school is placed under the general jurisdiction of another department. I would like to emphasize again the point that it should correspond with the organization and development of similar types of professional schools in the university such as medicine, dentistry, and home economics. This makes for closer relationship with the other members of the faculty and makes it possible to secure recognition and cooperation from other schools and departments.

STATUS OF THE DIRECTOR

Perhaps the next essential factor is the appointment of a qualified nurse as director or dean, with appropriate rank. This nurse should be qualified professionally, and should have at least a master’s degree. It would also be wise if she could be a person who has had university teaching and administrative experience. From my own experience and observation, if I were selecting, I would prefer to have a younger woman who had been an assistant in a university school or department rather than a nurse with wide hospital experience, but without the university experience.

The organization within the university is highly decentralized, with a great deal of authority delegated to faculty committees. It takes experience to understand this type of administrative work. The director needs to interpret constantly the work of the hospital to the university, and the work of the university to the hospital. She must represent nursing in faculty meetings, on faculty committees, and to the administration. She is the pivotal person and the success or failure of the school depends on her ability and vision.

RELATIONSHIPS

There should be a clear definition of policy between the university and the hospital regarding their responsibilities in relation to the school. The university should finance the administration and the teaching load in the school of nursing, while the hospital should carry the responsibility and expense for the nursing care of patients. May I suggest the following definition of policies which has worked with a minimum number of problems at the University of Washington.

A. The college or university and the hospital should appoint a committee to work out the details of the plan.
   I. The responsibility of the university should be:
      1. To appoint a qualified faculty member to take charge of nursing education.
      2. To create a school or department of equal rating with other similar types of work.
      3. To provide the necessary classes in basic sciences and arts for the students before entrance to the professional work. These courses should not be special courses for nurses, but should be general courses, and taken with other university students.
4. To direct the professional education in the hospital by appointing a faculty member of appropriate rank to administer the professional curriculum in the hospital. It should share with the hospital the salary of clinical instructor and teaching supervisors.
5. To restrict the hours of student work to forty-four a week, including classes.
6. To provide library facilities and teaching materials.

II. The responsibility of the hospital is:
1. To work with the university in selection of students.
2. To work with the university in the selection of faculty.
3. To work with the university in building a sound curriculum. This curriculum should be viewed as a whole educational unit and not as prenursing and professional. The professional part should be built very definitely on the needs of the students and of the community resources.
4. To plan for the care of the sick in such a way that clinical material will be available to students, that the rotation of service as outlined by the university will not be interrupted, and that the hours of work will be limited. It should be willing to provide sufficient graduate nursing staff to adequately take care of the patients.
5. To permit teaching supervisors the necessary time for classwork and preparation.

The administration of the school should be in the hands of the university; the administration of the nursing service should be in the hands of the hospital. I believe that this is true regardless of whether the hospital is owned by the university or some other community group.

Organisation of the Committee

This joint committee from the university and the hospital, with a representative from the community at large and from the medical and nursing associations, is a very useful and wise method of coordinating the work of the two institutions and of helping to determine policies and iron out differences. This committee may be an administrative committee or an advisory committee. If it is an administrative committee, the administrators from both the hospital and the university must be members of the committee; if it is an advisory committee they may be ex officio members only. Such committees are of great value in carrying through a university program. From my own experience I believe that an administrative committee is preferable.

Finance and Budget

This brings us to the question of finance and budget. Sufficient studies have been made to determine definitely the fact that the hospital should not finance a nursing school from the fees of patients. Therefore, two ways are open: endowment, or funds through regular channels of the university. In a private university it is often necessary to have special endowment; while in a state university it is possible to expect that nursing education should be supported through regular funds just as other professional and vocational fields. There seems to be an increasing tendency on the part of general educational institutions to develop professional and vocational curricula.
Many state universities and colleges are now supporting nursing education as a part of their regular programs. Where this can be done it is highly desirable, and I believe it is to be preferred to endowment. In some cases, grants from outside sources may help to lay foundations and to establish the work, which may be taken over by the university later. However, either through endowment or regular funds, a sufficient budget should be set up to carry the work in the university and to provide for administration and supervision on a university level in the hospital.

If the hospital meets its responsibility of providing the nursing experience, it should expect to pay for the services rendered by the student group. This may be paid into a special fund which can be used for educational purposes. At the University of Washington, through regular funds the university provides for all the work on the campus and finances the administration and supervision of the educational program in the hospital divisions. The hospital does not assume financial responsibility for the school of nursing, but pays for nursing service into an educational fund on a replacement basis. This fund is administered by the joint committee, and is used to pay for all lectures in medicine, surgery, and other medical and nursing subjects, as well as the students' tuition, the library, and other factors incidental to a school of nursing. Thus, the cost of the school is borne by the regular funds of the university and by the student through her work in the hospital. The Rockefeller Foundation has helped in starting new services through granting supplementary funds. These have gradually been absorbed over a period of time by the university. A budget should be stable and allow for a per cent of increase each year. It should not be dependent on student fees alone, or any other unknown factor.

**Faculty Selection and Status**

The teaching of the student throughout the entire course must be of university level. This entails wise selection of faculty and must include not only the instructors in the preliminary arts and sciences but also those in nursing arts, medical nursing, surgical nursing, pediatric nursing, and so forth. It seems wise to expect the supervisors of departments and head nurses to teach their own field and since emphasis today is being placed on ward teaching and bedside teaching it really means that everyone who is in charge of students must have a faculty appointment.

While certain academic rules must be adhered to it is also necessary to consider special training in the clinical fields. A bachelor's degree should be required, and a master's degree as fast as we can, with special preparation beyond the basic training in whatever field the person is to teach. Those who carry the teaching load in the hospital should be appointed by the university with at least the rank of instructor. As yet there is not a sufficient number of nurses with master's degrees and qualifications in special fields. Much can be done in helping nurses to obtain advanced work through leaves of absence, reduced schedules, scholarships, and encouragement; also through offering more opportunities for a person to combine
academic work with special clinical fields. The teaching load should conform in general to that of other faculty members. Adequate time should be allowed for preparation and attention to the many details of good teaching.

THE BASIC CURRICULUM

In setting up the curriculum, the objectives of the school must be held in mind and wherever possible, available university classes and facilities should be used. While it is recognized that there is a difference of opinion in regard to applied courses, it can be said with safety that courses such as general chemistry, English, psychology, and sociology, regular courses already in the university curriculum, should be taken with other students, in the first year, while a freshman course in history or survey of nursing should be instituted and opened to any woman student in the university.

During the second year the applied courses need to be considered and we have the necessity for organizing or adapting courses in some of the sciences fundamental to nursing education such as physiology, anatomy, bacteriology, and organic chemistry. It is important also to include courses in social sciences and liberal arts so that the student will have a better background for working with people and communities. A few elective courses should be introduced during the professional period of the work. There should be a careful balance in the program and during the period in the hospital it is important to have sequence of subjects and coordination between theory and practice. We have found it advisable, on a quarter basis, in the four major services to have the theory precede the practice by one quarter. During the special services such as mental nursing, the theory and practice can be arranged concurrently.

All hospital classes and practice should be on a university semester or quarter credit basis rather than given a blanket credit at the end of the hospital period, because this makes it possible for the university to have control of the practice work. Students are scheduled for certain services in advance by the director of nursing education in the hospital division. The director of nursing service receives these schedules and plans her work accordingly. It is necessary, of course, to have a sufficient staff of graduate nurses to carry such a plan. Once started, however, it works smoothly. In considering the curriculum it should be remembered that it includes not only classes and practice, but every phase of life and experience in the hospital. The extracurricular activities and social life are important, and should receive careful planning and direction.

GRADUATE NURSE CURRICULA

Curricula for the graduate nurse leading to a bachelor's and master's degrees may be developed. These programs should be arranged so that the clinical specialties, public health, teaching, supervision, and administration may be included. They should provide a period of practice on an academic credit basis.

Often in starting new work in a university these courses for graduate
nurses may be developed first, giving a nucleus for future faculty members in the basic course. The logical development, however, is to organize these after the basic course has been in operation for a period of time.

The importance of working slowly, with one development at a time, should always be considered.

**Development of Clinical Facilities in the Community**

In developing a new curriculum it is important to study the various facilities in the community. Ordinarily no one hospital can offer the variety of services that are necessary today to give the student a well-rounded course. Often the first view of the community will not disclose any hospitals or institutions ready to give special services, such as mental nursing. However, the school of nursing should not be discouraged by this, but make the attempt to work with these institutions and gradually develop the student program.

In our own experience we found that over a period of three years it was possible to develop an excellent teaching unit in one of the state mental hospitals. At the time we first approached this institution there was only one graduate nurse employed. We found, however, that they were anxious to develop a program of better care for their patients and with the advice and help of the university gradually secured qualified nurses for the administrative and supervisory positions. A course was developed first for the graduate nurse, and at the end of two and one-half years it was possible to place basic students in this institution.

Similar educational facilities have been developed in the field of tuberculosis and in public health. The university has paid part of the salary for an instructor in these institutions or agencies. In that way a qualified person has been secured who is in charge of the students' work and who develops the teaching program. This program must include the medical lectures and nursing classes as well as the ward clinics and conferences. It is in the development of these resources in the community that the advisory committee is of great value. We have found that many of these institutions are glad to become a part of the university teaching field.

**Admission Requirements**

The student admission requirements should be the same as those required throughout the university. In addition to the general university requirements in regard to high school units we should include college aptitude tests and many universities have found it advisable to also use a nursing aptitude test. Our practice has been to allow any student who wishes, to come into the first year on the campus. During this first year she may be eliminated for poor scholarship, or any physical handicaps, or anti-social behavior. In the second year the loss is much less. After entrance to the hospital division the loss of students has been small, running from 6 to 8 per cent. Some of this loss has been due to illness and the student has returned later. The number who resign from the nursing course voluntarily
or by request, has been very few. A two-point average, or a high "C" grade is required for entrance to the hospital division, and must be maintained by the student while there.

**Hours**

The number of required hours of work a week is of great importance as the student must have time for preparation, recreation, and rest. At the University of Washington hospital divisions the students had a forty-eight hour week including class hours until last year. In January 1938, it was possible to reduce the hours to forty-four including class periods. This reduction in hours is having some effect on the happiness and ability of the students. A comparison with former years of student health will be made at the end of the present year.

**Health and Living Conditions**

A thorough physical examination upon entrance to the university is advisable including a Mantoux test with an x-ray. A second check should be made of the student just before entrance to the hospital division. Immunization for smallpox and typhoid, and a Schick test are necessary. All defects should be corrected before entrance to the hospital. During the time in the hospital division there should be an annual physical examination for all students and more frequent checks wherever indicated.

**Library and Teaching Equipment**

The general university library is always available to nursing students. In addition, the hospital division library should be well kept up with carefully selected reference books. The professional journals should be available and a lantern and moving picture machine are necessary for good teaching. The equipment for teaching nursing procedures should be the same as that used on the ward units and extra or special equipment should be requisitioned out of the stockroom as it is needed. This is less costly and guarantees fresh equipment of the kind being used on the wards. Regular items should be provided in the budget for library and equipment. A careful selection of reference books should be available in the supervisor's office on each ward.

**Records**

The permanent official records in the university registrar's office should show the high school work, family background, a record of all classes and practice during the university and hospital period, and should be so recorded that an official transcript can be made when desired. The director of the school of nursing education should have copies of these records on file in her office and in addition she should have all of the detailed information in regard to the student's hospital work and special abilities as well as a summary for the purpose of recommendation.

**Service To The Rest Of The University**

The school of nursing education should contribute to the education of other students in the university through classes in health education, child
care, home hygiene, and others. This not only offers valuable education to other students but makes for a closer relationship with other departments and since these classes are usually large it reduces the cost of professional education. At the University of Washington I feel that the offering of these classes has helped very definitely in establishing our standing in the university and in making it possible to secure a larger faculty. Recently, the School of Nursing Education was asked to assume leadership in the organization of a new health education curriculum, cooperating with the School of Education, and other interested departments.

**SUMMARY**

In summarizing, I should like to quote Miss Goodrich in regard to a university school.

A university school, in a real sense of the term, demands the following: (1) An established and recognized status. That is to say, it must be a school admitted to all the rights and privileges accorded the other schools and colleges of any given university. (2) The resources accepted as essential for the creation, maintenance, and future development of professional education, and in addition the resources demanded by the special nature of any given profession. (3) A qualified student body.²

In other words:

1. An independent school or department.
2. A qualified director with sufficient status to make it possible for her to do her work. A well-qualified faculty both in the campus and hospital divisions of the work.
3. A well-organized curriculum, with the university responsible for the teaching program and with credit for all courses and practice.
4. Proper teaching equipment.
5. A well-selected student body.
6. Healthy and normal living conditions for the students.
7. A contribution to the rest of the university through classes for students in other departments and schools.

**BIBLIOGRAPHY**


JOHNS, ETHEL, and PFEFFERKORN, BLANCHE. *An Activity Analysis of Nursing*. Prepared under the auspices of the Committee on the Grading of Nursing Schools. 1934. National League of Nursing Education.


Closing Business Session

Friday, April 29, 2 p.m.

Presiding: Nellie X. Hawkinson, R.N., President.

Committee on Nominations for 1939

Members of the Committee on Nominations appointed by the President, in accordance with the provisions of the By-laws, were:

Edna Peterson, Missouri, Chairman
Ruth Henley, Virginia

Nominations from the floor were:

Sister M. Berenice Beck, Wisconsin
Cordelia Cowan, District of Columbia
Agnes Ohlson, Connecticut

These nominations were duly accepted.

It was reported that the registration at this convention, exclusive of exhibitors, guests, and other lay people admitted without registration, was 5,430.

Report of the Committee on Resolutions

The National League of Nursing Education wishes to express its sincere appreciation to all who have contributed in making this, the Forty-fourth Annual Convention, an outstanding success. We are especially grateful to our hostesses, the officers and directors of the Missouri State Nurses' Association, and the Missouri League of Nursing Education, with their various committee members. It has been a pleasure to meet in Kansas City where unusual facilities combining comfort and beauty are available. We are deeply appreciative of the cordial hospitality, the interest, and the friendliness afforded us throughout the community. Especially, we would like to mention the courteous consideration of the press, the photographers, the exhibitors, and management of the Kansas City Hotel.

The program, which was carefully planned and presented, brought stimulation and challenge to all. The progress reports of the committees represent untiring effort in the study of our problems. We are truly grateful to all who contributed to the success of the program.

The League enjoyed its participation in the joint meetings of the national nursing organizations. The rich setting and the excellent speakers made these meetings events of real distinction, which we will cherish in our memories.

Respectfully submitted,

Dorothy Rogers
Sister Celestine
Margorie Bartholf
Myrtle M. Hollo
Olga M. Breihan, Chairman

1 By-laws—Article VII, Section 6. The Committee on Nominations. This committee shall consist of five members, two of whom shall be appointed by the Chair and three by the house.
CONVENTION PROCEEDINGS

REPORT OF TELLERS AND INSPECTORS OF ELECTION

Total number of ballots cast ................................................. 352
Number of invalid ballots ................................................. 1
Number of valid ballots ......................................................... 351

For President
   Nellie X. Hawkinson ..................................................... 349

For Treasurer
   Lucile Petry ............................................................... 232
   Fayre Grabbe .................................................................. 109

For Directors
   Effie J. Taylor ............................................................... 289
   Elizabeth C. Burgess ....................................................... 223
   Edna S. Newman ............................................................ 193
   Henrietta Froehlke ......................................................... 163
   Irene Murchison ............................................................. 156
   Pearl I. Castile .................................................................. 132
   Henrietta Adams .............................................................. 120
   Olga M. Breihan ............................................................... 119

Respectfully submitted,

   LUCY P. GERMAIN, Chairman

   Tellers
   ANNE E. RADFORD
   JESSIE A. BIDDLE
   LUTIE C. LEAVELL
   BLANCHE GRAVES
   MARION L. ZILLEY
   MARIE L. LUPPOLD

The report was accepted and the Chair declared the following officers and directors elected:

President
   Nellie X. Hawkinson, Chicago, Illinois

Treasurer
   Lucile Petry, Minneapolis, Minnesota

Directors
   Effie J. Taylor, New Haven, Connecticut
   Elizabeth C. Burgess, New York, New York
   Edna S. Newman, Cleveland, Ohio
   Henrietta Froehlke, Kansas City, Kansas

Miss Hawkinson announced that invitations for the 1939 convention had been received from Richmond, Virginia, and New Orleans, Louisiana, and the place would be selected by the Board of Directors.

She took this occasion to express sincere thanks to the officers and directors of the Missouri League of Nursing Education, to Miss Froehlke, chairman of the Committee on Program, to Miss Frauens, chairman of the Committee on Arrangements, to Miss Jeisy, chairman of the program monitors, and to all others who had assisted in making the convention a pleasant and successful one.

The Forty-fourth Annual Convention was then declared adjourned.
NATIONAL LEAGUE OF NURSING EDUCATION

CERTIFICATE OF INCORPORATIONRecorded in the office of the Recorder of Deeds for the District of Columbia, April 18, 1918. Accepted as the charter of the National League of Nursing Education, April 20, 1918

By-laws amended June 21, 1924; May 29, 1925; May 22, 1926; June 17, 1929; June 10, 1930; April 11, 1932; June 12, 1933; April 23, 1934; June 3, 1935; May 10, 1937; April 25, 1938.

CERTIFICATE OF INCORPORATION

KNOW ALL MEN BY THESE PRESENTS, that we, the undersigned, citizens of the United States, Jane Delano, Clara D. Noyes, and Georgia Nevins, citizens of the District of Columbia, and Lillian Clayton, a resident of Philadelphia, Pa., and Elizabeth A. Greener, a resident of the City of New York, desiring to avail ourselves of the provisions of Sec. 599, et sequitur, of the code of law of the District of Columbia, do hereby certify as follows:

1st. This organization shall be known as the National League of Nursing Education.

2d. The term for which it is organized shall be perpetual.

3d. The object of this association shall be to consider all questions relating to nursing education; to define and maintain in schools of nursing throughout the country minimum standards for admission and graduation; to assist in furthering all matters pertaining to public health; to aid in all measures for public good by cooperating with other bodies, educational, philanthropic, and social; to promote by meetings, papers, and discussions, cordial professional relations and fellowship and in all ways to develop and maintain the highest ideals in the nursing profession.

4th. The number of its trustees for the first year of its existence shall be thirteen.

IN WITNESS WHEREOF we have hereunto set our hands and seals on this 13th day of March, 1917.

James Picker, E. J. Morton as to .................... { Elizabeth Greener, R.N. (Seal)
Lillian Clayton, R.N. (Seal)
Jane A. Delano (Seal)
Georgia Nevins (Seal)
Clara D. Noyes (Seal)

Robert E. P. Kreiter as to .......................... 

BY-LAWS

ARTICLE I

Membership

Section 1. Membership in the National League of Nursing Education shall consist of three classes:

a. Active, including sustaining and junior active
b. Associate
c. Honorary

Sec. 2. An applicant for active membership shall, after March 1, 1938, qualify by:

a. (1) Having been graduated by a school of nursing accredited by the state board of nurse examiners and connected with a hospital having a daily average of 50 patients during the final year of the applicant's course, and offering a program consisting of practice and instruction in medical, surgical, obstetric, and pediatric nursing; or

(2) Having been graduated by a school of nursing accredited by the state board of nurse examiners and connected with a hospital having a daily average of from 30 to 49 patients, and either having had in her undergraduate course an affiliation of not less than six months in an accredited school of nursing connected with a hospital hav-
BY-LAWS

1. Having a minimum daily average of 100 patients, or having completed satisfactorily a postgraduate course of not less than six months; or,

2. Having been graduated by a school of nursing in a foreign country, such school of nursing having been accredited by a board or other authority constituted for that purpose in the country in which such school of nursing is located.

3. Having become a registered nurse in one or more states;

4. Being a member of the American Nurses' Association;

5. Holding an advisory, executive, or teaching position in an educational, preventive, or government nursing organization; and

6. Being recommended for active membership by the Committee on Eligibility.

Sec. 3. An applicant for junior active membership shall, after March 1, 1938, qualify by:

a. Having been graduated by a school of nursing accredited by the state board of nurse examiners and connected with a hospital having a daily average of 50 patients during the final year of the applicant's course, and offering a program consisting of practice and instruction in medical, surgical, obstetric, and pediatric nursing; or

b. Having been graduated by a school of nursing accredited by the state board of nurse examiners and connected with a hospital having a daily average of from 30 to 49 patients, and either having had in her undergraduate course an affiliation of not less than six months in an accredited school of nursing connected with a hospital having a minimum daily average of 100 patients, or having completed satisfactorily a postgraduate course of not less than six months; or

Sec. 4. A sustaining member is an active member who has paid the dues required of such membership.

Sec. 5. An applicant for active or junior active membership in the National League of Nursing Education may be accepted in one of three ways:

a. As a member of a local league of nursing education which gives automatic membership into state and National Leagues of Nursing Education;

b. As a member of a state league where there is no local league and which gives automatic membership into the National League of Nursing Education;

c. As an individual member in states which have no state league of nursing education, or upon special action of the Board of Directors.

Sec. 6. An applicant for associate membership shall, after March 1, 1938, qualify by:

a. Having been graduated by a school of nursing accredited by the state board of nurse examiners and connected with a hospital having a daily average of 50 patients during the final year of the applicant's course, and offering a program consisting of practice and instruction in medical, surgical, obstetric, and pediatric nursing; or

b. Having been graduated by a school of nursing accredited by the state board of nurse examiners and connected with a hospital having a daily average of from 30 to 49 patients, and either having had in her undergraduate course an affiliation of not less than six months in an accredited school of nursing connected with a hospital having a minimum daily average of 100 patients, or having completed satisfactorily a postgraduate course of not less than six months; or

a. Having been graduated by a school of nursing in a foreign country, such school of nursing having been accredited by a board or other authority constituted for that purpose in the country in which such school of nursing is located.
b. Having become a registered nurse in one or more states;
c. Being a member of the American Nurses' Association;
d. Being enrolled as a student in university or college nursing courses, an executive or instructor in a hospital or school of nursing in a foreign country; and
e. Being recommended for associate membership by the Committee on Eligibility or by special action by the Board of Directors.

Sec. 7. a. A state league of nursing education desiring to join the National League of Nursing Education shall make application on the form furnished by the Secretary or Executive Secretary. The form shall be properly filled in to meet the specified requirement and a card of approval of the constitution and by-laws of the state league signed by the chairman of the Committee on Revision of the National League of Nursing Education shall be attached thereto. This form with the card of approval attached, together with a copy of the constitution and by-laws of the state league, shall be sent to the headquarters of the National League of Nursing Education for approval by the Board of Directors.

b. Applicants for individual membership desiring to join the National League of Nursing Education shall make application on a form furnished by the Secretary or Executive Secretary. The form after being properly filled in shall be sent with the required dues to the Executive Secretary.

Sec. 8. An active or associate member in good standing in any state league who changes her residence to another state, may be admitted by transfer sent by the treasurer of the state league she is leaving to the treasurer of the state league to which she is going, entitling her to membership for the remainder of the fiscal year without further payment of dues. At that time she may continue her membership only through the state league of the state in which she is a resident.

Sec. 9. An active or associate member who has withdrawn from the National League of Nursing Education, or whose membership has lapsed on account of non-payment of dues, may be reinstated by paying the regular annual dues for the current year.

Sec. 10. Honorary membership may be conferred by a unanimous vote of the voting body at the annual convention on persons who have rendered distinguished service or valuable assistance to the nursing profession, the names having been recommended by the Board of Directors. Honorary membership shall not be conferred on more than two persons at any convention.

**ARTICLE II**

**Officers**

Section 1. The officers of the National League of Nursing Education shall consist of a president, a vice president, a secretary, and a treasurer. These four officers and eight directors, with the President of the American Nurses' Association, the President of the National Organization for Public Health Nursing, and the Editor of the American Journal of Nursing, shall constitute a Board of Directors.

**ARTICLE III**

**Elections**

Section 1. The President, the Treasurer, and four Directors shall be elected in the even-numbered years to serve for two years. The Vice President, the Secretary, and four Directors shall be elected in the odd-numbered years to serve for two years.

Sec. 2. All elections of officers and directors referred to in Section 1 of this Article shall be held at the annual convention. All elections shall be by ballot. All elections shall be held by plurality vote.

Sec. 3. The President shall appoint the necessary tellers and inspectors of election.

Sec. 4. The Secretary shall furnish to the chairman of the tellers a list of officers, presidents of the state leagues, and active members. The teller in charge of the register shall check the name of the member voting.
Sec. 5. The teller in charge of the ballot box shall place her initials upon the back of the ballot and voter shall then deposit the ballot.
Sec. 6. Polls shall be open for such a period of time as shall be specified by the Board of Directors.
Sec. 7. Each officer shall hold office until the adjournment of the annual meeting at which her successor has been elected.
Sec. 8. In the event of a vacancy in any office, the Board of Directors shall fill the vacancy until her successor is elected.

**Article IV**

**Duties of the Board of Directors and Officers**

Section 1. The Board of Directors shall:

a. Supervise the affairs of the League, perform all necessary functions of management, and devise and mature measures for its advancement and welfare;
b. Hold a business meeting immediately preceding and immediately following each convention and shall meet at other times at the call of the President or at the request of five (5) or more members of the Board;
c. Transact the general business of the League in the interim between annual conventions;
d. Report to the League at each annual convention the business transacted by it during the preceding year;
e. Provide for the proper care of all books and papers of the League;
f. Select a place of deposit for funds and provide for their investment;
g. Provide for the auditing of accounts;
h. Provide for the maintenance of National Headquarters and for the making of this office the center of all activity of the League in connection with the American Nurses’ Association and the National Organization for Public Health Nursing;
i. Appoint an Executive Secretary, define her duties, except as herein provided, and fix her compensation;
j. Appoint all committees not otherwise provided for;
k. Act upon applications for membership; and
l. Determine the hours during which polls shall be open for election.

Sec. 2. The President shall:

a. Preside at conventions, at all meetings of the Board of Directors and Advisory Council, and be a member ex officio of all committees;
b. Issue vouchers for all bills paid by the Treasurer;
c. Perform all other acts and duties of a general nature as may be incident to her office.

Sec. 3. The Vice President shall perform the duties of the President in her absence or during her inability to act, and such other duties as may be delegated to her by the President.

Sec. 4. The Secretary shall:

a. Keep the minutes of the convention and of the meetings of the Board of Directors and of the Advisory Council;
b. Preserve all papers, letters, and records of all transactions, and have custody of the corporate seal;
c. Present to the Board of Directors all applications for membership together with the recommendations of the Committee on Eligibility;
d. Report to the Board of Directors at each annual convention or upon request;
e. Within one month after retiring, deliver to the new Secretary all books, papers, and reports of the League in her custody with a supplemental report covering all transactions from January 1 to the close of the annual convention;
f. Send a notice of the annual convention to each member at least one month in advance.
Sec. 5. The Treasurer shall:

a. Collect, receive, and have charge of all funds of the League, and shall deposit such funds in a bank designated by the Board of Directors;

b. Pay only such bills as have been ordered by the President;

c. Give a bond subject to the approval of the Board of Directors for the faithful performance of her duties, said bond to be paid from the treasury;

d. Report to the Board of Directors the financial standing of the League at each annual convention and upon request;

e. Deliver, one month after retiring, to the new Treasurer all papers, books, records, money of the League in her custody, with a supplemental report covering all transactions from January 1 to the close of the annual convention.

Sec. 6. Necessary expenses incurred by officers or committees in the service of the League shall, upon approval of the Committee on Finance, be refunded from the general treasury. Necessary expenses of the directors shall be fixed at an appropriate amount by the Committee on Finance in its absolute discretion, and shall be included in the budget of the finances of the League. The amount so fixed shall be refunded from the general treasury.

**ARTICLE V**

**Advisory Council**

Section 1. The officers of the National League and the presidents of the state leagues belonging to the National League shall constitute an Advisory Council.

Sec. 2. The duties of the Advisory Council shall be to keep the National League informed of the progress of nursing education in the states represented and to cooperate with the National League of Nursing Education.

Sec. 3. Meetings of the Advisory Council shall be held in connection with each annual convention, at such times as shall be designated in the program. The members shall be prepared to report on the work in their respective state leagues.

Sec. 4. In the absence of its president a state league may be represented in the Advisory Council by an alternate appointed by the state league.

**ARTICLE VI**

**Executive Secretary**

Section 1. Except as herein specifically provided, the duties of the Executive Secretary shall be outlined by the Board of Directors.

Sec. 2. She shall be responsible for the disbursements of all headquarters funds as assigned by the Board of Directors, and in this capacity shall be bonded.

Sec. 3. She shall attend the meetings of the Board of Directors and shall be a member ex officio of all committees.

**ARTICLE VII**

**Standing Committees**

Section 1. Except as otherwise specifically provided, standing committees shall be appointed by the Board of Directors to serve for one year. They shall consist of at least three members and shall be as follows:

a. Accrediting
b. Convention Arrangements
c. Curriculum
d. Eligibility
e. Finance
f. Headquarters
g. Nominations
h. Program
i. Publications
j. Revision
k. Studies
Sec. 2. The Committee on Accrediting. This committee is responsible for determining the standards and procedures for the accreditation of schools of nursing. It is also responsible for putting the program into operation and for its administration.

Sec. 3. The Committee on Convention Arrangements. This committee shall be responsible for the plans to be followed in carrying on the annual convention, by making arrangements for suitable places for general and committee meetings, hotel accommodations, exhibits, and general information.

Sec. 4. The Committee on Curriculum. The work of this committee shall include the study and presentation of the curriculum for schools of nursing and any other activity approved by the Board of Directors.

Sec. 5. The Committee on Eligibility. This committee shall check the qualifications of the applicants applying for individual membership according to the requirements of the By-laws, and if sufficient data are not furnished on the application form, shall secure such data by correspondence.

Sec. 6. The Committee on Finance. This committee shall prepare and present a budget of the finances of the League to the Board of Directors, advise concerning investments, and approve other than routine expenditures.

Sec. 7. The Committee on Headquarters. This committee shall have the power to act between Board meetings upon all matters which are referred by the President or Executive Secretary which do not require the formation of new policies, and to pass upon applications for membership which come from states where there are no state leagues.

Sec. 8. The Committee on Nominations. This committee shall consist of five members, two of whom shall be appointed by the chair and three by the house. On or before each September 1 preceding the annual convention, this committee shall issue to each state league a form on which the state league shall submit the name of one nominee for each office to be filled. These forms shall be signed by the president or secretary of the state league and returned to the Committee on Nominations of the National League of Nursing Education before December 1 preceding the annual convention.

From the forms returned by the state leagues, the Committee on Nominations shall prepare a ticket consisting of two names of the nominees receiving the highest number of votes for each office, and eight names for the office of directors. If the list of names submitted is not sufficient to form a ticket, the Committee on Nominations shall have power to add names so that a full ticket may be made up. No name shall be presented to the Board of Directors or to the convention, either by the Committee on Nominations or from the floor, unless the nominee has consented and is free to serve if elected. This report shall be in the hands of the Secretary by January 1.

The list of nominations shall be published in the March issue of The American Journal of Nursing, shall be mailed to each state league at least two months previous to the annual convention, and shall be posted on the daily bulletin board on the first day of the annual convention.

Sec. 9. The Committee on Program. The chairman of this committee shall request from the members of the Program Committee, the officers of the National League of Nursing Education, the state leagues, and chairmen of all committees, suggestions for the program. This committee shall submit a draft of this program to the Board of Directors to be acted upon at the mid-year meeting. The committee shall be responsible for all correspondence unless otherwise instructed.

Sec. 10. The Committee on Publications. The committee shall keep informed concerning the contents of professional nursing magazines and pamphlets and other journals publishing material of interest to nursing and nursing education, recommend and decide upon reprints of articles contained in such periodicals, cooperate with the Committee on Curriculum in matters pertaining to its publications and prepare such other publicity material as may be indicated and approved by the Board of Directors and as allowed by the budget.
Sec. 11. The Committee on Revision. This committee shall investigate the eligibility of all state leagues applying for membership in this organization. It shall devise ways and means for cooperation with states and territories for securing members and report its findings to the Board of Directors, whose decision as to the eligibility shall be final. It shall receive all proposed amendments to the By-laws of this association, and submit them for action at the annual convention. This committee shall also advise state leagues concerning proposed amendments to their constitution and by-laws for the purpose of keeping them in harmony with the Articles of Incorporation and By-laws of this organization.

Sec. 12. The Committee on Studies. This committee shall approve the studies to be undertaken by the Director of Studies, the plans for and reports of such studies, and otherwise serve in an advisory capacity to the Director.

Sec. 13. Each committee shall present a written report of its activities to the annual convention and to the Board of Directors at the mid-year meeting, and keep the Executive Secretary informed of its work, as may be indicated, during the year.

Article VIII

Dues

Section 1. The annual dues for all active members of the National League of Nursing Education shall be $3.00.

a. In states where there is a state league, dues ($3.00) for all active members shall be paid through the state league on the basis of membership March 1 of each year, except the first year of membership, when dues shall be paid at the time of application.

b. In states where there is no state league, dues ($3.00) shall be paid directly to the National League of Nursing Education. Dues shall accompany application.

Sec. 2. The annual dues for junior active and associate members shall be $2.00.

a. In states where there is a state league, dues ($2.00) shall be paid through the state league on the basis of membership March 1 of each year, except the first year of membership, when dues shall be paid at the time of application.

b. In states where there is no state league, dues ($2.00) shall be paid directly to the National League of Nursing Education. Dues shall accompany application.

Sec. 3. The annual dues for sustaining members shall be $8.00, which shall entitle the members to receive all pamphlets and reprints published by the League during the year.

a. In states where there is a state league, dues ($8.00) for all sustaining members shall be paid through the state league on the basis of membership March 1 of each year, except in the first year of membership, when dues shall be paid at the time of application.

b. In states where there is no state league, dues ($8.00) shall be paid directly to the National League of Nursing Education. Dues shall accompany application.

Sec. 4. Any state league or individual member failing to pay the annual dues by the first day of April shall receive a notice from the Treasurer, and if the dues are not paid within two months they shall have forfeited all privileges of membership. Active individual members having forfeited their membership may be reinstated upon the payment of dues for the fiscal year.

Associate members having forfeited their membership may be reinstated upon the payment of dues for the fiscal year.

Article IX

Meetings

Section 1. A convention of the National League of Nursing Education shall be held annually. In the even-numbered years it shall be held conjointly with the convention
of the American Nurses’ Association, in the odd-numbered years it shall be held at
such time and place as shall be determined by the Board of Directors.
Sec. 2. The order of business at each convention shall include:
a. Reading of the minutes
b. Annual reports of all officers
c. Annual reports of all Presidents of all State Leagues of Nursing Education
d. Annual reports of all Standing Committees
e. Address of President
f. Miscellaneous business
g. Election of officers and directors

**ARTICLE X**

**Representation**

Section 1. The voting body at the annual convention of the National League of
Nursing Education shall consist of active, junior active, and sustaining members of
state leagues in good standing, and individual active, junior active, and sustaining
members in good standing.
Sec. 2. The associate members shall have no vote at state or national meetings.

**ARTICLE XI**

**Quorum**

Section 1. A quorum of the Board of Directors shall be eight (8) members.
Sec. 2. A quorum of the Advisory Council shall be ten (10) members other than
the officers.
Sec. 3. Members from fifteen (15) states shall constitute a quorum for the trans-
action of business at any annual convention.

**ARTICLE XII**

**Fiscal Year**

The fiscal year of this association shall be the calendar year.

**ARTICLE XIII**

**Application of the Term “State League”**

Where the term “state league” is used in these By-laws the word “state” shall be
understood to apply equally to any state of the United States of America, to the Dis-
trict of Columbia, or to any territory, possession, or dependency of the United States
of America, and the rights and privileges, responsibilities and obligations of all mem-
ers in the states, the District of Columbia, the territories, possessions, or depend-
cencies shall be the same. (See Article XIV, By-laws, American Nurses’ Association.)

**ARTICLE XIV**

**Duties of State Leagues**

It shall be the duty of each state league:
a. To know that all requirements for membership in the state and local leagues
meet the requirements for membership in the National League of Nursing Education;
b. To know that the dues are paid by the first day of April of each year on the
basis of membership the first day of March of each year;
c. To send to the President, Secretary, and Executive Secretary of the National
League of Nursing Education and to the American Journal of Nursing, the names
and addresses of all officers, immediately after their election or appointment, together
with the date and place of their next annual meeting;
d. To report the activities of the state and local leagues at the annual convention, and at such other times as may be required;
e. To confer with the Committee on Revision of the National League of Nursing Education regarding changes in their state constitution and by-laws; all such changes to be made shall have attached to them a card of approval, signed by the Chairman of the Committee on Revision of the National League of Nursing Education, before being presented to the state league for action; upon the adoption of any changes by a state league, three copies of the changes adopted, accompanied by the card of approval, shall be sent to the Executive Secretary, one copy shall be retained at National Headquarters, one copy sent to the Secretary, and one to the Chairman of the Committee on Revision;
f. To help organize local leagues when desired;
g. To provide official representation as a member of the Advisory Council at each annual convention.

ARTICLE XV
Parliamentary Authority

Deliberations of all meetings of the National League shall be governed by Parliamentary Usage for Women's Clubs, by Mrs. Emma A. Fox.

ARTICLE XVI
The Official Organ

The American Journal of Nursing shall be the official organ of the National League of Nursing Education.

ARTICLE XVII
Amendments

Section 1. These By-laws may be amended at any annual convention by a two-thirds vote of the active members present and voting. All proposed amendments shall be in the possession of the Secretary at least two months before the date of the annual convention and be appended to the call of the meeting.

Sec. 2. These By-laws may be amended at any annual convention, by the unanimous vote of the active members present and voting, without previous notice.
LIST OF MEMBERS

HONORARY MEMBERS

BOARDMAN, MABEL T. .......... The American Red Cross, Washington, D. C.
BOLTON, MRS. CHESTER C. ... Richmond Road, South Euclid, Ohio
FENWICK, MRS. BEDFORD ...... 39 Portland Place, London W. 1, England
LOCKWOOD, MRS. CHARLES ...... 295 Markham Place, Pasadena, Calif.
OSBORN, MRS. WILLIAM CHURCH. 40 East 36 Street, New York, N. Y.
WINSLOW, C.-E. A., DR.P.H. ... School of Public Health, Yale University, New Haven, Conn.

DeWitt, Katharine ......... 14 Grand Avenue, Poughkeepsie, N. Y.
Nutting, M. Adelaide ....... 500 West 121 Street, New York, N. Y.

LIFE MEMBERS

Dock, L. L. ............... Fayetteville, Pa.

ACTIVE MEMBERS

SYMBOLS USED

(*) Indicates junior active member
(**) Indicates sustaining member
(*) Preceding state names indicates that state leagues have been organized

ALABAMA—26

Allen, Edyth L. ............ 1127 S. 12 St., Birmingham
Denny, Linna H.** .......... 1320 N. 25 St., Birmingham
Enright, Mary C. .......... St. Vincent’s Hospital, Birmingham
Gilchrist, Buena V. ...... St. Vincent’s Hospital, Birmingham
Golightly, Bert A.** ...... Garner Municipal Hospital, Anniston
Jurlow, Nena ............... 2030 Ninth Ave., S., Birmingham
Keoughan, Modesta ......... 960 Dauphin St., Mobile
La Forge, Zoe .............. Box 2591, Birmingham
Lowe, Maye ................. Norwood Hospital, Birmingham
McKenzie, Janie ........... 812 Adams St., Montgomery
Parker, Magiwaide ......... 702 Washington Ave., Montgomery
Roberts, Mrs. Ross E. .... Norwood Hospital, Birmingham
Sister Helen Neuhoff ** ... Providence Infirmary, Mobile
Sister Irene Flanagan ....... 812 Adams St., Montgomery
Sister Jane Frances Byrne 812 Adams St., Montgomery
Sister Justin ... 812 Adams St., Montgomery
Sister Laura Nicaise ** ... City Hospital, Mobile
Sister Lydia ............... St. Vincent’s Hospital, Birmingham
Sister Valeria ** ........ St. Margaret's Hospital, Montgomery
Stockton, Helen I. ....... Box, 2591, Birmingham
Stuart, Lucile .............. 812 Forest Ave., Montgomery
Thrasher, Jewell W.** ... Frasier-Ellis Hospital, Dothan
Vinson, Mary E. ........... 812 Adams St., Montgomery
Warlick, Hattie ............ 1127 S. 12 St., Birmingham
Wortman, Jessie C.** ....... 708 Tuscaloosa Ave., Birmingham
Yauko, Mildred .......... 814 St. Francis St., Mobile

1 This list includes only those members whose 1938 dues reached the National office by July first when this Report went to press.
2 By-laws, Article I, Section 4. A sustaining member is an active member who has paid the dues required of such membership.
3 Article VIII, Section 3. The annual dues for sustaining members shall be $8.00, which shall entitle the members to receive all pamphlets and reprints published by the League during the year.

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ARIZONA—15

Benson, Minnie C. ........ Room 210, S. Arizona Bank Bldg., Tucson
Braddock, Esther ........ Box 748, Prescott
Buzzell, Pauline ......... 505 N. 6 St., Phoenix
Griffin, Eveline L. ....... Good Samaritan Hospital, Phoenix
Haugsten, Martha K. .... St. Joseph's Hospital, Phoenix
Hutchison, Kathryn G. .... Cochise County Hospital, Douglas
McDonald, M. Edna ...... Good Samaritan Hospital, Phoenix
McDonnel, Helen M. ...... R. R. 2, Box 444, Tucson
Potthoff, Lydia .......... 727 E. Willette, Phoenix
Sister Mary Alexine ....... St. Joseph's Hospital, Phoenix
Sister Mary Marguerite Ellard St. Mary's Hospital, Tucson
Sister Mary Theophane .... St. Joseph's Hospital, Phoenix
Sister Mary Veronica .... St. Joseph's Hospital, Phoenix
Stott, Katherine B. ...... Good Samaritan Hospital, Phoenix
Walsh, Ellen G. .......... 83 Columbus Ave., Phoenix

§ ARKANSAS—7

Atwood, Eva ............... St. John's Hospital, Fort Smith
Buffalo, Rachel E.* .... St. Joseph's Hospital, Hot Springs
MacNally, Mary A. ....... Ozark Sanatorium, Hot Springs
Rose, Daisy ............... Baptist Hospital, Little Rock
Sister Mary Angela Flanagan St. Vincent's Infirmary, Little Rock
Sister M. Evangelist ...... St. Edwards School of Nursing, Fort Smith
Teter, Martha Anne B. .... Trinity Hospital, Little Rock

§ CALIFORNIA—333

Adams, Daphne Y. .......... 336 34 St., Oakland
Alberti, Mary J. .......... San Joaquin General Hospital, French Camp
Alford, Marian ............ 479 37 St., Oakland
Allen, Josephine .......... St. Luke's Hospital, San Francisco
Anderson, Helen D. ....... 3922 Stockton Blvd., Sacramento
Avelar, Eliza C.* ......... 1326 Eighth Ave., San Francisco
Bain, Beatrice .......... Sutter Hospital, Sacramento
Baird, Mrs. Beatrice McL. Santa Clara County Hospital, San Jose
Baker, Louise ............. 2400 Bath St., Santa Barbara
Balzer, Laverne L. ....... 425 N. Rampart, Los Angeles
Baratini, Azalea L. ...... 2340 Sutter St., San Francisco
Barnes, Sarah Bessie .... General Hospital, San Diego
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Beebee, Elinor L. .......... 405 Hilgard Ave., Los Angeles
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Biggam, Jean L. .......... Huntington Memorial Hospital, Pasadena
Bigler, Minnetta .......... Samuel Merritt Hospital, Oakland
Black, Lena .............. 2340 Clay St., San Francisco
Blakeley, Mrs. Maxine ... 1401 E. 31 St., Oakland
Blum, Mildred E. .......... 3634 Kingsley St., Oakland
Boerman, Jane * .......... 179 S. 3 St., San Jose
Booth, Aletha ............. 2367 Ardmore St., Los Angeles
<table>
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<tr>
<th>Name</th>
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<tr>
<td>Borg, Martha E.</td>
<td>312 N. Boyle Ave., Los Angeles</td>
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<td>Bosworth, Ida</td>
<td>2005 N. California, Stockton</td>
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<td>Kern County General Hospital, Bakersfield</td>
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<td>Children’s Hospital, San Francisco</td>
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<td>Brown, Elizabeth H.</td>
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<td>Brown, Rowena S.</td>
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<td>Children’s Hospital, Los Angeles</td>
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<td>Bryan, Edith S.</td>
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<td>Bunston, H. Ruth</td>
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<td>Byers, Inez</td>
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<td>Cady, Mrs. Dorothy N.</td>
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<td>Cafferty, Kathryn W.</td>
<td>405 State Bldg., Sacramento</td>
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<td>Cameron, Claudia M.</td>
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<td>Campbell, Ann J.</td>
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<td>Casper, Frances K.</td>
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<td>Castile, Pearl I. **</td>
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<td>Chapin, Mrs. Eleanor R.</td>
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<td>Clarke, Eleanor S.</td>
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<td>Cobban, Franke F.</td>
<td>St. Helena Sanitarium, St. Helena</td>
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<td>Kern County General Hospital, Bakersfield</td>
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<td>Dobey, Elizabeth N.</td>
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<td>Dolan, Mary H.</td>
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<td>Downes, Opal C.</td>
<td>Los Angeles County General Hospital, Los Angeles</td>
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<td>Dugan, Margaret</td>
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<td>Dunbar, Virginia M. **</td>
<td>University of California Hospital, San Francisco</td>
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<td>Dwyer, Laurette</td>
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<td>Easley, Louise R.</td>
<td>537 Lambert Ave., El Monte</td>
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<td>Glendale Sanitarium, Glendale</td>
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<td>Engstrom, Mildred W.</td>
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<td>Erickson, Helen I.</td>
<td>2340 Clay St., San Francisco</td>
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<td>Evans, Opal</td>
<td>129 Laswell St., San Jose</td>
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<td>Falconer, Mary W.</td>
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<td>Farnsworth, Marybeth</td>
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<td>Ferguson, Carrie</td>
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<td>Foleidorn, Mrs. Gertrude R.</td>
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<td>Fore, Kathleen M.</td>
<td>Fairmont Hospital, San Leandro</td>
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MAGUIRE, Mrs. Margaret .......... Franklin Hospital, San Francisco
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MANN, Estella .......... St. Vincent's Hospital, Los Angeles
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Ruddy, Sarah ......................... Community Hospital, Long Beach
Ryle, Jessica M. .................... St. Joseph's Hospital, Stockton
Safford, Edna ....................... 906 44 St., Sacramento
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<td>San Francisco Hospital, San Francisco</td>
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<td>SCHUPPICH, MARGARET G.*</td>
<td>2040 Fell St., San Francisco</td>
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<td>SCHWEDLER, ALICE E.</td>
<td>Stanford University Hospital, San Francisco</td>
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<td>SCLATER, ANNA J.</td>
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DUNLAP, ELA M.              Corwin Hospital, Pueblo
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WERME, ELLEN J. Grace Hospital, New Haven
WEST, FRANCES P. Middlesex Hospital, Middletown
WHITE, CONSTANCE J. Hartford Hospital, Hartford
WHITTIER, VIRGINIA C.* 672 Howard Ave, New Haven
WILCOX, ONA M. 28 Crescent St, Middletown
WILD, ANNA Stamford Hospital, Stamford
WILSON, IRENE Shady Lawn, E. Wharf Rd, Madison
WOLCOTT, MARION A. 9 Howe St, New Haven
WOODWARD, FRANCES E. 37 Jefferson St, Hartford
ZABEL, DOROTHY A.* R. F. D. No. 4, Bridgeport

‡ DELAWARE—26

BEACH, BEULAH P. 1501 Van Buren St, Wilmington
BROWN, WINONA T. Milford Emergency Hospital, Milford
CASTLE, MRS. ANNA VAN W. 1101 Gilpin Ave, Wilmington
CHAMBERS, ELLEN Milford Emergency Hospital, Milford
CLAUSON, BEDA E. Homeopathic Hospital, Wilmington
DITTMAR, KATHRYN Homeopathic Hospital, Wilmington
DOUGHERTY, MILDRED L. Wilmington General Hospital, Wilmington
DOWNES, GLADYS M. 823 West St, Wilmington
DUGAN, LUCILE E. Delaware Hospital, Wilmington
FERRY, MARY M. Wilmington General Hospital, Wilmington
HALLOWAY, EDNA M. Delaware Hospital, Wilmington
HERMAN, GLADYS L. Delaware Hospital, Wilmington
KAHLE, EFFIE E. Delaware State Hospital, Farnhurst
MASER, ROSE A. 607 W. 20 St, Wilmington
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QUAY, ANNA M. Homeopathic Hospital, Wilmington
ROEDER, FRIEDA J. Homeopathic Hospital, Wilmington
SCHRANK, BERTHA C. Delaware Hospital, Wilmington
SISTER M. ELAINE St. Francis Hospital, Wilmington
SMITH, REBECCA M. Wilmington General Hospital, Wilmington
STEVENSON, ALICE L. Milford Emergency Hospital, Milford
WHITESELL, EVELYN M. Wilmington General Hospital, Wilmington
WORTHINGTON, MABEL M. Milford Emergency Hospital, Milford

‡ DISTRICT OF COLUMBIA—101

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BERDAN, ELSIE T. Providence Hospital, Washington
BLACKMAN, MRS. JOSEPHINE W. 1301 Massachusetts Ave, N. W., Washington
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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</thead>
<tbody>
<tr>
<td>Bloom, Mrs. Laura R.</td>
<td>Garfield Memorial Hospital, Washington</td>
</tr>
<tr>
<td>Bowling, Gertrude H.</td>
<td>810 Albee Bldg., Washington</td>
</tr>
<tr>
<td>Bulman, Mary M.</td>
<td>Catholic University School of Nursing, Washingto n</td>
</tr>
<tr>
<td>Burnett, Dorothy L.</td>
<td>Washington Sanatorium, Takoma Park</td>
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<tr>
<td>Burns, Helen J.</td>
<td>Gallinger Hospital, Washington</td>
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<tr>
<td>Butcher, Mrs. Carolyn R.</td>
<td>Gallinger Hospital, Washington</td>
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<tr>
<td>Butler, Mary E.</td>
<td>Gallinger Hospital, Washington</td>
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<tr>
<td>Buxton, Elizabeth*</td>
<td>1150 N. Capitol St., Washington</td>
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<tr>
<td>Case, Marie J.</td>
<td>Georgetown University Hospital, Washington</td>
</tr>
<tr>
<td>Cassase, Mrs. Elsie C.</td>
<td>Sibley Memorial Hospital, Washington</td>
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<tr>
<td>Chapman, Fern</td>
<td>1445 Ogden St., N. W., Washington</td>
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<tr>
<td>Cluff, Thelma</td>
<td>St. Albans School, Washington</td>
</tr>
<tr>
<td>Connor, Mary C.</td>
<td>2308 Ashmead Place, N. W., Washington</td>
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<tr>
<td>Cowan, Amy R.</td>
<td>1441 Spring Rd., N. W., Washington</td>
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<tr>
<td>Cowan, M. Cordelia**</td>
<td>1746 K St., N. W., Washington</td>
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<tr>
<td>Dalton, Bernice I.</td>
<td>Georgetown University Hospital, Washington</td>
</tr>
<tr>
<td>Daniel, Deborah E.</td>
<td>1711 New York Ave., N. W., Washington</td>
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<tr>
<td>Defandorf, Janet W.</td>
<td>1715 New York Ave., N. W., Washington</td>
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<tr>
<td>Delaskey, Mary E.</td>
<td>2019 Eye St., N. W., Washington</td>
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<tr>
<td>Dennis, Marie</td>
<td>Emergency Hospital, Washington</td>
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<tr>
<td>Deutsch, Naomi</td>
<td>U. S. Children's Bureau, Washington</td>
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<td>Dillon, Mary R.</td>
<td>512 C St., S. E., Washington</td>
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<td>Dinkelspiel, Stella E.</td>
<td>3529 10 St., N. W., Washington</td>
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<td>Doerry, Maud</td>
<td>Garfield Memorial Hospital, Washington</td>
</tr>
<tr>
<td>Donovan, Irene M.</td>
<td>1825 New Hampshire Ave., Washington</td>
</tr>
<tr>
<td>Dunn, Mary J.</td>
<td>4701 Connecticut Ave., N. W., Washington</td>
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<tr>
<td>Dutton, Mrs. Harriett R.</td>
<td>Sibley Memorial Hospital, Washington</td>
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<tr>
<td>Earle, Elizabeth C.</td>
<td>St. Elizabeth's Hospital, Washington</td>
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<td>Fay, Alice M.</td>
<td>810 Albee Bldg., Washington</td>
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<td>Fish, Janet</td>
<td>Emergency Hospital, Washington</td>
</tr>
<tr>
<td>Fisher, Lillian E.</td>
<td>1150 North Capitol St., Washington</td>
</tr>
<tr>
<td>Forster, Margaret A.</td>
<td>Nurses' Home, Gallinger Hospital, Washington</td>
</tr>
<tr>
<td>Gaffney, Clare</td>
<td>3146 Que St., N. W., Washington</td>
</tr>
<tr>
<td>Gardiner, Lillian A.</td>
<td>Catholic University of America, Washington</td>
</tr>
<tr>
<td>Gardiner, M. Louise*</td>
<td>Georgetown University Hospital, Washington</td>
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<tr>
<td>Gibson, Mattie M.</td>
<td>Children's Hospital, Washington</td>
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<td>Graham, Mary E.</td>
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<td>Greene, Nita E.</td>
<td>Gallinger Hospital, Washington</td>
</tr>
<tr>
<td>Griffee, Mrs. Leah M.</td>
<td>Washington Sanitarium and Hospital, Takoma Park</td>
</tr>
<tr>
<td>Griffith, Pearle A.</td>
<td>816 E St., N. E., Apt. 510, Washington</td>
</tr>
<tr>
<td>Harris, Leslie V.</td>
<td>Gallinger Hospital, Washington</td>
</tr>
<tr>
<td>Hasselbusch, Charlotte</td>
<td>637 Ingraham St., N. W., Washington</td>
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<tr>
<td>Havel, I, Malinde</td>
<td>Amer. Red Cross, 18 &amp; D Sts., Washington</td>
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<td>Hawthorne, Mary L.</td>
<td>2019 Eye St., N. W., Washington</td>
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<tr>
<td>Haydon, Edith M.</td>
<td>St. Elizabeth's Hospital, Washington</td>
</tr>
<tr>
<td>Heintzelman, Ruth A.</td>
<td>2220 20 St., N. W., Washington</td>
</tr>
<tr>
<td>Hickey, Mrs. Mary A.</td>
<td>The Montana, 1726 M St., N. W., Washington</td>
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<td>Hoffman, Leah M.</td>
<td>Garfield Hospital, Washington</td>
</tr>
<tr>
<td>Jensen, Kathryn L.</td>
<td>Seventh Day Adventists, Takoma Park</td>
</tr>
<tr>
<td>Jorgenson, Gladys</td>
<td>1150 N. Capitol St., Washington</td>
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<td>Kaufmann, Margaret E.</td>
<td>Georgetown University Hospital, Washington</td>
</tr>
<tr>
<td>Klev, Emily M.</td>
<td>1746 K St., N. W., Washington</td>
</tr>
<tr>
<td>Kramer, Vivetta</td>
<td>Gallinger Hospital, Washington</td>
</tr>
</tbody>
</table>
MARSH, VEDA S. Washington Missionary College, Takoma Park
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HOWINGTON, PEARL** Florida Sanitarium and Hospital, Orlando
KREUGER, CLARA Brewster Hospital, Jacksonville
MABBBETTE, CYNTHIA M. State Board of Health, Ocala
MCCASKILL, MARGRET M.** State Board of Health, Ocala
METTINGER, RUTH E. Box 210, State Board of Health, Jacksonville
MISCALy, ELIZABETH Good Samaritan Hospital, West Palm Beach
MOORE, FLORENCE Orange General Hospital, Orlando
MUNN, EDITH Florida Sanitarium and Hospital, Orlando
MURPHY, VIOLET Florida Sanitarium and Hospital, Orlando
<table>
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<th>Name</th>
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<td>Nelson, Inez M.</td>
<td>Box 1223, State Board of Health, Orlando</td>
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<tr>
<td>Nevison, Victoria R.</td>
<td>Orange General Hospital, Orlando</td>
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<tr>
<td>Reed, Elizabeth</td>
<td>Box 549, Marianna</td>
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<td>Richards, Lena</td>
<td>Orange General Hospital, Orlando</td>
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<td>Robson, Juanita</td>
<td>Pensacola Hospital, Pensacola</td>
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<td>Sister Camilla Forwood</td>
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<td>Sister Miriam Harold</td>
<td>St. Vincent's Hospital, Jacksonville</td>
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<td>Sister Odile Allnut</td>
<td>Pensacola Hospital, Pensacola</td>
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<td>Steinacker, Clara E.</td>
<td>St. Luke's Hospital, Jacksonville</td>
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<td>Stokes, Lela M.</td>
<td>Orange General Hospital, Orlando</td>
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<td>Thompson, Margrete</td>
<td>210 First Ave., N. St., Petersburg</td>
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<td>Trentham, Jean</td>
<td>St. Luke's Hospital, Jacksonville</td>
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<td>Watt, Irene B.</td>
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<td>Zellmer, Gertrude M. H.</td>
<td>St. Luke's Hospital, Jacksonville</td>
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**Georgia—39**

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<tr>
<td>Ackerman, Eleanor</td>
<td>Thomaston</td>
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<td>Atkinson, Lucile</td>
<td>Harbin Hospital, Rome</td>
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<td>Babin, Ruth A.</td>
<td>St. Joseph's Infirmary, Atlanta</td>
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<td>Banks, Mattie Lou</td>
<td>St. Joseph's Infirmary, Atlanta</td>
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<td>Bethel, Mary B.</td>
<td>Henry Grady Hotel, Atlanta</td>
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<td>Bratton, Jimmie K.</td>
<td>Georgia Baptist Hospital, Atlanta</td>
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<td>Brodgon, Mina</td>
<td>Grady Hospital, Atlanta</td>
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<td>Candlish, Jessie M.</td>
<td>Egleston Memorial Hospital, Atlanta</td>
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<td>Claxton, Moll G.</td>
<td>Emory University Hospital, Emory University</td>
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<td>Davis, Effie</td>
<td>Patterson Hospital, Cuthbert</td>
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<td>Dickerson, Durice A.</td>
<td>131 Forrest Ave., N. E., Atlanta</td>
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<td>Doig, Grace W.</td>
<td>Emory University Hospital, Emory University</td>
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<td>Erb, Florrye</td>
<td>450 East Ave., N. E., Atlanta</td>
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<td>Feebeck, Annie B.</td>
<td>Grady Hospital, Atlanta</td>
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<td>Garron, Genevieve</td>
<td>Piedmont Hospital, Atlanta</td>
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<td>Gross, Edith T.</td>
<td>St. Joseph's Hospital, Savannah</td>
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<td>Hamrick, Shirley N.</td>
<td>Egleston Memorial Hospital, Atlanta</td>
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<td>Piedmont Hospital, Atlanta</td>
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<td>Harris, Lucy</td>
<td>Georgia Baptist Hospital, Atlanta</td>
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<td>Hope, Willie</td>
<td>Georgia Baptist Hospital, Atlanta</td>
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<td>Horn, Mary E.</td>
<td>Georgia Baptist Hospital, Atlanta</td>
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<tr>
<td>Jones, Mrs. Mae M.</td>
<td>Georgia State Sanatorium, Milledgeville</td>
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<tr>
<td>Kemp, Mrs. Lucille T.</td>
<td>Milledgeville State Hospital, Milledgeville</td>
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<tr>
<td>King, Mrs. Bernice Henry</td>
<td>Baldwin Memorial Hospital, Milledgeville</td>
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<tr>
<td>Lane, Mildred</td>
<td>Middle Georgia Sanatorium, Macon</td>
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<tr>
<td>Mace, Lucy I.</td>
<td>Cox Carlton Hotel, Atlanta</td>
</tr>
<tr>
<td>Muse, Margaret*</td>
<td>Box 344, West Point</td>
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<tr>
<td>Nelson, Lillian O.</td>
<td>Piedmont Hospital, Atlanta</td>
</tr>
<tr>
<td>Sister Mary Anita</td>
<td>St. Joseph's Infirmary, Atlanta</td>
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<tr>
<td>Sister Mary Brendan</td>
<td>St. Joseph's Infirmary, Atlanta</td>
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<td>Sister Mary Gloria McNally</td>
<td>St. Joseph's Hospital, Savannah</td>
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<td>Sister Mary Theresa Byerly</td>
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<td>Stewart, Alice F.</td>
<td>University Hospital, Augusta</td>
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<td>Thompson, Alice R.</td>
<td>Crawford W. Long Hospital, Atlanta</td>
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<tr>
<td>Tupman, Mrs. Eva S.</td>
<td>Box 185, R. F. D., Smyrna</td>
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<tr>
<td>Van De Vrede, Jane</td>
<td>610 Yorkshire Rd., Atlanta</td>
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<tr>
<td>Watts, Mrs. Wilhelmina H.</td>
<td>Emory University Hospital, Emory University</td>
</tr>
<tr>
<td>Williams, Ruth</td>
<td>Room 111, The Capitol, Atlanta</td>
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</tbody>
</table>
FORTY-FOURTH ANNUAL REPORT

IDAHO—8

ALDRICH, DOROTHY M.* 
BLACKWOOD, ELLEN V. 
CHAPMAN, NELLIE J. 
GIST, ELLON G. 
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PINE, EMILY 
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† ILLINOIS—394

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ADAMS, RACHEL T. 
ANDERSON, EMMA 
ANDERSON, MARION 
ANDERSON, MAXINE A.* 
ANDERSON, RUBY M. 
ANSLEY, LEATA B. 
ANTE, MARIE C. 
ARMENTROUT, ALICE* 
ARNOLD, MARGARET 
AXEN, FRIEDA** 
BAKER, GLADYS* 
BAKKEN, OLGA J.* 
BALL, EYTHA* 
BALTZ, KATHERINE E.* 
BARNETT, MARGARET S. 
BAUER, SOPHIE A. 
BAUMGART, MRS. BEATRICE C. 
BELL, ALICE J. 
BELLINGER, P. ANNE** 
BENDER, EDITH D. 
BENTON, MRS. MARY E. B. 
BERGQUIST, EDITH A. 
BIGNERT, HELEN 
BIGLER, ROSE 
BINDER, BEATRICE 
BINNER, MABEL W. 
BIRK, MAMIE 
BLACK, JESSIE B. 
BLANKENBILLER, HARRIET 
BLATT, MRS. ESTELLE W. 
Bogardus, Mary I.** 
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BROADHEAD, FRANCES O'C.* 
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2325 E. 92 Pl., Chicago
2816 Ellis Ave., Chicago
2816 Ellis Ave., Chicago
1900 W. Polk St., Chicago
303 E. Superior, Chicago
2816 Ellis Ave., Chicago
1519 Warren Blvd., Chicago
4950 Thomas St., Chicago
2517 Prairie Ave., Chicago
700 Fullerton Ave., Chicago
1459 S. Michigan Ave., Chicago
11321 Wentworth Ave., Chicago
536 Webster Ave., Chicago
6400 Irving Park Blvd., Chicago
700 Fullerton Pkwy., Chicago
707 Fullerton Ave., Chicago
4544 N. Winchester, Chicago
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950 E. 59 St., Chicago
Veterans Administration, North Chicago
2816 Ellis Ave., Chicago
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700 Fullerton Pkwy., Chicago
1660 Ogden Ave., Chicago
806 E. 58 St., Chicago
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<td>303 E. Superior, Chicago</td>
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<td>Wesley Memorial Hospital, Chicago</td>
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<td>MACNEILL, JULIA M.</td>
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<td>McCLEERY, ADA BELLE</td>
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<td>MCCONNELL, MADELINE***</td>
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<td>MCCORD, GERTRUDE M.</td>
<td>700 Fullerton Parkway, Chicago</td>
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<td>MCDERMID, MRS. HAZEL A. J.</td>
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<td>MCCLEIN, GLADYS</td>
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<td>MCDONELL, ITA R.**</td>
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<td>MCELHINNEY, MRS. ALMA O.</td>
<td>East Moline Hospital, East Moline</td>
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<td>McINNIS, HELEN</td>
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<td>MCLAUGHLIN, JANE R.</td>
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McMillan, M. Helena**  1750 W. Congress St., Chicago
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Pohlon, Mrs. Agnes K.  1967 Callom, Chicago
Porteous, Marguerite*  1900 W. Polk St., Chicago
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<td>Powell, Frances L. A.</td>
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<td>Powell, Katherine C.</td>
<td>628 University Pl., Evanston</td>
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<td>Prim, Leona M.*</td>
<td>3341 Odell Ave., Chicago</td>
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<td>Questill, Naomi L.</td>
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<td>Reed, Dorothea M.</td>
<td>1660 W. Ogden Ave., Chicago</td>
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<td>Reeve, Ferne B.*</td>
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<td>Resar, Angela</td>
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<td>Ridley, Marie</td>
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<td>Rieckman, Bernice D.</td>
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<td>Robeson, Kathryn A.</td>
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<td>Root, Helen*</td>
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<td>Ross, Ann E.</td>
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<td>Rudolph, Elsa A.</td>
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<td>Russ, J. Myrl</td>
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<td>See, Alverna C.</td>
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<td>Senour, Wilma R.</td>
<td>Brokaw Hospital, Normal</td>
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<td>Shew, Emma I.</td>
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<td>Shoemaker, Maude S.</td>
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<td>Sister Agatha Barrett</td>
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<td>Sister Mary Altissima</td>
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<td>St. Charles Hospital, Aurora</td>
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Sister Mary Leo .......................... 95 and California, Evergreen Park
Sister M. Loyola** ........................ 1401 E. State St., Rockford
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updike, Mrs. Madolin R. ............... 5400 Greenwood Ave., Chicago
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WALSH, MILDRED K. ........304 S. 5 St., Champaign
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WEBER, KATHERINE** ..........Olney Sanitarium, Olney
WEBER, MAMMY R. ...........606 E. Main St., Olney
WESTON, MARY L. ..........1900 W. Polk St., Chicago
WESTPHAL, MARY E. ..........104 S. Michigan Ave., Chicago
WHEELER, BEATRICE ........1810 W. Jackson Blvd., Chicago
WHITFORD, MRS. MAB L. ......427 Jefferson Bldg., Peoria
WILKIE, JUANITA** ..........216 E. Crawford, Paris
WILLENBORG, ANNA ..........2100 Burling St., Chicago
WILLIAMS, NAOMA L. .........645 S. Central Ave., Chicago
WILSON, HELEN* .............700 Fullerton Ave., Chicago
WINDBERG, DAGMAR* ..........1900 W. Polk St., Chicago
WINSON, CLARA J. ..........Jackson Park Hospital, Chicago
WUBBENA, ELLA .............830 N. La Salle St., Chicago
YUNDT, AVA P. ..............2816 Ellis Ave., Chicago

$INDIANA—69$

ANDERSON, ELLEN M. ..........1812 N. Capitol Ave., Indianapolis
BARITEAU, NORMA J. ..........735 W. Berry St., Fort Wayne
BIERSDORFER, HELEN M. ......401 N. Notre Dame Ave., South Bend
BISCOFF, PAULINE G.** ......Lutheran Hospital, Fort Wayne
BROWN, NELLIE G. ..........Ball Memorial Hospital, Muncie
CANDY, ELIZABETH ..........Indiana University Hospital, Indianapolis
CHEEK, MARY V.** ..........604 N. Main St., South Bend
CLARKSON, MARY L.* .........St. Joseph Hospital, Mishawaka
COLLINS, AGNES L. ..........St. Joseph Hospital, Mishawaka
COY, FERN ..................1232 W. Michigan St., Indianapolis
CZUBA, STELLA T. ..........25 Douglas St., Hammond
DAILEY, MARY J. ............St. Vincent's Hospital, Indianapolis
DIX, AGNES A. ...............St. Joseph Hospital, Fort Wayne
DOHERTY, M. ESTELLE ......1707 Spring St., New Albany
FRENCH, MRS. FLORENCE S. ....1640 N. Meridian St., Indianapolis
GERRIN, BEATRICE E. ......City Hospital, Indianapolis
GILBERT, MRS. OPAL E. ....Bloomington Hospital, Bloomington
GOULD, METTA** ............Welborn-Walker Hospital, Evansville
GREGG, MARY L. ..........Indiana University Hospital, Indianapolis
GROVES, JESSIE L. ..........Indiana University Hospital, Indianapolis
HALFTER, CAROLINE ..........1812 N. Capitol Ave., Indianapolis
HAUK, MARTHA L. ...........26 E. 14 St., Indianapolis
HECKARD, MARY E. ..........Indiana University Hospital, Indianapolis
HINSHAW, MARY E. ..........1812 N. Capitol Ave., Indianapolis
HOEFLIN, CORDELIA** ......Indiana University Hospital, Indianapolis
HOWARD, GRACE M. ..........Ball Memorial Hospital, Muncie
HUBBLE, JUANITA ..........1232 W. Michigan St., Indianapolis
HUGHES, WILKIE** ..........Ball Memorial Hospital, Muncie
JOHNSON, H. LOUISE ........Lutheran Hospital, Fort Wayne
KENDALL, ORPHA M. ..........1812 N. Capitol Ave., Indianapolis
LILLARD, MRS. MADONNA ....Ball Memorial Hospital, Muncie
McGUIRENESS, EVELYN ......Epworth Hospital, South Bend
MOSLEY, WENIFRED A. .......Union Hospital, Terre Haute
MURPHY, JOSEPHINE M. ......St. Mary's Hospital, Evansville
MURRAY, PEARL E. ..........Deaconess Hospital, Evansville
PALS Grove, Mrs. Ethel H. ......... 1733 N. Meridian St., Indianapolis
POTZL ZINE, Mary E. ............. 42 W. 42 St., Indianapolis
POXON, Mary E.* ................. Lake County Sanatorium, Crown Point
PRUSS, Mrs. Edna C. ............. 49 Beach Grove Ave., Batesville
QUALLS, Anna M. ................. 813 W. Iowa St., Evansville
SCOTT, Anna M. ........... Ball Memorial Hospital, Muncie
SHARP, Carmen .............. 1812 N. Capitol Ave., Indianapolis
SHORT, Beatrice ............ 47 S. Pennsylvania St., Indianapolis
SHROCK, Beulah ............ Route 1, Napoleon
SISTER ANDREA .......... St. Vincent's Hospital, Indianapolis
SISTER GEORGIANA MILLER .... St. Mary's Hospital, Evansville
SISTER MARIA AMADEO** ...... St. Mary's College, Notre Dame
SISTER M. BERCHMANS** .... St. Joseph Memorial Hospital, Kokomo
SISTER M. CONFIRMA ........... St. Joseph's Hospital, Fort Wayne
SISTER MARY ELLEN** ...... St. Joseph Hospital, South Bend
SISTER M. FLAVIA ............ St. Mary's Mercy Hospital, Gary
SISTER MARY FLORINA** ..... St. Anthony's Hospital, Terre Haute
SISTER MARY HENRICA LAKER** . St. Elizabeth Hospital, Lafayette
SISTER M. MILBURGA .......... St. Joseph Hospital, Mishawaka
SISTER MARY VIRGINIA ...... St. Catherine's Hospital, E. Chicago
SISTER M. VITALIS .......... St. Mary's Mercy Hospital, Gary
SISTER ROSE .................. St. Vincent's Hospital, Indianapolis
SMITH, Luella C. ............. 1812 N. Capitol Ave., Indianapolis
SPENCER, Sara ................. Lutheran Hospital, Fort Wayne
TEAL, Helen ................. 1227 Circle Tower, Indianapolis
UNDERWOOD, Marion N. .... 604 N. Main St., South Bend
Up John, Gertrude .......... Indianapolis City Hospital, Indianapolis
WALSH, Mary T. .............. 4530 Washington Blvd., Indianapolis
WELLIK, Mary H. ............ St. Vincent's Hospital, Indianapolis
WILKEN, Elfreda E. ......... Luthern Hospital, Fort Wayne
WILLERS, Aurelia ........... 1332 W. Michigan St., Indianapolis
WILLIAMS, Edythe Y. ......... 604 Mary St., Evansville
WILLS, Edith G. .............. Good Samaritan Hospital, Vincennes
WORSTER, Mary ................. Liberty

$IOWA—137$

ADAIR, Addie M. ......... 1117 Pleasant St., Iowa City
ATKINSON, Katherine ........ 406 Center St., Des Moines
ATWILL, Arvely A. ......... St. Luke's Hospital, Davenport
BAKER, Miriam B. .......... 406 Center St., Des Moines
BAKKER, Roelynne* ......... St. Luke's Hospital, Davenport
BECHTELHEIMER, Alice .... Westlawn, Iowa City
BELIEK, Winifred J.* ....... 1818½ Esplanade, Davenport
BERLIN, Margaret T. ... Burlington Protestant Hospital, Burlington
BJERKESTRAND, Tavia .... 712 Parnell, Des Moines
BRANDT, Sena H. ............. Jennie Edmundson Hospital, Council Bluffs
BROERMAN, Dorothy* ...... 1134 6 Ave., Des Moines
BROWN, Olive ............... 17 and Hickman Rd., Des Moines
CAIRNS, Sylvia A ............ Westlawn, Iowa City
CARLSON, Anna C. .......... Broadlaw Hospital, Des Moines
CARLSON, Rubie M. ........... Lutheran Hospital, Fort Dodge
CARR, Lelia G. ............... 933 Pyth Ave., Des Moines
CHAPMAN, Laura B. ......... Jennie Edmundson Hospital, Council Bluffs
CORDER, Lois B. .......... Westlawn, Iowa City
DARRINGTON, Mable I.* .... Westlawn, Iowa City
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<td>St. Luke's Hospital, Cedar Rapids</td>
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</table>
Pfeiffer, Agatha I.  712 Parnell, Des Moines
Plate, Ethel H.  400 Center St., Des Moines
Prentice, Daisy  211 28 St., Des Moines
Ranck, Marie  St. Luke’s Hospital, Davenport
Raper, Lillian  Westlawn, Iowa City
Reimers, Agnes*  1010 23 St., Des Moines
Reinhart, Edith  Jane Lamb Memorial Hospital, Clinton
Rhodes, Dorothy  Finley Hospital, Dubuque
Rodabaugh, Clara L.  Mercy Hospital, Des Moines
Rodgers, Opal  Westlawn, Iowa City
Roemer, Catherine E.  406 Center St., Des Moines
Sage, Vera M.  Mercy Hospital, Burlington
Schlapper, Emma  Jane Lamb Memorial Hospital, Clinton
Scott, Sara M.  1440 6 Ave., Des Moines
Seelien, Bernice M.*  St. Luke’s Hospital, Davenport
Seibert, Ethel R.*  St. Luke’s Hospital, Davenport
Seibert, Jeannette A.  Iowa Methodist Hospital, Des Moines
Sheetz, Naida  1949 6 Ave., Des Moines
Sister Erna Schweer**  Evangelical Deaconess Hospital, Marshalltown
Sister Margaret Mary Kane  St. Joseph Mercy Hospital, Sioux City
Sister Marie Elizabeth Hopp  Evangelical Deaconess Hospital, Marshalltown
Sister Marie Woizeschke  Evangelical Deaconess Hospital, Marshalltown
Sister Mary Alberta  Mercy Hospital, Council Bluffs
Sister Mary Aloise  Sacred Heart Hospital, Le Mars
Sister M. Alverna  St. Anthony Hospital, Carroll
Sister M. Barbara Ann  Mercy Hospital, Cedar Rapids
Sister Mary Benigna Manning  St. Joseph Mercy Hospital, Sioux City
Sister Mary Camillus**  Mercy Hospital, Council Bluffs
Sister Mary Cajeton  Mercy Hospital, Cedar Rapids
Sister Mary Conception Mullins  Mercy Hospital, Des Moines
Sister Mary Eleanor McManus  Mercy Hospital, Davenport
Sister Mary Etheldreda Collins  St. Joseph Mercy Hospital, Fort Dodge
Sister M. Geraldine Gleeson  Mercy Hospital, Des Moines
Sister M. Helen Mackenzie  Mercy Hospital, Des Moines
Sister Mary Immaculata  Mercy Hospital, Council Bluffs
Sister Mary Irma McManus  Mercy Hospital, Davenport
Sister Mary Magdalene Stran- sky  Mercy Hospital, Iowa City
Sister Mary M. Morrow  Mercy Hospital, Cedar Rapids
Sister Mary Olivia Rockford**  Mercy Hospital, Dubuque
Sister M. Petronilla  St. Joseph Mercy Hospital, Fort Dodge
Sister Mary Placida  St. Vincent’s Hospital, Sioux City
Sister Mary Redeemta  Mercy Hospital, Cedar Rapids
Sister Mary Thomas  Mercy Hospital, Burlington
Sister M. Thomas Phelan  Mercy Hospital, Council Bluffs
Sister Mary Virginia Williams  1600 N. Ash, Ottumwa
Smith, Dorothy E.  Westlawn, Iowa City
Soucek, Bessie E.  Westlawn, Iowa City
Squires, Esther M.  Community Hospital, Grinnell
Stohl, Amanda  Iowa Methodist Hospital, Des Moines
Stolenson, Helen E.  Burlington Hospital, Burlington
Strohmaier, Clematis R.  Westlawn, Iowa City
Stutsman, Mrs. Alice M.  4040 11 St. Place, Des Moines
Swenson, Emilene*  Westlawn, Iowa City
Tully, Catherine M.  St. Joseph’s Mercy Hospital, Dubuque
Tyler, Mary E.  1117 Pleasant St., Des Moines
VATTHAUER, ERNA S. Burlington Protestant Hospital, Burlington
WEBER, FLORA C. Westlawn, Iowa City
WESSLUND, FLORENCE H. Iowa Methodist Hospital, Des Moines
WILSON, MAY S. Iowa Methodist Hospital, Des Moines
WREN, MAE W. Mercy Hospital, Des Moines
YACKEL, GRACE L. Westlawn, Iowa City
YOCKEY, MILDRED A. Graham Hospital, Keokuk

‡ KANSAS—46

BENDER, SARAH E. University of Kansas Hospital, Kansas City
BOTEN, CATHARINE University of Kansas Hospital, Kansas City
CAUBLE, IVA J. University of Kansas Hospital, Kansas City
CLARK, MARJORIE Menninger Sanitarium, Topeka
COWELL, NANCY* Veterans' Hospital, Topeka
COLLINS, EVA LYNNE M. St. Margaret's Hospital, Kansas City
COOPER, FRANCES Newman Hospital, Emporia
COX, MINNIE McPherson County Hospital, McPherson
ERICKSON, ISABEL I. Menninger Sanitarium, Topeka
FORD, ESTHER Grace Hospital, Hutchison
FRITZMIEHRER, MARTHA H. Grace Hospital, Hutchison
FROEHLKHE, HENRIETTA** University of Kansas Hospital, Kansas City
GILLIES, KARLEE M. Newman Memorial Hospital, Emporia
HARTUNG, ELSA M. University of Kansas Hospital, Kansas City
HASTINGS, ETHEL L. Bethany Hospital, Kansas City
HICKS, RUTH 1606 W. 39 St., Kansas City
JOHNSTON, MRS. LAURA S. Menninger Sanitarium, Topeka
KERN, ROSELLA M. Wesley Hospital, Wichita
LANDIS, MAUDE Lawrence Memorial Hospital, Lawrence
LAW, IRMA Wesley Hospital, Wichita
LEASURE, ZILLAH Wesley Hospital, Wichita
LEUENBERGER, CHARLOTTE University of Kansas Hospital, Kansas City
MARTIN, WILMINA P. Extension Division K. S. A. C., Manhattan
MICHAL, SYLVIA A. St. Francis Hospital, Wichita
MILLER, CORA A. 1224 N. Market St., Emporia
ANDERSON, MARJORIE E. Bethany Hospital, Kansas City
SAVAGE, MABEL A. Bethany Hospital, Kansas City
SHIELDS, BEULAH M.** 3617 W. Sixth St., Topeka
SISTER FRANCES CLAIRE HARRINGTON St. John's Hospital, Leavenworth
SISTER FRANCIS XAVIER Providence Hospital, Kansas City
SISTER LENA MAE SMITH Bethel Deaconess Hospital, Newton
SISTER M. DOMITILLA St. John's Hospital, Leavenworth
SISTER M. GONZAGA BETZEN St. Francis Hospital, Wichita
SISTER M. HILDEGARDIS St. Margaret Hospital, Kansas City
SISTER MARY SYLVESTER St. Francis Hospital, Topeka
SISTER M. WINIFRED SHEEHAN St. Anthony's Hospital, Dodge City
SISTER ROSE VICTOR** St. Mary's College, Leavenworth
SOURS, MARY V. University of Kansas Hospital, Kansas City
STEG, ILSE Grace Hospital, Hutchinson
TEMPLIN, ETHEL Asbury Hospital, Salina
THOMAS, HAZEL Wesley Hospital, Wichita
THOMAS, FLORENCE Cushing Memorial Hospital, Leavenworth
UPPENDAHN, FRIEDA Dighton
WADDELL, MRS. HATTIE H. Menninger Sanitarium, Topeka
WOLF, CAROLYN Eighth and Vermont, Kansas City
WOLFE, WINIFRED Ellsworth Hospital, Ellsworth
<table>
<thead>
<tr>
<th>Name</th>
<th>Hospital/Location</th>
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<tbody>
<tr>
<td>Applegate, Mrs. Myrtle C.</td>
<td>Henry Clay Hotel, Louisville</td>
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<tr>
<td>Berry, Mrs. A. L.</td>
<td>Deaconess Hospital, Louisville</td>
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<tr>
<td>Breckenridge, Mrs. Mary</td>
<td>Wendover, Leslie County</td>
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<tr>
<td>Brown, Amy F.**</td>
<td>Good Samaritan Hospital, Lexington</td>
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<td>Bussy, Mrs. Margaret G.</td>
<td>Deaconess Hospital, Louisville</td>
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<td>Carroll, Rhoda K.*</td>
<td>Pattie A. Clay Hospital, Richmond</td>
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<td>Graves, Mrs. Catherine P.</td>
<td>Norton Memorial Infirmary, Louisville</td>
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<tr>
<td>Clark, Jessie M.</td>
<td>Jewish Hospital, Louisville</td>
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<td>Corbin, Anna*</td>
<td>Norton Memorial Infirmary, Louisville</td>
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<td>Dixon, Effie D.*</td>
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<td>Duggins, Zelma*</td>
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<td>Sister Agnes Miriam Payne</td>
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Sister Agnes Marie Fitzsimons ... Our Lady of the Lake Sanitarium, Baton Rouge
Sister Carlos McDonnell ... 1532 Tulane Ave., New Orleans
Sister Celestine Strosina*** ... Hotel Dieu, New Orleans
Sister Eugenia Murray ... Hotel Dieu, New Orleans
Sister Gregory Paff ... Hotel Dieu, New Orleans
Sister Henrietta Dedisse ... Our Lady of the Lake Sanitarium, Baton Rouge
Sister Henrietta Guyot*** ... Charity Hospital, New Orleans
Sister Ignatia O’Neill ... Charity Hospital, New Orleans
Sister Jane Frances Bey ... Charity Hospital, New Orleans
Sister Laurentia Walsh ... Charity Hospital, New Orleans
Sister Marie Auberge Younge ... St. Francis Sanitarium, Monroe
Sister Marie Brendan Donegan ... St. Francis Sanitarium, Monroe
Sister Marie de Liguori Lawton ... St. Francis Sanitarium, Monroe
Sister Marie de Nazareth McGinn ... St. Francis Sanitarium, Monroe
Sister Marie Magdelene Lemoine ... Our Lady of the Lake Sanitarium, Baton Rouge
Sister Mary Angele Verne ... Our Lady of the Lake Sanitarium, Baton Rouge
Sister Mary Boniface Kemp ... U. S. Marine Hospital, Carville
Sister Mary Boromeo Donovan ... Schumpert Sanitarium, Shreveport
Sister M. Brigid Broussard ... Mercy Hospital-Soniat Memorial, New Orleans
Sister Mary Elizabeth Huff ... Charity Hospital, New Orleans
Sister Mary Fidelma Donovan ... Schumpert Sanitarium, Shreveport
Sister Mary Gertrude Hennesey ... Our Lady of the Lake Sanitarium, Baton Rouge
Sister Mary Hedwige Budnik ... Schumpert Sanitarium, Shreveport
Sister Mary Hilda Minkin ... Mercy Hospital-Soniat Memorial, New Orleans
Sister Mary Irene Broussard ... Mercy Hospital-Soniat Memorial, New Orleans
Sister Roberta Degnan ... Hotel Dieu, New Orleans
Sister St. Michael O’Shea ... Our Lady of the Lake Sanitarium, Baton Rouge
Sister St. Patrick Comerford ... St. Francis Sanitarium, Monroe
Sister Scholastica Atzel ... Charity Hospital, New Orleans
Sister Stanislaus Malone ... Charity Hospital, New Orleans
Sister Sylvia Brown ... Charity Hospital, New Orleans
Sister Thedora Penn ... Hotel Dieu, New Orleans
Sister Urban Oberle ... Charity Hospital, New Orleans
Sister Zoe Schieswohl ... U. S. Marine Hospital, Carville
Smith, Hazel V. ... 2021 Canal St., New Orleans
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Stenberg, Loretta M. ... North Louisiana Sanitarium, Shreveport
Stokoff, Ida ... Veterans’ Facility, Alexandria
Stuart, Mary ... Charity Hospital, New Orleans
Tebo, Julie C.*** ... 508 Pere Marquette Bldg., New Orleans
Torrance, Katherine ... Highland Sanitarium, Shreveport
Valentine, Else M. ... Shreveport Charity Hospital, Shreveport
Winebrenner, Mary R. ... 1240 Texas Ave., Shreveport
Wright, Christine ... Charity Hospital, New Orleans
Yarbrough, Mary I. ... 136 N. Lopez St., New Orleans
Zilley, Marion L. ... Touro Infirmary, New Orleans

MAINE—26

Anderson, Mrs. Theresa A. ... Box 403, Pittsfield
Bailey, Harriet ... 28 Grant St., Bangor
Barbin, M. Georgina ... 489 State St., Bangor
Beal, Gertrude E. ... Central Maine General Hospital, Lewiston
Bryant, Margaret A. ... 489 State St., Bangor
Campbell, Eleanor F. ... 79 Bramhall St., Portland
Cleland, R. Helen ... Dennysville
Fenlason, Elizabeth M.  ....... Rumford Community Hospital, Rumford
Goodwin, Helen  ....... Rumford Community Hospital, Rumford
Hibbert, Margaret A.  ....... 150 Dresden Ave., Gardiner
Hill, Emma J. McC.  ....... 22 Arsenal St., Portland
Hilton, Isabel V.  ....... Central Maine General Hospital, Lewiston
Lowd, Beatrice A. L.  ....... Central Maine Sanitarium, Fairfield
McBurney, Florence M.  ....... Rumford Community Hospital, Rumford
Meisner, Marjorie B.  ....... 489 State St., Bangor
Moody, Mrs. Mary Y.  ....... 79 Bramhall St., Portland
Morse, Alice M.  ....... 489 State St., Bangor
Nelson, Agnes M.  ....... 187 Middle St., Portland
Osborne, Mary R.  ....... Maine General Hospital, Portland
Sharpe, Florence I.  ....... Presque Isle General Hospital, Presque Isle
Sister Vincent Carrigan  ....... Sisters Hospital, Waterville
Tedford, Ruth E.  ....... 178 Middle St., Portland
Trafford, Mrs. Mary C.  ....... 27 Military St., Houlton
White, Mercedes E.  ....... Cary Memorial Hospital, Caribou
Young, Madeline A.  ....... 489 State St., Bangor
Zwisler, Irene L.  ....... 27 West St., Portland

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Adamson, Jane C.  ....... Johns Hopkins Hospital, Baltimore
Ames, Miriam  ....... Johns Hopkins Hospital, Baltimore
Apei, Mary E.  ....... Union Memorial Hospital, Baltimore
Baldwin, Estella C.  ....... Elkridge, Howard County
Bartlett, Helen C.  ....... 604 Reservoir St., Baltimore
Belyea, Margaret S.  ....... Sheppard and Enoch Pratt Hospital, Towson
Best, Dorothy R.  ....... Johns Hopkins Hospital, Baltimore
Boston, Helen L.*  ....... Sinai Hospital, Baltimore
Bowman, Sara K.*  ....... 620 W. Lombard St., Baltimore
Brantley, Frances M.  ....... St. Joseph's Hospital, Baltimore
Brillhart, Gertrude B.  ....... Sinai Hospital, Baltimore
Cannon, Mrs. Camsadel S.  ....... 2635 St. Paul St., Baltimore
Cashell, Nellie T.  ....... Union Memorial Hospital, Baltimore
Chaney, Yolanda W.  ....... 620 W. Lombard St., Baltimore
Conner, Evelyn A.  ....... University Hospital, Baltimore
Constantine, Mildred  ....... Memorial Hospital, Cumberland
Creutzburg, Freda L.  ....... Church Home and Infirmary, Baltimore
Crighton, Annie  ....... University Hospital, Baltimore
DeCourcy, Rose  ....... Adult Tuberculosis Sanatorium, Glenn Dale
Delawter, Margaret*  ....... 620 W. Lombard St., Baltimore
Doetsch, Agnes J.*  ....... Johns Hopkins Hospital, Baltimore
Dooley, Angela*  ....... 620 W. Lombard St., Baltimore
Durkant, Constance S.  ....... Church Home and Infirmary, Baltimore
Earling, Hannah T.  ....... Maryland General Hospital, Baltimore
Elliott, Margaret  ....... Church Home and Infirmary, Baltimore
Fischer, Charlotte M.  ....... Union Memorial Hospital, Baltimore
Flagg, Virginia  ....... Children's Tuberculosis Sanatorium, Glenn Dale
Fowler, Lesl M.*  ....... Sinai Hospital, Baltimore
Fraizer, Louise B.*  ....... Sinai Hospital, Baltimore
Frederick, Hester K.  ....... Johns Hopkins Hospital, Baltimore
Gardner, Maud M.  ....... James Lawrence Kernan Hospital, Hillsdale
Gassaway, Helen M.  ....... Church Home and Infirmary, Baltimore
Gault, Alma E.**  ....... Union Memorial Hospital, Baltimore
Hanson, Hazel  ....... Sinai Hospital, Baltimore
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‡ MASSACHUSETTS—229

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<td>Barnaby, Marietta D.</td>
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<td>Salem Hospital, Salem</td>
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<td>Brandt, Evelyn F.*</td>
<td>81 Highland Ave., Salem</td>
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<td>Braun, Gertrude H.</td>
<td>Harrington Hospital, Southbridge</td>
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<td>Broadland, Agnes*</td>
<td>3 Vila St., Boston</td>
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<td>Cooley Dickinson Hospital, Northampton</td>
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<td>Brouthers, Helen F.</td>
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<td>Brown, Mabel M.</td>
<td>94 Maple St., Malden</td>
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<td>Brown, Nora A.*</td>
<td>Symmes Hospital, Arlington</td>
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<td>Brown, Norah E.</td>
<td>710 Massachusetts Ave., Boston</td>
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<tr>
<td>Browne, Ethel C.</td>
<td>Long Island Hospital, Boston Harbor</td>
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<td>Bruce, Margaret J.</td>
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<td>Carlson, Edith V.*</td>
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<td>Cartland, Mildred H.</td>
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COX, EDITH I. .......................... Robert B. Brigham Hospital, Boston
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HOPPER, RUTH J.*** .................. Hallowell House, Wellesley
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MURPHY, ESTHER M. 25 Summer St., Stoneham
NELSON, SOPHIE C. 197 Clarendon St., Boston
NORCROSS, MARY E. The Children’s Hospital, Boston
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DAUBERT, DOROTHY D. ....... Couzens Hall, Ann Arbor
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<td>Hurley Hospital, Flint</td>
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<td>LUSSOW, MRS. BERYL T.</td>
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COLLISON, MAUDE ......... 1621 Grattan St., St. Louis
COUPE, ANNA L. .......... St. Joseph Hospital, St. Joseph
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cowie, Amyne M.</td>
<td>2220 Holmes St., Kansas City</td>
</tr>
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<td>Dacey, Phyllis M.</td>
<td>1325 Rialto Bldg., Kansas City</td>
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<td>Davis, Jessie V.</td>
<td>1621 Grattan St., St. Louis</td>
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<td>Davis, Mrs. Sarah E.</td>
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<td>Dawson, Mary E.</td>
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<td>Deshler, Frances</td>
<td>305 S. Euclid Ave., St. Louis</td>
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<td>Dersch, Esther H.</td>
<td>Research Hospital, Kansas City</td>
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<tr>
<td>Dierberg, Florence</td>
<td>Greve Coeur</td>
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<tr>
<td>Elkins, Mrs. Amy L.</td>
<td>University Hospital, Columbia</td>
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<td>Erdman, Lucy J.</td>
<td>2516 Goode St., St. Louis</td>
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<td>Farnsworth, Helen</td>
<td>4420 Lloyd St., Kansas City</td>
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<tr>
<td>Fee, Dorothy H.</td>
<td>4949 Rockhill Rd., Kansas City</td>
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<tr>
<td>Ford, Virginia E.</td>
<td>216 S. Kingshighway, St. Louis</td>
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<tr>
<td>Frauens, Grace</td>
<td>403 Corby Bldg., St. Joseph</td>
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<td>Gulmi, Dillie R. A.</td>
<td>1621 Grattan St., St. Louis</td>
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<td>Hampton, Mary N.</td>
<td>416 S. Kingshighway, St. Louis</td>
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<td>Harlan, Cleola</td>
<td>Children's Mercy Hospital, Kansas City</td>
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<td>Hartman, Barbara H.</td>
<td>416 S. Kingshighway, St. Louis</td>
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<td>Haslam, Mrs. Carolyn C.</td>
<td>5826 Cabanne, St. Louis</td>
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<td>Hoblitzele, Lucy F.</td>
<td>416 S. Kingshighway, St. Louis</td>
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<tr>
<td>Hochuli, Bertha</td>
<td>Boone County Hospital, Columbia</td>
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<td>Hollis, Grace</td>
<td>216 S. Kingshighway, St. Louis</td>
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<td>Hotchkiss, Bernice</td>
<td>Burge Hospital, Springfield</td>
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<td>Ingram, Ruth</td>
<td>416 S. Kingshighway, St. Louis</td>
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<td>Jarboe, Della</td>
<td>4304 W. Pine, St. Louis</td>
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<tr>
<td>Jeisy, Aileen M.</td>
<td>Children's Hospital, Kansas City</td>
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<td>Karstensen, Hulda A.</td>
<td>2646 Potomac St., St. Louis</td>
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<tr>
<td>Kimrey, Leta N.</td>
<td>515 E. 24 St., Kansas City</td>
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<tr>
<td>Kinney, A. Louise</td>
<td>5840 Cabanne, St. Louis</td>
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<td>Klein, Clara</td>
<td>2645 Potomac St., St. Louis</td>
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<td>Koeberlein, Agnes P.</td>
<td>416 S. Kingshighway, St. Louis</td>
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<td>Krug, Elsie E.</td>
<td>316 S. Kingshighway, St. Louis</td>
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<td>Kunz, Gertrude M.</td>
<td>4116 Shenandoah, St. Louis</td>
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<tr>
<td>Landers, Emma B.</td>
<td>5400 Arsenal St., St. Louis</td>
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<td>Laurent, Viola</td>
<td>1621 Grattan St., St. Louis</td>
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<tr>
<td>Layher, Laura</td>
<td>615 Central Trust Bldg., Jefferson City</td>
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<tr>
<td>Lucht, Marie M.</td>
<td>5535 Delmar Blvd., St. Louis</td>
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<td>Lunbeck, Zola S.</td>
<td>4343 Oak St., Kansas City</td>
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<td>1112 Terrace Dr., Richmond Heights</td>
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<td>MacKenzie, Margaret</td>
<td>5535 Delmar Blvd., St. Louis</td>
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<td>MacNicol, Ethel</td>
<td>1755 S. Grand, St. Louis</td>
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<td>Macy, Letha</td>
<td>1710 Independence Ave., Kansas City</td>
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<td>Marrodick, Jewel</td>
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<td>McClaskie, Maude</td>
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<td>McClellan, Rose A.</td>
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<tr>
<td>McCracken, Veda</td>
<td>4917 McPherson, St. Louis</td>
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<td>McCrackin, Bess*</td>
<td>5742 McPherson, St. Louis</td>
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<tr>
<td>McKinley, Margaret</td>
<td>4543 Westminster Pl., St. Louis</td>
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<td>McLaughlin, L. Margaret</td>
<td>14 S. Court St., St. Louis</td>
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<td>Meyer, Adolpha M.*</td>
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<td>Moore, Marjorie M.</td>
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<tr>
<td>Montgomery, Mable</td>
<td>615 Central Trust Bldg., Jefferson City</td>
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<td>Moore, Minnie</td>
<td>General Hospital, Kansas City</td>
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<td>Nahm, Helen</td>
<td>University Hospital, Columbia</td>
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<tr>
<td>Newton, De Monte A.</td>
<td>324 S. Brighton, Kansas City</td>
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</table>
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Guelkey, Ethel L. ................... Deaconess Hospital, Billings
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KENT, MARY G. ....................St. Elizabeth Hospital, Lincoln
LANTZ, LUCILE ....................Covenant Hospital, Omaha
LOVE, AGNES D. ..................Lincoln
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MILLER, CLARA ....................St. Joseph’s Hospital, Omaha
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TRUTNA, Mildred ............ Covenant Hospital, Omaha
WARD, Alice ..................... Winnebago Agency, Winnebago

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CARNEY, Eleanor G. ........ Hillsboro County General Hospital, Grasmere
CLELAND, Alice ............... New Hampshire Memorial Hospital, Concord
COLLINS, Ona ................... Margaret Pillsbury Hospital, Concord
COREY, Mrs. Jessie R. ........ Hillsboro County General Hospital, Grasmere
DENIO, Bessie A. ............. New Hampshire State Hospital, Concord
GRIGGS, Mary H. ............. New Hampshire State Hospital, Concord
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LAWLOR, Lucy M. ............ 345 Myrtle St., Manchester
LOCKE, Mabel B. ............. Laconia Hospital, Laconia
MACLACHLAN, Margery .... Margaret Pillsbury Hospital, Concord
MCKAY, Elizabeth M. ............ 70 Grant St., Manchester
MCREAVY, Katherine ......... Laconia Hospital, Laconia
MOLESKE, Alexandrina R. .... Mary Hitchcock Memorial Hospital, Hanover
MOORE, Addie M. ............ Hillsboro County General Hospital, Grasmere
MORGAN, Grace M. ........... R. F. D. 2, Box 205, Manchester
O'DONOGHUE, Rosanna ....... Portsmouth Hospital, Portsmouth
PRATT, Thelma A. ............ New Hampshire State Hospital, Concord
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SISTER MARY DOLOROSA ..... Sacred Heart Hospital, Manchester
SISTER M. VIRGINIA .......... Sacred Heart Hospital, Manchester
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WILLIAMS, Lillian G. ......... Laconia Hospital, Laconia

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ANDERSON, Bernice E.*.* 17 Academy St., Newark
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ASHMUN, Margaret .......... Orange Memorial Hospital, Orange
AUSTIN, Ida F. ............... 91 Prospect St., East Orange
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BAUMANN, LYDIA ................................... Orange Memorial Hospital, Orange
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BORDA, MAUDE R. ................................. 313 High St., Millville
BRENCIKMAN, ESTHET R. ....................... 911 E. Jersey St., Elizabeth
BROADMAN, MARION G.* ........................ 116 Fairmount Ave., Newark
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BUCKLEY, THEMLA M. ............................ Memorial Hospital, Orange
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CODY, MARY V. ................................... Orange Memorial Hospital, Orange
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DAKIN, FLORENCE ................................. 468 Ellison St., Paterson
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HUNT, CATHERINE*  116 Fairmount Ave., Newark
HYDE, SADIE A. Essex County Hospital, Cedar Grove
HYLTON, PEARL  Monmouth Memorial Hospital, Long Branch
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<tr>
<td>Race, Anne E.</td>
<td>926 Third St., Plainfield</td>
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Beard, Anne C.* ... 8 W. 16 St., New York
Beard, Mary ... 49 W. 49 St., New York
<table>
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<th>Name</th>
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<td>Beaty, M. Louise</td>
<td>St. Luke's Hospital, New York</td>
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<tr>
<td>Becker, MRS. Jula B.*</td>
<td>436 E. Utica St., Buffalo</td>
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<td>Beckman, Margaret</td>
<td>111 E. 76 St., New York</td>
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<td>Beeby, NELL V.</td>
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<td>317 W. 45 St., New York</td>
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<td>Benning, Louise</td>
<td>116 E. Castle St., Syracuse</td>
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<td>Bentley, Anna</td>
<td>Brooklyn Hospital, Brooklyn</td>
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<td>Bently, Louise</td>
<td>Syracuse Free Dispensary, Syracuse</td>
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<td>Bergen, DELLA S.</td>
<td>Prospect Heights Hospital, Brooklyn</td>
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<td>Bergstrom, Flora J.</td>
<td>1320 York Ave., New York</td>
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<td>Berkwits, Nanette</td>
<td>Rockland State Hospital, Orangeburg</td>
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<td>Best, ELLA G.</td>
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<td>Bickford, Elizabeth*</td>
<td>1320 York Ave., New York</td>
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<td>Blaisdell, Faustina</td>
<td>5 Howe Ave., New Rochelle</td>
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<td>Blaisdell, Leah M.</td>
<td>Visiting Nurse Service, 1825 Empire State Bldg., New York</td>
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<td>Bliss, MARY E. G.</td>
<td>50 W. 50 St., New York</td>
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<td>Boehm, M. Frances*</td>
<td>1086 Lexington Ave., New York</td>
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<td>Boggeiss, Aletitia</td>
<td>440 E. 26 St., New York</td>
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<td>Bong, Ernestine H.</td>
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<td>Bowen, Millicent*</td>
<td>83 Adams St., Rochester</td>
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<td>Boyd, Anne M.</td>
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<td>Bradley, Lenore N.</td>
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CHESTER, RUTH ......................... Samaritan Hospital, Troy
CHYLACK, ANNA ................. 121 Westchester Ave., White Plains
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CLANTON, SARAH E. ......... 5 E. 98 St., New York
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LINDTNER, MRS. CATHERINE H.
LIPSCOMB, AMELIA
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LUNDGREN, GRACE M.
LYNCH, THERESA I.
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LYON, LOIS H.
LYONS, A. VERONICA
MACKAY, LEONORA L.
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MACLEOD, MARION A.
MANDIGO, SARAH A.
MANN, FLORENCE B.
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MARSHALL, PHILOMENE
MARTY, DORTHEA B.
MAXLEY, KATHLEEN
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MCCARRON, IRENE M. P.
MCCARTHY, NORA T.
MCCARTY, ESTHER G.
MCLINTOCK, MARGARET B.
MCCORMON, RACHEL F.
MCTOHER, RACHEL C.
MCKEON, ANNE G.
MCMAHON, EDNA C.
MCMANUS, MRS. R. LOUISE
MCKEEN, HARRIET S.
MEIER, GERTRUDE M.
MENDELSON, FANNY L.
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MILLER, CORA M.
MILLER, ELISE K.
MITCHELL, MRS. LORNA D.
MOE, JUNE
MOIR, HELEN M.
MOORE, ANNA J.
MOORE, NONIE A.
MOORE, SARAH E.
MORRISON, LOTIE M.
MORSE, EDNA C.
MUCKLEY, MARY M.
MULHEARN, SALLIE M.
MUNSON, MRS. HELEN W.
MURPHY, PAULINE
MUSE, MAUDE B.
NAPIER, LILA J.
NAST, MINETTE
NELSON, GERTRUDE B.
NEWELL, FLORENCE E.

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1320 York Ave., New York
1047 Lexington Ave., New York
106 Park St., Jamestown
Grasslands Hospital, Valhalla
N. Y. State Tuberculosis Hospital, Mt. Morris
Millard Fillmore Hospital, Buffalo
Arcady Country Club, The Hague
1320 York Ave., New York
School of Education New York University, New York
Grasslands Hospital, Valhalla
600 E. 116 St., New York
1320 York Ave., New York
1320 York Ave., New York
Brooklyn Hospital, Brooklyn
115 E. 61 St., New York
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Box 135, Trudeau
121 Westchester Ave., White Plains
1320 York Ave., New York
1086 Lexington Ave., New York
16 Guion Pl., New Rochelle
Russell Sage College, Troy
Roosevelt Hospital, New York
1083 Bushwick Ave., Brooklyn
St. Joseph Hospital, Syracuse
87 Morris St., Albany
Vassar Brothers Hospital, Poughkeepsie
101 Woodbine Ave., Syracuse
Long Island College Hospital, Brooklyn
176 Morris St., Albany
Teachers College, New York
27-56 Curtis St., East Elmhurst
204 W. 69 St., New York
25 E. 86 St., New York
224 Alexander St., Rochester
Arnot-Odgen Hospital, Elmira
Kingston Avenue Hospital, Brooklyn
Sea View Hospital, Staten Island
Oneida City Hospital, Oneida
French Hospital, New York
224 Alexander St., Rochester
22 West 87 St., New York
1320 York Ave., New York
620 W. 168 St., New York
1230 Amsterdam Ave., New York
American Nurses’ Association, 50 W. 50 St., New York
141 W. 109 St., New York
50 W. 50 St., New York
1320 York Ave., New York
525 W. 120 St., New York
Bronx Hospital, New York
440 E. 26 St., New York
Strong Memorial Hospital, Rochester
722 W. 168 St., New York
MEMBERS

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SISTER ANGELICA ............. Our Lady of Lourdes Memorial Hospital, Binghamton
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>Sister Edward Mary</td>
<td>St. Vincent’s Hospital, New York</td>
</tr>
<tr>
<td>Sister Edward Patricia</td>
<td>St. Mary’s Hospital, Amsterdam</td>
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<td>Sister Ellen Mary</td>
<td>St. Mary’s Hospital, Amsterdam</td>
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<td>Sister Frederick</td>
<td>St. Mary’s Hospital, Amsterdam</td>
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<tr>
<td>Sister Julia Marie</td>
<td>St. Francis Hospital, Poughkeepsie</td>
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<tr>
<td>Sister Loretto Bernard</td>
<td>153 W. 11 St., New York</td>
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<tr>
<td>Sister Louis Bertrand</td>
<td>St. Joseph’s Hospital, Elmira</td>
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<tr>
<td>Sister Louise Nagel</td>
<td>Troy Hospital, Troy</td>
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<tr>
<td>Sister Margaret Mary</td>
<td>St. Joseph’s Hospital, Elmira</td>
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<tr>
<td>Sister Margaret Regina</td>
<td>Our Lady of Lourdes Memorial Hospital, Binghamton</td>
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<tr>
<td>Sister Marie Charles</td>
<td>175 E. 68 St., New York</td>
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<tr>
<td>Sister Marie Consilio Lillis</td>
<td>St. Vincent’s Hospital, New York</td>
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<tr>
<td>Sister Marie Immaculate</td>
<td>Misericordia Hospital, New York</td>
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<td>Sister Marie Stephen</td>
<td>153 W. 11 St., New York</td>
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<td>Sister Marie Vincent</td>
<td>175 E. 68 St., New York</td>
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<td>Sister Martina Murray</td>
<td>St. Mary’s Hospital, Rochester</td>
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<tr>
<td>Sister Mary Adora</td>
<td>Mercy Hospital, Buffalo</td>
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<tr>
<td>Sister Mary Ambrosia</td>
<td>St. Joseph’s Hospital, Yonkers</td>
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<tr>
<td>Sister Mary Austin</td>
<td>Benedictine Hospital, Kingston</td>
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<td>Sister Mary Callista</td>
<td>Benedictine Hospital, Kingston</td>
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<td>Sister Mary Carmen</td>
<td>Champlain Valley Hospital, Plattsburg</td>
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<td>Sister Mary Cephas</td>
<td>St. Peter’s Hospital, Albany</td>
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<tr>
<td>Sister M. Concordia</td>
<td>Our Lady of Victory Hospital, Lackawanna</td>
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<td>Sister Mary Cyrilla</td>
<td>Mercy Hospital, Buffalo</td>
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<tr>
<td>Sister M. Eugenia</td>
<td>133 Bushwick Ave., Brooklyn</td>
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<tr>
<td>Sister Mary Frederic</td>
<td>Champlain Valley Hospital, Plattsburg</td>
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<td>Sister M. Ildephonse</td>
<td>St. Catherine’s Hospital, Brooklyn</td>
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<tr>
<td>Sister M. Immaculata</td>
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</table>
MEMBERS

Wendover, Ruth A. .................................. 736 Irving Ave., Syracuse
West, Mae H. ..................................... 1001 Playland St., Rye
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Zorn, Katherine* ................................... 2325 91 St., Jackson Heights
Zukaitis, Nellie M.* ................................ 1600 South Ave., Rochester

‡ North Carolina—59

Akers, Irene N. .................................. Martin Memorial Hospital, Mount Airy
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Bridges, Margaret* ................................ Grace Hospital, Banners Elk
Brownsberger, Elsie ................................ Mountain Sanitarium and Hospital, Fletcher
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Clary, Minnie ...................................... St. Peter's Hospital, Charlotte
Clinkscales, Lena .................................. Highland Hospital, Asheville
Coleman, Clara A. .................................. City Memorial Hospital, Winston-Salem
Conyers, Mrs. Dorothy H. ......................... Sternberger Hospital, Greensboro
Corker, Lottie C. .................................. Rex Hospital, Raleigh
Council, Ruth ...................................... Baptist Hospital, Winston-Salem
Daniel, Josephine L. ................................ North Carolina State Board of Health, Raleigh
Dickhut, Hulda G. .................................. City Memorial Hospital, Winston-Salem
Finlay, Elizabeth .................................. Anson Sanatorium, Wadesboro
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**NORTH DAKOTA—11**

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ADKINS, GLADYS B. Children’s Hospital, Akron
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DUDLEY, MARGARET E. Jewish Hospital, Cincinnati
DUMM, ELIZABETH Christ Hospital, Cincinnati
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<td>George, Frances L.</td>
<td>1694 N. High St., Apt. 2, Columbus</td>
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<td>Vreeland, Johanna R.</td>
<td>St. Vincent's Hospital, Portland</td>
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<td>Walker, Harriet</td>
<td>University of Oregon Medical School, Portland</td>
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<td>Wetzel, Maisie V.</td>
<td>University of Oregon Medical School, Portland</td>
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<tr>
<td>Witchen, Elsie</td>
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<td>Adams, Emily A.</td>
<td>West Side Hospital, Scranton</td>
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<tr>
<td>Alder, Willie L.</td>
<td>1012 Spruce St., Philadelphia</td>
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<td>Alexander, Rose M.*</td>
<td>State Hospital, Allentown</td>
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<td>Anderson, Inez M.</td>
<td>Eagleville Sanatorium, Eagleville</td>
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<td>Ashburn, Ruth P.</td>
<td>Hahnemann Hospital, Philadelphia</td>
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<td>Austin, Lois M.</td>
<td>Elizabeth Steel Magee Hospital, Pittsburgh</td>
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<td>Baldwin, Jessie E.</td>
<td>Easton Hospital, Easton</td>
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<td>Ballamy, Emma S.</td>
<td>Wilkes-Barre General Hospital, Wilkes-Barre</td>
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<td>Barber, Segrid</td>
<td>Woman's Medical College Hospital, East Falls, Philadelphia</td>
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<td>Barron, Mabel A.</td>
<td>Western Pennsylvania Hospital, Pittsburgh</td>
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<td>Baumann, Katherine</td>
<td>1945 Fifth Ave., Pittsburgh</td>
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<td>Baumgarten, Hilda G.</td>
<td>Philadelphia General Hospital, Philadelphia</td>
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<td>Bayer, Olive M.</td>
<td>Altoona Hospital, Altoona</td>
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<td>Bealer, Nettie E.**</td>
<td>Blair Memorial Hospital, Huntingdon</td>
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<td>Beamer, Mary E.</td>
<td>Palmerton Hospital, Palermo</td>
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<td>Beamish, Grace E.**</td>
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<td>C. H. Buhl Hospital, Sharon</td>
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<td>Beck, Alma E.</td>
<td>St. Luke's Hospital, Bethlehem</td>
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<td>Behman, Anna B.</td>
<td>Protestant Episcopal Hospital, Philadelphia</td>
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<td>Bell, Sarah C.</td>
<td>Philadelphia General Hospital, Philadelphia</td>
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<td>Benson, Martha L.</td>
<td>530 S. Aiken Ave., Pittsburgh</td>
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<td>Berger, Irene</td>
<td>Mount Sinai Hospital, Philadelphia</td>
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<td>Best, Lillian R.</td>
<td>St. Luke's Hospital, Bethlehem</td>
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<td>Bevan, Mabel</td>
<td>Elizabeth Steel Magee Hospital, Pittsburgh</td>
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<td>Bielski, Loretta A.</td>
<td>5230 Center Ave., Pittsburgh</td>
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<td>Blaser, Lydia</td>
<td>Pennsylvania Hospital, Philadelphia</td>
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<td>Black, Anna B.</td>
<td>D. T. Watson Home for Crippled Children, Leetsdale</td>
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<tr>
<td>Boltz, Mary K.</td>
<td>218 South Sixth St., Lebanon</td>
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<td>Bolland, Mrs. Margaret B.</td>
<td>Children's Hospital, Pittsburgh</td>
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<tr>
<td>Bower, C. Ruth**</td>
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<td>Brackett, Mary E.</td>
<td>Geisinger Memorial Hospital, Danville</td>
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<td>Brandt, Mrs. Vera S.</td>
<td>Bradford Hospital, Bradford</td>
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<td>Braun, Eva M.</td>
<td>Suburban General Hospital, Bellevue</td>
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<td>Bresnahan, Mary A.</td>
<td>Allegheny General Hospital, Pittsburgh</td>
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<td>Brinton, Jane*</td>
<td>Chester County Hospital, Pocomson</td>
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<td>Brown, Grace D.</td>
<td>Hahnemann Hospital, Scranton</td>
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<td>Jeannes Hospital, Fox Chase</td>
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<td>Brunner, Clara M.</td>
<td>Lancaster General Hospital, Lancaster</td>
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<td>Burgener, Maud M.</td>
<td>Allegheny General Hospital, Pittsburgh</td>
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<td>Burkhard, Nannette L.</td>
<td>Episcopal Hospital, Philadelphia</td>
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<td>Bush, Mrs. Doris J.</td>
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<td>Butler, Miriam C.</td>
<td>Philadelphia General Hospital, Philadelphia</td>
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<td>Cantwell, Elsie B.</td>
<td>Methodist Episcopal Hospital, Philadelphia</td>
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<td>Carson, Lillian H. S.</td>
<td>2131 N. Natrona St., Philadelphia</td>
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<td>Cathcart, Mittie I.</td>
<td>State Hospital, Danville</td>
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</table>
Cavanaugh, Rose .................. Pottsville Hospital, Pottsville
Charon, Florence E. ............... St. Vincent's Hospital, Erie
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SISTER MARY MARTINA HELMSTETTER .......... New Castle Hospital, New Castle
<table>
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<tr>
<th>Name</th>
<th>Hospital/Location</th>
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<tr>
<td>Sister M. Monica</td>
<td>Misericordia Hospital, Philadelphia</td>
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<td>Sister M. Placide McCoy</td>
<td>Mercy Hospital, Pittsburgh</td>
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<td>Sister Mary Regina</td>
<td>Mercy Hospital, Wilkes-Barre</td>
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<td>Sister Mary Rita</td>
<td>Pittsburgh Hospital, Pittsburgh</td>
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<td>Sister M. Robert Lynott</td>
<td>St. Mary's Misericordia Hospital, Scranton</td>
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<td>Sister M. Rosalita Boyle</td>
<td>St. Vincent's Hospital, Meadville</td>
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<td>Sister M. Scholastica Brinkmeier</td>
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<td>Sister M. Thomas Charles</td>
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<td>Sister Miriam J. Okum</td>
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<td>Sister Rita Quinan</td>
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<td>Skooglund, Charlotte C.</td>
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<td>Smith, Gertrude A.</td>
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<td>Smith, Eunice E.</td>
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<td>Smith, Mrs. Genevieve R.</td>
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<td>Smith, Helen M.</td>
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<td>Smith, Nina A.</td>
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**Rhode Island—112**

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SCHROEDER, MADELEINE M. .......... Memorial Hospital, Pawtucket
SEDACH, FANNIE .......... Memorial Hospital, Pawtucket
SHERMAN, ELIZABETH F. .......... 11 Medway St., Providence
SIMOENS, ALINE J.* ............ Butler Hospital, Providence
SISTER MARY GABRIEL .......... St. Joseph's Hospital, Providence
SISTER MARY PAUL .......... St. Joseph's Hospital, Providence
SISTER MARY PAULA .......... St. Joseph's Hospital, Providence
SLAYTON, EDNA A. .......... Rhode Island Hospital, Providence
SMITH, EUNICE .......... Homeopathic Hospital, Providence
SMITH, HARRIET E. .......... Rhode Island Hospital, Providence
SMITH, JEAN .......... Homeopathic Hospital, Providence
STONE, ALMA M. .......... Rhode Island Hospital, Providence
SUTTON, FRANCES* .......... Memorial Hospital, Pawtucket
THIELBAR, FRANCES C. ** .......... Butler Hospital, Providence
WALSH, CECILIA E. .......... 136 Whitford Ave., Providence
WEIGNER, FLORENCE M. .......... Homeopathic Hospital, Providence
WEYGAND, MRS. DOROTHY M.* .......... Homeopathic Hospital, Providence
WHITE, LOUISA .......... 287 Highland Ave., Providence
WILSON, AGNES E. .......... Rhode Island Hospital, Providence
YOUNG, MARY .......... Memorial Hospital, Pawtucket

SOUTH CAROLINA—6

ANDELL, MARGUERITE .......... Roper Hospital, Charleston
CHAMBERLIN, RUTH C. .......... Roper Hospital, Charleston
GARDNER, BEULAH L. .......... State Hospital, Columbia
HUFF, KATHLEEN .......... General Hospital, Spartanburg
MCALISTER, MARY C. .......... 134 Broad St., Charleston
WELSH, MARGUERITE J. .......... Columbia Hospital, Columbia

‡ SOUTH DAKOTA—28

ANDERSON, BELLE S. .......... Dakota Hospital, Vermillion
BANKS, M. MERCEDES .......... St. Charles St., Deadwood
BERDAHL, MRS. ANNA H. .......... Sioux Valley Hospital, Sioux Falls
BLAKE, MARY E. .......... Luther Hospital, Watertown
BREWICK, MRS. FAYE .......... Methodist State Hospital, Mitchell
CHAK, CLARA A. .......... St. Joseph's Hospital, Mitchell
CLIFF, CARRIE E. .......... Box 543, Rapid City
COOK, MARY R. .......... Selby
ERICKSON, R. ESTHER .......... South Dakota State College, Department of Nursing, Brookings
FISHER, IRENE M. .......... Sioux Valley Hospital, Sioux Falls
GIVEN, LEILA I. .......... South Dakota State College, Department of Nursing, Brookings
HAGEL, MRS. I. P. .......... Mound City
HUBBS, HAZEL I. .......... Methodist Hospital, Mitchell
KELLER, LYDIA H. .......... Martin
MCLEAN, DOROTHY H. .......... Luther Hospital, Watertown
NELSON, ELVIRA .......... 803 South St., Rapid City
OCHS, MARY F. .......... St. Joseph's Hospital, Mitchell
PARDEN, LORETTA A. .......... St. Luke's Hospital, Aberdeen
RICE, MRS. CLARA M. .......... Britton Hospital, Britton
SISTER MARY CONCEPTION DOYLE .......... St. Luke's Hospital, Aberdeen
SISTER M. EMERENTIA .......... Sacred Heart Hospital, Yankton
SISTER MARY ITA .......... St. Luke's Hospital, Aberdeen
MEMBERS

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‡ TENNESSEE—42

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<td>MASSENGILL, ZELLA</td>
<td>2457 Kingston Pike, Knoxville</td>
</tr>
<tr>
<td>MILLER, ALMA</td>
<td>860 Madison Ave., Memphis</td>
</tr>
<tr>
<td>MORRIS, LILLIAN B.*</td>
<td>Nashville General Hospital, Nashville</td>
</tr>
<tr>
<td>NEWMAN, ELIZABETH</td>
<td>Baroness Erlanger Hospital, Chattanooga</td>
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<td>NORMAN, MABEL</td>
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<tr>
<td>PETERSON, HELEN M.</td>
<td>Protestant Hospital, Nashville</td>
</tr>
<tr>
<td>POTTS, Aurelia B.</td>
<td>George Peabody College for Teachers, Nashville</td>
</tr>
<tr>
<td>RAST, GEORGE M.</td>
<td>Methodist Hospital, Memphis</td>
</tr>
<tr>
<td>REISER, ROSAMOND</td>
<td>264 Jackson Ave., Memphis</td>
</tr>
<tr>
<td>RODEKOHL, ADELE**</td>
<td>Nashville General Hospital, Nashville</td>
</tr>
<tr>
<td>ROGERS, BERTA K.</td>
<td>La Follette Hospital, La Follette</td>
</tr>
<tr>
<td>SANDERS, Mary</td>
<td>860 Madison Ave., Memphis</td>
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<tr>
<td>SISTER MARY BERNARD</td>
<td>St. Mary’s Hospital, Knoxville</td>
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<tr>
<td>SISTER MARY CELESTE</td>
<td>St. Mary’s Hospital, Knoxville</td>
</tr>
<tr>
<td>SLOAN, Ermine J.</td>
<td>860 Madison Ave., Memphis</td>
</tr>
<tr>
<td>SULLIVAN, Mary N.</td>
<td>1841 Nelson Ave., Memphis</td>
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<tr>
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<td>Madison College, Madison</td>
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<td>Methodist Hospital, Memphis</td>
</tr>
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<td>WILLIAMS, GOLDEN</td>
<td>991 Cleveland Pl., Knoxville</td>
</tr>
<tr>
<td>WIVEL, ELIZABETH C.</td>
<td>Vanderbilt University Hospital, Nashville</td>
</tr>
<tr>
<td>WOOTTON, Nina E.</td>
<td>414 Cotton States Bldg., Nashville</td>
</tr>
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‡ TEXAS—138

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<tr>
<th>Name</th>
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<tr>
<td>ALLEN, IREMADENE*</td>
<td>Baylor University Hospital, Dallas</td>
</tr>
<tr>
<td>AMBLE, MARGARET</td>
<td>Baylor University Hospital, Dallas</td>
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<tr>
<td>BERGTHOLD, MARTHA</td>
<td>Baylor University Hospital, Dallas</td>
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</tbody>
</table>
Bhael, Inez .......................... St. Joseph's Hospital, Fort Worth
Blackburn, Wynona J. .......... Methodist Hospital, Fort Worth
Blair, Dorothy M. ................. Baylor University Hospital, Dallas
Boeker, Bertha ................. John Sealy Hospital, Galveston
Bolz, Juanita ..................... Fred Roberts Memorial Hospital, Corpus Christi
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Kibbe, Mrs. R. L. .......... Box 632, Fort Worth
King, Evelyn K. ........ Seton Infirmary, Austin
Klein, Helen A. ........ Hotel Dieu, El Paso
<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
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<tbody>
<tr>
<td>KOLLER, Lena A.</td>
<td>Baylor University Hospital, Dallas</td>
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<td>Baylor University Hospital, Dallas</td>
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<td>Kings Daughters Hospital, Temple</td>
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<td>Baylor University Hospital, Dallas</td>
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<td>LE LACHEUR, HELEN</td>
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<td>LE SUEUR, HAZEL K.</td>
<td>Kendrick Memorial Hospital, Abilene</td>
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<td>LINDLEY, MRS. ETHEL W.</td>
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<td>LORENZ, MARIE E.</td>
<td>Cameron Hospital, Cameron</td>
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<td>MACLEOD, DOROTHY C.</td>
<td>John Sealy Hospital, Galveston</td>
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<td>MALMBERG, MOLLIE</td>
<td>St. Joseph's Hospital, Fort Worth</td>
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<td>MCCLESKY, OLA</td>
<td>Bradford Memorial Hospital for Children, Dallas</td>
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<td>McCoy, IVA D.</td>
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<td>McCULLOUGH, STELLA</td>
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<td>Baylor University Hospital, Dallas</td>
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<td>McMAHON, MYRA L.*</td>
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<td>MOORE, DAISY R.</td>
<td>Memorial Hospital, Houston</td>
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<tr>
<td>MOTHER MARY OF LOURDES</td>
<td>Incarnate Word Convent, San Antonio</td>
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<td>MUIR, HELEN E.*</td>
<td>625 Second Ave., Dallas</td>
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<td>MURRAY, ITA L.</td>
<td>City and County Hospital, Fort Worth</td>
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<td>MURRELL, MARGARET F.</td>
<td>Methodist Hospital, Fort Worth</td>
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<td>NEATHERLAND, MRS. MARY E.*</td>
<td>Baylor University Hospital, Dallas</td>
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<td>NEWBILL, JOSEPHINE</td>
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<td>NITE, GLADYS*</td>
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<td>OVERSTREET, MRS. BILLIE</td>
<td>San Antonio State Hospital, San Antonio</td>
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<td>John Sealy Hospital, Galveston</td>
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<td>PITTMAN, MARY H.</td>
<td>2221 Wentworth, Houston</td>
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<td>Parkland Hospital, Dallas</td>
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<td>Jefferson Davis Hospital, Houston</td>
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<td>RADCLIFFE, ROSE M.</td>
<td>Northwest Texas Hospital, Amarillo</td>
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<td>RIGLER, MRS. LEAH M.*</td>
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<td>ROBERSON, MARTHA P.**</td>
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SISTER MARY REGINALD ........ Hotel Dieu, Beaumont
SISTER MARY SAUCIER ........ Providence Hospital, Waco
SISTER MARY VICTORY ......... Incarnate Word College, San Antonio
SIZER, MRS. ED. R.** ........ Fred Roberts Memorial Hospital, Corpus Christi
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WULFF, HELEN ............... Seton Infirmary, Austin
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ZEIG, MARY .................. McAllen Municipal Hospital, McAllen
ZURAWSKI, HELEN ............ Baylor University Hospital, Dallas

‡ UTAH—21

BILGER, ANNETTA J .......... Salt Lake General Hospital, Salt Lake City
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JOHNSON, MARIA** .......... Latter Day Saints Hospital, Salt Lake City
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MIKALS, JULIA M. ........... Latter Day Saints Hospital, Salt Lake City
MILLER, AMELIA** .......... Thomas D. Dee Memorial Hospital, Ogden
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WELLMAN, THORA .......... St. Mark’s Hospital, Salt Lake City
WILSON, SARITA E. .......... 1506 24 St., Ogden

VERMONT—7

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Wyant, Annie L. .................... University of Virginia Hospital, University
Zeigler, Frances H. .................. Medical College of Virginia, Richmond

† WASHINGTON—72

ADAMS, Henrietta M. .................. Harborview Hospital, Seattle
ADAMS, Mary E. ...................... St. Luke's Hospital, Spokane
Anderson, Nell E. .................... Everett General Hospital, Everett
Baer, Lucille .......................... Children's Orthopedic Hospital, Seattle
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Gantz, Ella ............................ Sacred Heart Hospital, Spokane
Gibson, Laura G. ...................... Tacoma General Hospital, Tacoma
Grant, Evelyn F. ...................... Columbus Hospital, Seattle
Gustafson, Katherine T. ............ Swedish Hospital, Seattle
Hall, Evelyn H. ....................... Harborview Hospital, Seattle
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HejtmameK, Viola ...................... Seattle General Hospital, Seattle
Hoffman, Katherine J. ............... Tacoma General Hospital, Tacoma
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WEST VIRGINIA—13

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CAMPION, ORA A. ................................. Davis Memorial Hospital, Elkins
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FISHER, HILDA H. .................................. 811½ Swan St., Parkersburg
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HAUSER, PAULINE H. ............................... Woodlawn Ave., Beckley
ROBERTSON, MARIE ................................. Cook Hospital, Fairmont
SKOTT, HELENE C. ................................. Ohio Valley General Hospital, Wheeling
THIGGEN, LORENA I. ............................... Box 351, Elkins
WEDGEWORTH, OLA ................................. Williamson Memorial Hospital, Williamson
WILSON, MRS. JENNIE F.** .......................... 1300 Byron St., Wheeling

‡ WISCONSIN—127

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BLOCK, IRMA A. ................................... Luther Hospital, Eau Claire
BORLAND, GERALDINE G. .......................... 1845 N. 4 St., Milwaukee
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<thead>
<tr>
<th>Name</th>
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<tr>
<td>Braucke, Mabel M.</td>
<td>603 N. 18 St., Milwaukee</td>
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<tr>
<td>Brauer, Mrs. Clara</td>
<td>825 N. 25 St., Milwaukee</td>
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<tr>
<td>Brink, Frances V.</td>
<td>Milwaukee County General Hospital, Wauwatosa</td>
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<td>Brozovich, Anne</td>
<td>1410 N. Prospect Ave., Milwaukee</td>
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<td>Bruley, Ruth J.</td>
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<td>Bunge, Helen L.</td>
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<td>Burt, Marjorie E.</td>
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<td>Butt, Myrtle</td>
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<td>Carey, Gladys K.</td>
<td>Wisconsin General Hospital, Madison</td>
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<td>Church, Ellen</td>
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<td>Collins, Ida A.</td>
<td>Madison General Hospital, Madison</td>
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<td>Colcomb, Bessie B.</td>
<td>8700 W. Wisconsin Ave., Milwaukee</td>
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<td>Corrigan, Hazel</td>
<td>7429 Milwaukee Ave., Wauwatosa</td>
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<td>Crump, Margaret C.</td>
<td>430 N. Randall, Madison</td>
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<td>De Back, Marie</td>
<td>S. 84 and W. Oklahoma Ave., West Allis</td>
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<td>DeWitte, Mrs. Greta T.</td>
<td>Madison Methodist Hospital, Madison</td>
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<td>1414 Lorch Court, Madison</td>
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<td>Fenby, Caroline M.</td>
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<td>Gerhahn, Olga L.</td>
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<td>Goedert, Teresa</td>
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<td>Graves, Blanche</td>
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<td>Haemmerle, Rosena E.</td>
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<td>Halbach, Seraphine</td>
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<td>Halverson, Amy</td>
<td>865 N. 15 St., Manitowoc</td>
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<td>Hartzler, Lula B.</td>
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<td>Hays, Jeanette M.</td>
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<td>Henning, Elizabeth</td>
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<td>Hendricks, Adeline M.</td>
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<td>Herin, Bernice</td>
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<td>Herman, E. Verle</td>
<td>2463 W. Michigan, Milwaukee</td>
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<td>Hoffman, Clara</td>
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<td>Johnson, Elma B.</td>
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<td>Nicholson, Golden S.</td>
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<td>OLSON, ESTHER</td>
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<td>O'NEILL, MARION</td>
<td>Muirdale Sanatorium, Wauwatosa</td>
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<td>OTTERBLAD, HELEN</td>
<td>3521 N. Maryland Ave., Milwaukee</td>
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<td>State Hospital, Mendota</td>
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<td>PAQUIN, MARJORIE C.</td>
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<td>PETERS, FLORENCE</td>
<td>2324 W. Wisconsin Ave., Milwaukee</td>
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<td>PLATH, MRS. LYDIA</td>
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<td>ROTROFF, DORIS*</td>
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<td>SCHWOCHERT, ANNA B.</td>
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<td>SEBBOR, MRS. GRACE K.</td>
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<td>SEDMIRADSKY, Lillian</td>
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<td>SISTER Adelind Laskoski</td>
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<td>SISTER EMILIE NIEDHAMMER**</td>
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<td>SISTER Margaret Murphy</td>
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<td>SISTER MARY BERENICE BECK</td>
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<td>SISTER M. Edithrudis Winking</td>
<td>300-304 E. Front St., Ashland</td>
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<td>St. Joseph's Hospital, Milwaukee</td>
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<td>SISTER M. Florina Nieland**</td>
<td>St. Francis Hospital, La Crosse</td>
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<td>SISTER M. Laurita Weix</td>
<td>Main and K Sts., Sparta</td>
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<td>SISTER MARY Marcelline Koll-</td>
<td>Meyer St., Madison</td>
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<td>STEHLE, EDITH A.</td>
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<td>STILES, Laura</td>
<td>Luther Hospital, Eau Claire</td>
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<tr>
<td>STOLL, DOROTHY*</td>
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<td>STRIEGEL, CAROLINE A.*</td>
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<td>SVENDSON, LILLY</td>
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<td>SWAN, MARY</td>
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<tr>
<td>TOUTENHOOFD, KOREN E.</td>
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<td>VALLETTE, ALICE M.</td>
<td>Veterans' Administration, Wood</td>
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<tr>
<td>VOGLER, VILMA E.</td>
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KOONTZ, WINNIE M. ...... Memorial Hospital, Casper

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RICHMOND, ISABEL D. ... 27 Bold St., Hamilton, Ontario
ROSS, ELIZABETH B. ..... Homeopathic Hospital, Montreal

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DAVIS, MARY E. .......... Colon Beach, Cristobal

CHINA—2
HIRST, ELIZABETH ........ Peiping Union Medical College, Peiping
HODGMAN, GERTRUDE E.** Peiping Union Medical College, Peiping

HAWAII—4
AYERS, ADA G. .......... Memorial Hospital, Hilo
LARSEN, CHRISTINE A. ... The Queen's Hospital, Honolulu
WILLIAMS, ANNA G. ...... The Queen's Hospital, Honolulu
WILLIAMS, MARY ........ Board of Health, Honolulu

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PUERTO RICO—1
SISTER ROSITA MARIA CULLUM** .20 Marina St., Ponce

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ELLIS, KATHLEEN W. ..... 1761 Sarch St., Regina, Saskatchewan, Canada
FULTON, JANET .......... 11100 Euclid Ave., Cleveland, Ohio
HERSEY, MABEL F. ....... Royal Victoria Hospital, Montreal, Canada
JUNGERICH, ZOB .......... Bryn Athyn, Pennsylvania
JOHNS, ETHEL ............ 1411 Crescent St., Montreal, Canada
LAWRENCE, EDNA M  .................. Severance Hospital, Seoul, Korea
MORRISON, PEARL L  .................. General and Marine Hospital, Owen Sound, Ontario, Canada
PELLEY, MYRTLE A  .................. Raleigh Fitkin Memorial Hospital, Bremersdorp, Swaziland, South Africa
RYAN, ELEANOR M  .................. 326 St. Davis' Road, Wayne, Pennsylvania
SAUNBY, DORA  .................. Ellen T. Cowen Memorial Hospital, Kolar, South India
VAN ZANDT, JANE E  .................. American University of Beirut, Beirut, Lebanon
WHITESTIDE, FAYE  .................. Peiping Union Medical College, Peiping, China
WYNE, MARGARET R  .................. Peiping Union Medical College, Peiping, China

TOTAL MEMBERSHIP

Honorary members ............................ 9
Life members .................................. 1
Sustaining members ............................ 240
Active members ............................... 4,152
Junior active members ......................... 511
Associate members ............................ 14

Total ..................................... 4,927*

DECEASED MEMBERS

Names from 1893 to June 1937, are given in previous Annual Reports. The names of members whose deaths have been reported since June 1937, are:

MARY CAMPBELL  .................. June 5, 1937
MAGDALENE JEFFREY  .................. August 14, 1937
SADIE J. O'BRIEN  .................. August 26, 1937
NELLIE M. SENGER  .................. September 8, 1937
MARY ELLEN HOWARD (MRS.)  ................ September 17, 1937
IRENE NOLTING  .................. September 26, 1937
NELLIE M. ROBERTS  .................. October 25, 1937
MINERVA LUCE DICKLEY  .................. November 15, 1937
MAY FOSTER SMITH  .................. January 31, 1938
MINA M. BOOBER  .................. February 8, 1938
MARY MAY PETERSON  .................. February 8, 1938
CHRISTINE MACLEOD  .................. February 11, 1938
ANNA L. HANSEN  .................. March 11, 1938
ALICE P. KELLY  .................. April 4, 1938
MARY A. WELSH  .................. April 12, 1938
GRACE BREADON  .................. April 23, 1938
ELEANOR CECILIA BALTZLY  .................. May 16, 1938

* Since the Report went to press on July 1, we have received the dues of 78 members, making the total membership 5,005. We are sorry that the names were received too late to be included in the membership list.
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