examinations and 123 subject-matter experts assisted us as reviewers, making a total of 152 experts, representing 38 states and the District of Columbia. Sixty-three of these nurse specialists came from states located west of the Mississippi River. These new tests are being equated to the old series and will be available to schools of nursing as rapidly as the equating process is finished for each test.

Use of the Graduate Nurse Test Service is restricted by the somewhat limited number of schools offering advanced programs for graduate nurses. However, in 1948, over 2,000 graduate nurses wrote the examinations in the Graduate Nurse Test Battery. Colleges and universities, public health agencies and merit systems, totaling 43 in all, used these tests as an aid in selection, promotion, and guidance. Differentiated norms for graduate nurses were released in 1948 on the six achievement tests in this series. In the near future, the six new achievement examinations in the clinical areas will replace the six clinical tests now included in the Graduate Nurse Test Service. In addition, plans are being considered for the preparation of tests on the "advanced" level for nursing specialists in the clinical areas, as well as for the provision of more meaningful norms for the achievement tests included in this test battery.

The year of 1948 brought a marked increase in the State Board Test Pool Service from every standpoint—number of tests used per candidate, number of candidates tested, and number of states using these tests. Over 336,000 tests were used, representing an increase over 1947 of 43.3 per cent. Approximately 33,500 candidates were tested, representing an increase over 1947 of 34 per cent. There were 37 states plus the District of Columbia and Hawaii using the State Board Test Pool examinations for licensing purposes in 1948. We are happy to report that Mississippi, Texas, and Illinois have joined the Test Pool this year, making a total of 40 states, the District of Columbia, and Hawaii. We have tested 4,000 candidates with 35,829 tests in the period January through March of this year.

At the present time, 42 state board members, nominated by their respective state boards of nurse examiners and chosen because of their qualifications and geographic location, are assisting our Editorial Unit in the construction of the new series of State Board examinations. As you probably know, this new series of State Board examinations will be so-called "integrated" examinations. That is, into the six basic clinical areas (Medical Nursing, Surgical Nursing, Nursing of Children, Obstetric Nursing, Communicable Disease Nursing, and Psychiatric Nursing) will be "integrated" content from the three basic sciences (anatomy and physiology, chemistry, and microbiology), in addition to content from Nutrition and Diet Therapy, Pharmacology, Nursing Arts and the Social Studies. There will be, then, only six examinations in the new series, rather than thirteen as there are at present.

At least one state board member from each state which submitted nominations to us will have assisted in the test construction procedure, either as an
item writer or as a reviewer. Some states will be represented by both. These 42 specialists represent all nine census areas of the United States. A minimum of seventeen will work on the construction of each of the six examinations, which means that together with the test construction staff of the Department of Measurement and Guidance, a total of at least twenty-two persons, each trained in some area basic to the test construction procedure, will have worked on each of the examinations. State Board Series 949 will be made available for servicing to the state boards of nurse examiners in member states of the Test Pool this fall.

ACTIVITIES OF THE EDITORIAL UNIT
ELINOR V. FUERST, R.N.

When it was first suggested that the activities of the Editorial Unit of the Department of Measurement and Guidance be discussed at this meeting it seemed like an impossible task. A discussion of the activities of the past year alone could consume the entire afternoon. For in that time we have completed the eleven new achievement examinations—Medical Nursing, Surgical Nursing, Obstetric Nursing, Nursing of Children, Communicable Disease Nursing, and Psychiatric Nursing, Pharmacology and Therapeutics, Nutrition, Anatomy and Physiology, Chemistry, and Microbiology. The three science tests have a group of items specifically designed for testing the achievement of students completing the course and another group of items designed to test the senior student's application of the course content to her advanced courses and clinical experience. We also prepared the Catalog of Test Services and the Representative Items Booklet, and we are well along in the six integrated State Board Examinations. Two of these State Board examinations are already out to reviewers and the four remaining ones will be mailed as soon as possible. The very nature of this type of work makes it difficult to be definite about time because it is creative work and depends entirely upon the individual effort. We have often wished that we could deposit a textbook in one of our IBM machines and have a dozen or more finished items—distractors and all—come falling out.

However, there are several aspects of our work which are dependent to a large extent upon the cooperation of the general membership of the National League of Nursing Education; without this cooperation we could not function effectively. It is about your activities in the Editorial Unit of the Department of Measurement and Guidance that I wish to speak.

More than a year ago, the Department of Measurement and Guidance requested nominations for "nursing specialists" in the various areas of nursing education. These specialists were to be well-prepared nurses actively engaged in nursing education. We communicated with state boards of nurse examiners, state leagues of nursing education, state organizations for public health nurs-
ing, and state committees on measurement and guidance. To these groups we submitted mimeographed forms which were to be filled out by the organizations and the persons recommended giving us pertinent information about the nursing specialists. The response to this request was excellent, and, as a result, we have had the opportunity of working with many of these recommended persons since then—some of you present here in this audience.

For it was from these nominations that we selected nurse educators to come to Headquarters to work with us on the construction of test outlines, test blueprints, and test items for the eleven new achievement examinations which have just been completed. The recommendations of nursing specialists for the State Board Series, of necessity, came only from state boards of nurse examiners of member states in the pool.

In making our selection from the nominations submitted, it was necessary to have as much information about the nominee as possible. Some nomination forms gave us a name and no more and consequently were not as useful to us. It was also necessary to consider location because we wanted as wide a geographic distribution as possible. It was also necessary to know approximately how much student and clinical contacts the nominee had, because one of the most difficult aspects of constructing multiple choice type items is the construction of the plausible, attractive distractors, as many of you know too well. It is much easier for the item writer if she is well acquainted with the student's common misconceptions, pitfalls, and difficulties. Usually one item writer at a time comes to Headquarters and works with one of the members of the editorial staff. The item writer not only assists in planning the test but also writes items. The editorial staff member assumes the responsibility for the technical aspects of the items, but the specialists contribute the ideas and assist in the construction of the items.

There is not sufficient time now to go into the detail of each step used in the construction of all our tests; for such information we refer you to recent articles in the American Journal of Nursing, March and April 1949, and our Catalog of Test Services. I should like to continue explaining how you have helped to construct the tests which you use.

After the item writers for a test have been selected, it is also necessary to select reviewers for the test. The selection of reviewers is done on the same basis as the selection of the item writers. It is a policy to ask two reviewers from each of the nine census areas in the United States for each clinical test and one from each census area for the more clear-cut subjects such as the three sciences, nutrition, and pharmacology.

If reviewers in a census area do not respond or if they inform us that they are unable to assist us, and if that census area is not represented, it is necessary for us to communicate with another reviewer immediately. Each reviewer receives an individual copy of the tentative form of the test and specific instructions on what the reviewing procedure includes. The reviewer has the important responsibility of commenting on the content of the test, selecting
the best or correct answer, commenting on the items, and judging the difficulty of each item.

When the reviewer's copy is returned, the comments are tallied with the comments of all the other reviewers of that particular test. Then it is the job of the Editorial Unit to act on the comments, remove the problem items, check on information and references given, and attempt to reconcile all the suggestions made. This is no easy matter. It is impossible to construct any test which would please all persons.

As an aside, I should like to mention at this time that there is much disagreement on many points in the literature, and because we have found conflicting information on the same subjects in different texts we have had to remove items in order to prevent penalizing students.

We do not wish to determine the content of the examinations; we want that to come from educators active in their fields of specialty. We have asked for the names of people who are recognized as well qualified in their area, we have worked with these nurses from all parts of the country, we have carried on close correspondence with many others who reviewed the examinations, and we always welcome your comments about the tests as a whole or about any items you may question.

In the final form of our new achievement tests we have listed on the inside of the cover page the names, positions, and locations of all nurse educators who have assisted in the construction of the examinations—both item writers and reviewers.

May I suggest that when your local areas are written to again, you consider your membership carefully and submit nominations of your members who are well qualified in their area of specialization, who have close student contact, and who have had some preparation or experience in test construction.

I have very casually and quickly held up various parts of one of the new achievement tests to you, possibly to tempt you into wanting to see a complete test history. It is not possible to distribute a complete test history because of the confidential nature of the material; however, we are always happy to discuss our test histories and shall do so after this meeting or at your request at another time during the convention.

In closing, may I say that we in the Editorial Unit of the Department of Measurement and Guidance have had an enviable experience this past year for, in the preparation of eleven new achievement examinations and six integrated state board examinations, we have discussed not only the curriculum content thoroughly but also have had an almost complete refresher course in every major area in the curriculum.

By working with 40 item writers, 152 reviewers, a total of 192 nurse educators, representing almost every state in the United States, we truly are keeping our fingers on the pulse of nursing education.
THE GRADUATE NURSE TEST BATTERY

RITA KELLEHER, R.N.

The Graduate Nurse Test Battery includes six achievement tests and the American Council Psychological Examination and Reading Comprehension Test. The achievement tests are in Medical Nursing, Surgical Nursing, Obstetric Nursing, Nursing of Children, Psychiatric Nursing, and Communicable Disease Nursing. The last two, Psychiatric Nursing and Communicable Disease Nursing, are included only when the student has had related clinical experience in a segregated ward.

Reports are issued to the universities and colleges in the form of individual profiles showing scores and percentiles. The percentiles are based on the scores of graduate nurses in colleges and universities throughout the United States, a major portion coming from universities in the East and Midwest. Tests in the graduate nurse service were administered to 2,046 graduate nurses in 1948, from 35 universities and colleges.

These tests have proved of value to the universities and colleges in several areas. The results of the battery are used as one standard of admission along with the student’s high school record, nursing school record, and experience record in determining her readiness for and ability to do college work.

The tests also have a definite administrative value to the school in the granting of additional credit to students who achieve high placement in a number of the subtests. The method of determining this credit varies with the universities using the battery, but it is a sound procedure as a standardized test should have the same meaning in one school as another.

The guidance implications for the graduate nurse as a result of the tests are quite evident. Students are admitted to many universities as unclassified students, and a choice of specialization in certain clinical areas is allowed only after consideration of the test results and the first semester’s work. The individual profile gives the graduate a lead as to her strengths and weaknesses in given areas and encourages her further growth, development, and self-direction in making up deficiencies in her own education.

Public health agencies in many states have used the results of these tests to set up merit systems for the employment of nurses, and the state boards of registration have found them useful in evaluating the preparation of foreign nurses seeking state registration.

The Graduate Nurse Test Battery should prove of greatest value to the nursing profession and to society when sufficient statistical data have been accumulated to undertake much-needed research. We need to know relationships between scores and length of clinical experience, relationships between different subscores on the achievement tests and the American Council Psychological Examination, and the significance of these relationships.

More important, they might enable research as to what constitutes good
nursing and what can be measured by a pencil-and-paper test. Evaluation is impossible without a scale of values. Relationship between scores and success in nursing needs to be determined—success measured possibly by position, salary, tenure of office, job satisfaction, or ratings from nurses, doctors, or patients.

When this phase of evaluation has been determined we can truly say that the Graduate Nurse Test Battery can be of great service to systematic investigation and planning in nursing.

THE ACHIEVEMENT TEST SERVICE

MARY M. REDMOND, R.N.

The theme of this convention, "Systematic Investigation and Planning for Nursing," lends itself very beautifully to a discussion of the Achievement Test Service. For our purpose in this discussion, an achievement test is defined as an instrument used to measure the degree to which students are approaching the goals in a particular field of knowledge. The Achievement Test Service offered by the National League of Nursing Education, Department of Measurement and Guidance, is very definitely a method of scientific investigation designed to measure outcomes of instruction. This is an aid in evaluating the nurse's ability to give comprehensive nursing care to the patient, the community, and society. These tests may be used not only to evaluate the student's grasp of the course and experience content of learning, but also as instruments for guidance in the placement of students and for the improvement of the instruction of teachers. Thus we see interwoven in the Achievement Test Service—in fact, in the total work of the Department of Measurement and Guidance—the careful consideration of our convention theme.

Attempts to measure the outcomes of teaching are not new to the field of education. The early history of things which have been in existence for a long time is usually obscure. We do, however, find references to the use of tests in mathematics and the physical and biological sciences for several decades. Measurement in the social sciences developed more slowly perhaps because the study of the human being, the most complex of all biological organisms, and his social relationships which are more difficult to understand than purely individual responses does not respond readily to objective investigation. Horace Mann, a schoolman of brilliant perception and great ability, in 1845 advocated the written examination as a more suitable measurement of achievement in education than the oral examination which was popularly used at that time. The subjectivity of the ordinary examination received some

attention as early as 1864 when an English schoolmaster, the Reverend George Fisher, prepared a "Scale Book" made up of various standard specimens arranged in order of merit. From this time on, work has progressed on the construction of satisfactory comparative tests. The whole field of educational measurement was greatly benefited by the work of Dr. Edward L. Thorndike. His influential publications on statistical methods and his pioneer work on intelligence tests for college entrance gave new impetus to the movement. The first standardized achievement test was the Stone Arithmetic Test in 1908, and the first scale was the Thorndike Handwriting scale published in 1910.

There have been many changes in achievement tests since that time. These earlier years seemed to emphasize largely a general or survey type of examination which afforded a general all-round measure of a student's attainment in a given subject, but which did not give the detailed information required for remedial work. Attention has since been given to this outcome of testing, and today in elementary education there are specific tests available to be used as diagnostic tools to determine the strengths and weaknesses of a given student in a particular field of knowledge. Achievement tests on the high school and college level have not kept pace with the progress in the elementary schools.

Schools of nursing have certainly been rather lax in the development of acceptable achievement tests. Perhaps if we wished we could see in this failure the influence of the "service handicap" in nursing education. Instructors have very often had so many service responsibilities that they rushed to the classroom on examination day and hastily placed ten questions, more or less, on the blackboard, gave each question an arbitrary value and "graded the papers" accordingly. Even when time was available to give thought to the examination very often the instrument failed to measure the total objectives of the learning experience derived from course content and related clinical practice. The actual achievement of the student was very much an unknown factor and many instructors and schools waited until the returns from State Board Examinations were announced before actually giving much thought to the evaluation of their students or to their comparative relation with students of other schools.

Perhaps I speak with too much optimism when I refer to such practices in the past tense. However, it would seem to be an unnecessary procedure for an instructor to rely on self-made tests as the sole measurement of students' achievement at the present time. They are without doubt, when well constructed, very valuable, and their continued use is advocated. In addition, we do have the Achievement Test Service available from the National League of Nursing Education for the nominal sum of 50 cents per test. This service offers achievement tests in Anatomy and Physiology, Pharmacology, Micro-

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biology, Medical Nursing, Surgical Nursing, Nutrition and Diet Therapy, Chemistry, Fundamentals of Nursing Care, Obstetric Nursing, Nursing of Children, Social Foundations, Communicable Disease, Psychiatric Nursing, and Tuberculosis Nursing. Some serve as a terminal examination at the end of a course, and others are constructed to serve as measurement of achievement following the completion of a course and a period of clinical experience. These tests can be administered by faculty members and then returned to the Department of Measurement and Guidance for scoring. A report of the results is sent to the school in about ten days. The scores are given in terms of standardized test results and as such have much meaning and much value.\(^3\)

These are days in which nursing itself is undergoing an evaluation. Old definitions are being reviewed, emphasis is being changed, and new impetus is being given to professional thinking. All of us are in some way being affected by the emerging concepts of a nurse’s place and responsibility in our changing society. Our methods of education in nursing and the measurement of its effectiveness must keep pace with other fields of progress. Society has a right to adequate health care and to the prevention of disease. Professional nursing is a recognized part of the total health services of our country. Professional nurses are too few in number. Society cannot afford to wait, nor can the profession or the individual school faculty, to see what the nurse is able to achieve after she begins to function as a professional nurse. We need earlier valid measuring tools, and use of the standardized achievement test is one way of obtaining such a measurement.

Nursing is struggling to gain a clear-cut right to be called a profession. We need to define our functions, clarify our objectives, and bring unity of purpose and of knowledge into our basic curriculum. In my personal experience in affiliate schools of psychiatric nursing, and later in teaching students in the advanced program of nursing education, I have found a lack of uniformity in the basic knowledge which the students used in the daily care of patients. One such area of knowledge stands out vividly and that is the area of pharmacology. All of these students had successfully passed examinations in Drugs and Solutions and in Pharmacology and still there were wide gaps in the achievement of the various schools in this area. Individual differences in the students accounted in part but not entirely for the variation. It would seem to me that another function of the standardized achievement test might therefore be the pointing up of these differences early enough in the students’ program to have them receive further instruction in this matter. This would be a real service to the profession and to the people who depend on it for care.

An outstanding value of the use of the Achievement Test Service is motivation for both student and instructor. Motivation may be defined as an impulse, desire, or drive toward a definite line of action. In any process of

\(^3\)Department of Measurement and Guidance, National League of Nursing Education. Catalog of Test Services, 1948, pp. 9-14.
education the motivation must be toward the attainment of a goal that is seen and desired by the learner. The most effective motives arise from a sense of need.\textsuperscript{4} True, the attaining of a satisfactory score on an achievement test is not the most highly recognized motive for the student nurse. However, when that score is compared with established norms in a particular field of knowledge it takes on a new significance for the student. The score itself is not so much the desired goal as is the idea of being in a satisfactory comparative position when related to one's fellow student.

The instructor is also motivated by the results of these tests. She realizes that each examination used in the Achievement Test Service is the result of the combined efforts of nurse educators selected because of special ability in a specific area of nursing knowledge and of the personnel of the Department of Measurement and Guidance who are experienced experts in test construction, statistics, and editorial know-how. The instructor knows that the tests are the result of scientific work and, as such, are a valid and reliable measurement of instructional outcomes. It is practical and easy for the individual instructor to administer them. She therefore will become well acquainted with the tests and will be motivated by them to evaluate her own objectives, methods of teaching, and guidance of her students. This will result in improved instruction in many classrooms. Some educators might recognize a danger in this inasmuch as it would seem that teaching of the various subjects might be aimed to the answering of test questions. This is not possible as the tests are constructed not only to measure a specific item of knowledge by a particular question but to measure attitudes, understanding of skills, and the application of skills in the total care of the patient. Too much judgment is involved in the answering of the questions to have the results influenced by item teaching.

By the intelligent use of the comparative relation of the achievement scores with the previous records of the Pre-nursing and Guidance battery of tests, we shall find help in the guidance of students. We all recognize the important part guidance of our students plays in their education and in turn in the service which they will give as professional nurses. Every instrument of help is eagerly grasped by the faculties of the schools of nursing. The more objective the tools of guidance can be made the more acceptable will the student find this help.

It has been my experience that students appreciate writing these tests. They have a higher regard for the standardized test than is often realized. After all they are accustomed to these scientific instruments today throughout their previous educational experience and they expect them in nursing education. We are making a serious mistake if we do not recognize that many of our students come to us with previous standards by which to judge their educational process. The school of nursing will prove to be a disappointment to

\textsuperscript{4}Ross, C. C. \textit{op. cit.}, pp. 315-329.
many of them if it does not measure up to these preconceived ideas. They will frequently regard the use of the Achievement Test Service as a positive factor in favor of the educational system in which they are students.

In the March 1949, American Journal of Nursing, we have an article entitled "Who Writes the League's Tests?" by Miss Fuerst, the assistant test editor for the Department of Measurement and Guidance of the National League of Nursing Education. We are told of the cooperative effort by which the tests are constructed. The work is done by recommended experts in the various clinical fields and science areas from several sections of our country. This cooperative effort helps us much in coming together within the profession. Furthermore, all who use the tests are asked for comments concerning their effectiveness. It's not always possible to incorporate recommendations received, but the sound ideas are not lost in the making of new achievement tests.

We see, therefore, that the Achievement Test Service has many values, some of which bear objective scrutiny and others in themselves so intangible that they are felt more readily than they are expressed. The fundamental function is the measurement of student achievement in the subject area examined. By this factor alone society is assured of a finer quality of nursing. The profession profits much from the experience gained in the construction of the tests, the use of them as scientific tools of evaluation of instructional outcomes, and indirectly from the pooling of thought concerning aims and objectives of the various courses and clinical experiences. The individual instructor and the faculty as a whole receive stimulus for improved methods of instruction. The guidance program is enriched by further knowledge concerning the individual student. The student derives a certain amount of motivation and a better appreciation of the educational effort exerted by her school of nursing and the profession of nursing in helping her to develop into an effective professional nurse.

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THE PRE-NURSING AND GUIDANCE TEST SERVICE
EMILY C. CARDEW, R.N.

Probably the most apparent value of the pre-nursing and guidance test to schools of nursing has been its use as an additional technique in our admissions program. The use of the student's rank on the aptitude tests, in addition and in relation to the other information secured about the student, can be shown to be extremely valuable in the elimination of probable failures or the selection of students who will probably successfully complete the program.

I should like to emphasize in relation to other information rather than simply in addition to. Critical study of the results of a test battery and careful analysis of student's records can give us some valuable means of interpretation of other information. This analysis helps us to establish a pattern of the student's potential achievement which is more valuable than a simple addition of the individual items of information. For example, on examination of the admissions records of 15 students in one school of nursing who had had difficulty with or failed the preclinical course, it was discovered that 13 of these students ranked considerably above the average for that school on the pre-entrance test battery, but also that their high school records, although at a satisfactory level for admission, were nevertheless below that which the student probably should have achieved according to her potential ability as demonstrated by the test scores. Had these students developed a pattern of behavior which carried over into the school of nursing? Were they not working up to their individual ability because of inertia, poor study habits, or lack of motivation? A careful counseling program would, of course, attempt to assist these students according to their individual needs. More data about more students would, however, probably be helpful in determining, more specifically, the educational admissions requirements. Such studies, in order to give data about adequate numbers of students, would involve the participation of several schools and the pooling of information in order to arrive at some valid conclusion.

Another interesting and possibly valuable use of the test battery to the school of nursing is in the evaluation of an individual high school's grading system. We are all aware of the wide variations in the meaning of the high school grades and rank in the class. Persistent evidence of low achievement on tests, high grades in high school, and poor or mediocre performance in the school of nursing should lead us to scrutinize very carefully the validity of the high school record in that particular school or school system, and therefore help us to be more discriminating in our selection of students. For some students presenting credentials from high schools whose grades we have reason to question, a re-testing is indicated in order to be sure we are being very fair to the applicant.

I am assuming that each school of nursing using the test pool has estab-
lished for itself its own critical score for the level of qualification of the applicant; this will, of course, depend upon the objectives of the school. However, the collection of data from many schools would, it would seem, furnish more valuable evidence which would be helpful to other schools. It is in this way that the use of the League pre-entrance battery could contribute to systematic investigation in nursing.

Probably less use of the tests has been made which is of value to the individual student, and this is possibly the result of the weakness of our counseling programs in many of our schools of nursing. The use of the pre-entrance and guidance tests can be of value in a pre-entrance counseling program, and time spent on this type of counseling is well repaid in terms of good relationships with high schools and colleges, counselors and parents, and prospective students, as well as the “saving” of some potentially capable students with weakness in one or more areas. Guidance into remedial reading or arithmetic or into programs to enrich the student’s background in the social or biological sciences is done more effectively, and more accurately, with the test results as evidence of need. Counselors in the high schools and colleges are pleased and, I am sorry to say, sometimes surprised, when this type of counseling is given applicants. They are eager to assist, become more acquainted with our needs, and gain a new respect for the educational programs in our schools.

The test results, used in their relationship to other information about the student, are of great help in the educational guidance of the student after admission to the school. Specifically, the student who ranks high on the tests needs a different type of educational counseling when she is in scholastic difficulties than the student who tests in the higher levels and demonstrates poor achievement in the school. The senior student or young graduate finds an interpretation of test results of assistance in her selection of her program after graduation from the basic school.

The emphasis thus far has been on the values of the pre-nursing and guidance tests already demonstrated. I wonder if we have fully explored all of the potentialities of their future use in the investigation of and planning for nursing?

The attention given to the use of all available techniques on the admissions program in order to eliminate probable failures is an important aspect of the admissions program, and our available statistics on withdrawals indicate that even more attention should be given to this objective. But the elimination of probable failures, important as this may be, should not be the sole purpose of the admissions program. The degree to which a program of nursing education will be able to achieve its objectives depends, in a large part, on the selection of candidates with the potential ability to achieve full professional stature. Is there a pattern of admission qualifications common to our young graduates who seem to possess a professional level of knowledges, skills, and attitudes?
Is there any significant relationship between scores on individual tests of the battery and the student's previous course selection and content? Would these patterns help us to predict the student's potential growth, for instance, in the development of such attitudes as broad social sensitivity? Are there similarities common to many of our applicants which should suggest desirable enrichment of our own curriculum or additional preparation of our applicants? For example, we are beginning to notice the absence of history courses in the high school preparation of our applicants and a large number of relatively low scores in the social science area in the test battery. Is this apparent trend general, or is it limited to one geographic area? Will this apparent deficiency influence the student's ability to understand and appreciate social trends influencing nursing, and the social issues facing nurses as professional women and citizens? If we show that it is, then we have definite evidence for the need to enrich the student's background and/or our curricula.

If nursing education is to select young women with potential ability for a professional level of nursing we shall need to answer some of these questions. We must be prepared to direct young women into schools of nursing whose program meets the individual student's needs and aptitudes if we are to fulfill our obligations to them and to society.

The use of the Pre-nursing and Guidance Test Service of the League offers a possibility for the collection of a large amount of data which should enable us to answer many of these questions and assist us in evaluating our programs and their results. Obviously, the more schools making use of the tests and collecting information about the progress of their students, the more valuable will be the conclusions. We can all participate in systematic investigation and planning in our schools of nursing by contributing valuable source material and by doing an even better job in the selection and guidance of our potentially professional nurses.

**THE STATE BOARD TEST POOL SERVICE**

**JOY ERWIN, R.N.**

The State Board Test Pool Service is offered to state boards of nurse examiners to assist them in the licensing of nurses. The following objectives have been accepted by the American Nurses' Association and the National League of Nursing Education:

1. That such legislation is primarily set up for the protection of the public. If this objective is to be accepted, it follows that these persons licensed to practice as registered nurses must be shown to be competent to practice nursing.
2. Protection of the nursing profession and the nurses against those who are not qualified to practice nursing.
3. Advancement and maintenance of professional standards.
4. Protection of incoming students admitted to schools of nursing.
These objectives may be expanded to include the following: the licensing examination is a tool for measuring outcomes in terms of basic knowledge, judgment, and ability to supply principles in actual clinical situations, and for determining something of the applicant’s attitude and her knowledge of community and personal problems and their relation to health and disease.

In the short period since we have had this service offered by the Department of Measurement and Guidance, we find definite values accruing to the individual nurse, to the schools, and to the profession. The applicant for the examination does, I believe, have a greater sense of security in being measured by the same tests as other candidates over the United States. Colorado did not join the test pool at first. There came to be an increasing number of questions from student nurses about the licensing examinations being offered nationally, and it was in part due to this pressure from candidates that we decided to use the test pool. I am sure that when our senior students learn with what detailed care and with what widespread representation these tests are constructed they will feel that they are being evaluated by tests that are comprehensive and sound.

The student and graduate nurse may also see in the tests a force for the upgrading of their schools. Nurses have long wished for greater ease in passing from state to state. The tests are sure to aid in interstate registration. We have been pleased indeed to hear the report of progress of the Department of Measurement and Guidance, especially with the development of standard norms. We have listened this afternoon to reports on pre-nursing tests and achievement tests. The directors of the schools of nursing will, no doubt, see great possibilities opening for them in the matter of selecting students and continued guidance, and finally, the proof of the program in the licensing tests.

Boards of nurse examiners should hold themselves responsible for placing in the hands of faculties of each school such comparative figures and graphs based on the results of the examination as will help in analyzing the strengths of school programs. It should be a stimulating experience for the faculty to know first, the average performance of the state as compared with the average performance of all candidates in all states, and second, the average performance of candidates from the individual school as compared with all the schools in the state. This material should, of course, be prepared in code. Such an analysis might give the director the information that she needs to reach out for a badly needed affiliation. Faculty members may feel the necessity to seek further preparation in test construction that they may do a better job of evaluation of the product of their own teaching. In Colorado, we believe that each faculty member should have the opportunity to review the licensing tests in which she has special interests. This must be done in the state board office under careful supervision with the understanding that no notes may be made.

Weaknesses indicated by the students' scores in licensing examinations
should cause careful scrutiny of the curriculum, especially in those areas in which failures have occurred. This review, of course, would include methods of teaching and the evaluation of the student achievement in the course as measured by the instructor's tests and achievement tests. If the graph available from the Department of Measurement and Guidance shows that the school under consideration is making a below average record, those responsible for the school may well review their philosophy in terms of stated purposes. On the other hand, consistently high results on the licensing examinations might be the criteria to be used in determining whether a school is ready for experimentation.

The boards of nurse examiners now using the test pool—and they are a large majority of the boards—are benefited in several ways. First, we are satisfied that we, here, have available the service of experts in the construction of tests. Dr. Kemble has told you how experts are recruited from the entire country to assist in test-making. She has also reviewed for you the many screenings through which these tests must pass before they are released for use. Thus we feel assured that every effort is being made to test the candidate's competency. Interstate registration will be facilitated by cutting down the work of office staffs and speeding the licensing of nurses crossing state lines. Does it not appear likely that we shall approach the job of national accrediting with greater ease because we have already established evaluation of nurses on a national basis?

In the recent workshop in Akron, carried on by the state boards of nurse examiners, we found that we had the same problems no matter from what part of the country we came. When we heard Dr. Kemble and her staff report the perfectly amazing progress that has been made by the Department, we felt that here is a source of strength in solving some of our problems.

As a profession, nursing has had its problems thrown into the limelight by the Brown, the Ginzberg, and the Murdock reports. Are we going to emerge as a real profession? Shall we assume responsibility for nursing all the sick and do out part in building community health? Are we going to be members of health teams? If we are going to do these things, then we must have tools of evaluation to help us with the following: to point out our present weaknesses and strengths; to select students for both the professional group and for a second group to carry the responsibility of nursing those who do not require the services of a professional nurse; and to test our achievements as we go along in order to discover whether we are reaching our goals.

We hope then that we shall be able to say to our consumer public, "We are preparing and licensing nurses for you who are able to serve you in all capacities for which you need them." In all of these activities we shall need the continued help of a growing and resourceful Department of Measurement and Guidance.
CATHOLIC SISTERS' CONFERENCE

Wednesday, May 4—4:45–6:00 p.m.

Presiding: SISTER MARY XAVIER, R.N., R.S.M., Chairman, Committee on Sisters

Speakers:

SISTER M. MAURICE SHEEHY, R.N., R.S.M., Director of Nursing Education, Mercy College, Detroit, Michigan

SISTER MARY MATILDA, R.N., R.S.M., Director of Nursing Service, Mercy Hospital, Chicago, Illinois

Discussants: FATHER JOHN J. FLANAGAN, S.J., Educational Director, Conference of Catholic Schools of Nursing, St. Louis, Missouri

The meeting was opened by a prayer by Father Flanagan.

PRINCIPLES OF ORGANIZATION OF BASIC COLLEGIATE PROGRAMS IN NURSING

SISTER M. MAURICE, R.N., R.S.M.

A great deal has been written concerning the organization of basic nursing programs in colleges and universities. In spite of this there exists a confusing variety of organization patterns as shown in survey reports and studies. Nursing for the Future has thrown a great deal of light on the deficiencies of administrative organization and pointed the way to sound adjustments for present programs.

Dr. Brown has recommended that "schools of nursing within institutions of higher learning be autonomous units vested with the same status as other professional schools. . . ."

Contractual agreements between college or university and schools of nursing are of primary importance in securing sound educational facilities in which educational values are given precedence without interference of service needs.

Three areas of responsibility must be clearly defined: first, those in which the college assumes full responsibility; secondly, those in which the school of nursing assumes complete responsibility; and lastly, those in which responsibility is shared.

The qualifications, selection and duties of faculty members of the school of nursing must be the same as for all other units of the college or university.

Provision must be made for democratic methods of cooperation in the administration of the total educational program.
No educational program can succeed without ample financial resources. Unless this requirement is feasible no consideration should be given for establishing a basic program in nursing.

The adequacy of clinical facilities, finance, and faculty personnel are fundamental considerations for every collegiate program in nursing.

Discussion

Father Flanagan stated that the Catholic Conference of Schools of Nursing had gone on record as approving the three levels of nursing. Other points brought out were:

1. Catholics have a duty to prepare leaders not only in schools of nursing but in other circles.
2. Schools of nursing are agencies of the Catholic Church and, as such, they must be good agencies, and whatever they undertake must measure up to standards of excellence.
3. Collegiate schools cannot supply enough nurses to care for all bedside nursing; hence, the three-year program cannot be abolished.
4. A feverish rush has resulted from the trend to establish connections between schools of nursing and colleges and universities. This results in cheap colleges and universities and poor nursing programs unless the college really undertakes to give the degree in nursing.
5. College catalogue numbers are not sufficient. Also needed are a well-prepared faculty, well-equipped library and laboratories, and so on.
6. University or college education has its place, but it must give the individual a professional lift above the level of the three-year program.
7. In order that a good program may result, thought and planning must be done. A limited number of good Catholic programs in nursing education—from 25 to 30—should be sufficient in the United States.
8. In our basic schools, also, the program must be the best, in the second and third years as well as the first. We must be prepared with personnel and facilities to see our way through.

REPORT ON THE SURVEY OF A SELECTED GROUP OF SCHOOLS OF NURSING

SISTER MARY MATILDA, R.N., R.S.M.

In the fall of 1948 an institute was held in Chicago by the Sisters of Mercy of the Union. The institute was attended by the Mother Provincials, hospital administrators and directors of nurses from eight different provinces.

The chief purpose for such an assembly was to exchange ideas on the various problems confronting health and nursing education today.

The program was planned in conjunction with Dr. Malcolm T. MacEachern
of the American College of Surgeons and Dean Conley of the American College of Hospital Administrators.

The program covered pertinent problems existing in Sisters' hospitals and schools of nursing today. Following the morning session, time was allotted for discussion with the Mother General. At this time special groups were selected to study certain problems and bring back helpful recommendations.

One of the recommendations advised the Sisters to select a group of Sisters to prepare a questionnaire in which each school and hospital would have an opportunity for self-evaluation.

It was also agreed that a central committee be appointed to evaluate the returned questionnaires.

The following procedure was used in preparing for the survey:

1. The purpose for the survey was formulated (to enable each hospital and school to evaluate its own strengths and weaknesses and to make each administrator conscious of its own needs; also, to enable the Mother General to have an over-all picture of each Province in the Union).
2. A list of principles found in a good hospital and school was compiled.
3. Objectives to meet these principles were prepared.
4. Questionnaires to measure these principles and objectives were compiled.

The prepared questionnaire was sent to fifty-two schools of nursing for self-evaluation.

The response to the questionnaire was 100 per cent.

At the present time the questionnaire is being evaluated. The recommendations will be sent in the following order:

1. Each specific school and hospital will receive its own recommendations.
2. Each Mother Provincial will receive the recommendations for all of the schools and hospitals in her Province.
3. The Mother General will receive recommendations for all of the schools and hospitals.

The final report of the survey will be presented at the Second Mercy Institute which is to be held in the fall of this year, St. Louis, Missouri.

**General Discussion**

Sister M. Berenice Beck stated that no fees should be given for service and that the patient should not be asked to pay for nursing education.

Sister M. Olivia Gowan stated that universities and colleges must be careful not to exploit student nurses.

Sister Eucharista was interested in the question of credit hours for clinical experience. Sister M. Olivia gave the practice at The Catholic University of America—one semester hour for every fifty hours in the field. Miss Hidgerken suggested that one over-all credit be given for theory and practice as is
given in such subjects as chemistry. Mrs. Eugenia K. Spalding stated that clinical instructors draw lines between theory and practice.

Mrs. Spalding spoke of the need for good nursing situations where students can see and learn.

The meeting closed with a prayer.

LEAGUE DINNER

Wednesday, May 4—7:00 p.m.

Presiding: Agnes Gelinas, R.N., President

Speaker: R. L. Birdwhistell, M.A., Instructor, Department of Sociology, University of Louisville, Louisville, Kentucky

SOCIAL SCIENCE AND NURSING EDUCATION:
SOME TENTATIVE SUGGESTIONS

R. L. BIRDWHISTELL

It is with considerable personal pleasure that I appear with you tonight. Like every member of a particular science, I am happiest when bringing to an audience the material of that science. (I don’t suppose that there is too much difference between talking about yourself and talking about the group with which you are identified.) The subject announced by Miss Gelinas is broad enough to include almost everything about man, at any time in history, and under any condition. However, in terms of my own interests and in terms of the very worthy purposes to which this organization is devoted, I shall limit myself to the attempt to demonstrate some of the uses of the anthropological approach in its broadest sense to the problems of building and implementing a nursing curriculum.

The nineteenth century has been called the age of physical science; the twentieth may well come to be known as the age of social science. Not that these are so different. The difference lies in the adjectives "social" and "physical" rather than in the method employed. The decision which is being faced, though somewhat timorously, in this century is that of demanding the same objectivity, the same care in definition, and the same rigorous rules for observation of the subject matter, man and society, as in the last century came to be applied to that of biology, chemistry, and physics.

Today the resistances to such an approach are as strong as they were in other eras to astronomical, physiological, or biological phenomena. However, two wars, growing intergroup hatreds, a depression, and the atomic bomb have been events which have provided a milieu in which necessity is gradually overcoming prejudice. Increasingly have the engineer, the therapist,
and the educator turned to the social scientist for aid in meeting the obvious disharmonies in a world which has made such magnificent technological advances yet remained in the "dark ages" insofar as the problems of the relations of man are concerned.

This is not to say that there is no relationship between man's technology and his thinking. In fact they are inextricably interrelated. I recall a story told by a fellow anthropologist which demonstrates this.

On a small Pacific island there lived a group which depended for subsistence upon the fish in the surrounding lagoons and upon the yams which were raised in their tiny gardens. These latter they cultivated with digging sticks, a simple pointed stick by means of which small sections of land could be laboriously cultivated. Obviously such a tool was not a very efficient implement. It therefore represented a tremendous advance when some bright young islander noted that by placing a sharpened weight on the end of his stick, which now became a primitive hoe, much more ground could be tilled and many more yams could be planted and raised.

All was not well, however. It was soon noticed by the observant gardeners that some families were able to raise far more yams than others. Having as yet no idea of the relationship between fertilizer and watering and the yield of a crop, the islanders decided that the yams must not be staying where they were planted. They decided that the yams at nightfall became migratory and visited back and forth under ground. Unfortunately for some owners, the yams seemed to like certain garden plots better than others. These islanders trusted each other but little more than we trust each other in this more modern age. Accusation and counter-accusation were made against those with the larger yields. They were accused of having crept out of their houses at night and, by unfair practices, lured the yams from other men's gardens. But, as has been known to happen in other societies, when an "unfair practice" is efficient enough it is adopted by all. It had been noted that several of the successful farmers had decorated their hoe handles with magical symbols, so for the next two or three years more and more elaborate carving was done on the hoes. Eventually the hoes became so intricately carved that they would no longer carry the weight of the cutting blade. The islanders then hung their magical hoes up beside their gardens as lures and went back to the "old time" digging stick.

Too often have decisions concerning human relations been made with the same kind of mystical thinking. Too often by the support of mystical preconceptions has man been completely self-defeating in his attempt to organize his social world. Therefore, it is with this in mind that I wish to discuss with you tonight certain research which started out with its basic problem not "What should a nurse be and do?" but rather with another based upon the proposition that it is impossible to plan a cake or a nurse without knowing something about the ingredients, the preparation, and the milieu in which they are to appear.
Before we can undertake this task it is necessary for us to derive a few working tools. In answer to the question, "What is a nurse?" the social scientist answers, "A nurse is a person occupying the role identified by the society as a nurse." "Now, now," might reply the initial questioner, "I ask you what a nurse is and you tell me that a nurse is what society says a nurse is. You're not being very helpful." The social scientist might then lecture for a moment:

"Although this may be very distasteful to those who believe that nursing is attached to the forty-second chromosome, social roles differ from those played by animals in that they are established in the warp and weave of the social fabric. That is, there develops over the years in any grouping of mankind a series of specialized positions, the specialization usually depending upon what we call the amount of division of labor within that society.

"These roles do not hang in the air; they are filled by people, human beings, who carry out the functions prescribed by the particular kind of division of labor in operation in that society.

"This is not to say that a role is a strait jacket or that the individual occupying the role is merely a marionette pulled from task to task by a set of controlling strings. Obviously, these individuals have differential temperaments and have had differential past experiences, but they are strongly influenced by the set of behavior with which they must interrelate in the performance of the role. Thus, a nurse is not just a person or a role but is an integrate of these. To answer the question, 'What is a nurse?' we must examine then a set of questions:

"A. How does the society view and act in regard to the role?

"B. What are the experiences which relate to the individual's performance of the role?

"C. Is the behavior of the nurse, anticipatory and actual, consistent with the expectancies of the society regarding the role?

"In other words, is the young girl (or man) with her dreams and aspirations and her personality-forming past experience so equipped as to be able to meet the role which society is encouraging her to fill? If she is not, then the amount of unhappiness inherent in the position can but lead to failure or, at best, malperformance of her job and to her own personal dissatisfaction and rejection of her responsibilities."

At this point it is well for the social scientist to remind himself again that his task is not to suggest what a nurse should or should not be. There are two kinds of roles which he may legitimately discuss. The first is the ideal role. In every society there are a large number of statements posited by the society concerning the ideal behavior of the occupier of the role. I am going to pass lightly over the ideal role of the nurse. Such statements serve a very important function in every society in that they set goals, more often than not impossible to achieve, toward which the individual is encouraged
to strive. Incidentally, it has been my experience that these descriptions may often be used as rather elastic yardsticks against which an individual may be measured and rejected. I might suggest, too, just in passing, that at times in the nursing as in other professions the ideal concept is used to divert attention from salary scales.

The other class of roles, social scientists call real roles. Under this type of description it is necessary to gain perspective upon the way in which the other members of the society view the occupant of the particular role. This has been found to give us a much more reliable picture of the way in which other members of a society will act in relation to, in this case, the nurse, than does the sometimes misleading ideal description.

This kind of information is not too difficult to obtain in a simpler non-differentiated society wherein, in general, the members of the society share much the same set of expectancies and attitudes toward a given position. However, it is not so easy in a more complex, differentiated society such as ours. For years it was claimed that our society is composed of so many divergent opinions, attitudes, and possible behaviors in a situation that we could not possibly hope to generalize satisfactorily upon them. Generalization is just what we must do if we are going to do more than simply treat each case by itself, a prohibitive project for a busy administrator no matter how well-meaning.

From the allied fields of social psychology, sociology, and psychology, as well as from the social anthropologists who brought with them to their work the perspective gained by studying other groups than the one in which they matured, has come a series of studies which make our task somewhat easier. Margaret Mead, W. Lloyd Warner, Robert S. Lynd, and Kurt Lewin, just to name a few of the pioneer workers in this field, have pointed out that while it is true that modern America is complex, there is an ascertainable order to this complexity. Their researches have shown that within the concept "of our society" systematic variation could be defined. Within this complexity could be seen a series of sub-societies. These, which have been variably called classes, sub-cultures, and ethnic groups, proved to be describable in much the same terms as were the simpler societies, and, for the first time, a good number of hitherto baffling problems were open for investigation and solution. By use of these tools, students of human relations found themselves capable of examining behavior in other terms than the myopia-producing "good" and "bad" and of suggesting courses of action more fruitful than a manual of do's and don'ts.

It is with this work in mind that I should like tonight to send up some trial balloons for your consideration—to make some tentative working suggestions which may be useful in planning an educational program which has as its end the development of nurses who are better able to cope with both their professional and personal worlds. I hope that if my generalizations seem overdrawn and unfamiliar to those of you who know the nursing world far
better than I they will at least stimulate you to examine objectively the nursing world so that better, or at least more fruitful, blueprints for action can be set up.

In searching for some answer to question A, posited above, "How does society view the nurse and how does it act in relation to her?" I have for the last few months been interviewing patients, nonpatients, doctors, nurses, and my students at the University of Louisville. Unfortunately, this is the most limited of surveys. Geographically, it included Louisville and rural hill-Kentucky, Columbus and rural Ohio, and Chicago, Illinois. Consequently, it will probably have an undue middle-western slant. Further, it will not include a number of the problems associated with the various ethnic groupings from which a number of nurses come. However, I feel that some of the implications below apply to such cases. The techniques which I employed to get this material were:

A. *The open interview* with vocational guidance people and various professionals in which I frankly stated the problems being attempted in the paper and sought their advice.

B. *The concealed interview* by which I steered numerous conversations to nursing in order to derive unguarded statements.

C. *The dramatic perception technique*. I employed the traditional household game, charades, to ascertain the attitudes of the actors and observers. This proved so successful that I used it with five different groups: a faculty group, a settlement house group, a hill-family gathering, a group of high school girls from a rural high school, and a middle income Ladies Aid Society.

D. *A controlled association test* in which fifty students whose backgrounds were known were asked to put down the first kinship term—for example, mother, father, sister—that came to mind when a given profession was mentioned.

I should like to present to you the findings of this survey. It will be necessary to break them down into three rough groupings, upper, middle, and lower income brackets. The attitude is sufficiently different in these groups to demonstrate our case. I must ask the listener to remember that these are not my attitudes but those of these sub-cultures.

Abstracted and generalized into a profile, the upper income bracket views a nurse as follows:

The nurse is a skilled menial, somewhat higher in social prestige than the manicurist or hairdresser, but considerably below the social worker. She is placed in a class of people who should be tipped—like the barber, the caddy on the golf course, someone else's maid, and the personal attendant in a theater or department store.

Her job is viewed as an unpleasant one. She was regarded as "nice" to males and cruel to women, particularly those in childbirth. She should be treated with quiet respect in the hospital. Intimacy might be established in the hospital but should be terminated as the patient leaves. Private nurses should be encouraged to
have close relationships with the children (just as governesses are) but the nurse should be reminded, unless she has been established as a family retainer, that she is an employee. There was considerable disagreement as to whether she should eat with other servants or by herself.

Finally, she was not regarded by these women as a threat. Both males and females assumed that there would be casual affairs between the nurse and her male patients but reiterated, "It couldn't come to anything." (Meaning marriage, I presume.) Kinship response: cousin or poor relative.

The middle income group ($2,500 to $4,000 per year) gave the following picture:

The nurse is a semi-skilled to skilled individual who is variedly regarded by the women as someone who is working a while before marriage, who is widowed, divorced, or who is a "career woman" (which is the middle class woman's description of a woman who can't get a husband or who is a neglectful wife).

The nurse's is a self-sacrificing profession which has its rewards in the knowledge "that one is doing good." The women distrust the nurse and regard her as a husband-hunter capable of employing unfair tactics. (Incidentally, the nurse is not alone in this; the middle class woman tends to regard her husband as easy prey for any designing woman who can get him alone.)

Most of the women agreed that nursing is very good training for a wife to have had but felt that their daughters should go to college where they would have the opportunity of meeting "people of their own class." When questioned about the college training courses for nurses, they felt that these were "better" but that the girl was marked by the course much as if she were taking physical education or social work. The students disagreed, saying that the nurses were not as "queer" as the other two.

The position of the nurse was rated higher than a stenographer but lower than a secretary. This profile differs from that of the upper income group in that the middle group could not conceive of classifying the nurse with beauty parlor operators, waitresses, and maids. Most of them felt that tipping would be insulting. (The female of this group seldom tips and is inclined to be somewhat antagonistic to anyone who seems to expect it.) On the other hand, they insisted that the pay was very poor, "even for a woman."

The men of this group talked of nurses as "easy marks." Yet they seemed to have a respect for them, considering a nurse to be a "good fellow" with considerable knowledge which in a crisis could be useful. Several of the men of this group were married to nurses. These stressed the fact that their wives were "different" and that they had married the nurses when they were young. Both males and females in the charades games were somewhat ambivalent in their attitude toward nurses. In the characterization cleanliness was stressed. A number of the actors included quite ritualistic hand washing as part of the characterization. The nurse was portrayed as a person who tended to your needs, put soothing hands and cooling cloths on your fevered brow, but at the same time failed to answer buzzers and was rough in changing the bed and washing you.

Upon the controlled association test the men responded "mother" and, more rarely, "sister." The women responded "sister," "aunt," or "no relative."

Still another and quite distinct picture is given by the lower income grouping:

Nursing is one of the noblest of all professions. The nurse is one who has bettered herself by education and who in her everyday life is surrounded by excitement, glamour, and interesting people.
She is in a position in which she will be able to make a good marriage and to give her husband and children the advantages of her acquired knowledge. There were no particular comments concerning the nurse's morality by the women other than that the girls were "well chaperoned during training." The males agreed with the fact that the girls were "looked after" by the head nurses but added with sly snickers that the doctors probably "had a lot of fun with them." Both the men and women agreed that they would like their daughters to study nursing.

In the charades play the nurse is shown as a technical expert. She takes temperatures, gives hypodermics, and writes knowingly on report pads. By the members of this group the nurse was rated very high as a professional—"almost a doctor." Several of the portrayals supported the interview material by showing her relation to the doctor wherein she was both very efficient and very feminine. It was felt by those interviewed from this group that the pay "was good for a woman, especially when you remember that you get room and board." Several of this group reported without prompting that they gave a present, a handkerchief, or some home-cooked food as a parting gift. The lower income bracket and the small town and rural middle income groups added one thing which did not appear to any extent among either the urban middle group or the upper income group. This concerns the consideration of the nurse as a "friend of the family" or "just like a member of the family." Such a friend or quasi-family member is spoken of or introduced with pride as "Miss Smith, a nurse at Bishops, where I was."

To proceed to the second stage of our analysis again requires some introduction. It must be remembered that science is never interested in non-repetitive events, only in generalizations. To put it somewhat differently, a physiologist, in attempting to describe the endocrine system, attempts to make his generalizations broad enough that the behavior of any particular pineal gland will be included within his definition. It would be, of course, possible to discover differences in the behavior of any two endocrine systems. However, it is one of the physiologist's tasks to set up a silhouette which will make the differing behavior of any given endocrine system stand out. In other words, physiology is of use to the doctor in that the general descriptions which come from this science supply short cuts for diagnosis. Similarly, it aids the doctor to see the limits within which the gland operates, enabling him to avoid serious over- or under-treatment. No doctor ever has the time to study all of the physical aspects of every patient. Thus, in the discussion to follow it must be remembered that we are generalizing. The history of any particular student nurse probably differs in one or more aspects from our profile. The social scientist does not ignore differences any more than does the physiologist; he constantly seeks to refine his generalizations, that is, to try to find out whether or not the differences seen are significant. Thus, I hope that you will bear with me in this tentative pilot study realizing that only further study can refine its inadequacies.

Our second question, restated from above, is: "What do we know about the culture pattern from which the student nurse comes?" Knowledge of this should give us perspective upon the value system which she brings with her into nursing and which comes into conflict with or is harmonious with the value milieu which we have just described.
Although all of us could name exceptions, nursing tends to recruit its students from one general class area. In terms of W. Lloyd Warner's system, the nurse comes from the top of the upper lower class and the bottom of the lower middle class. To be somewhat more traditional in terms of parental occupation, she tends to have parents who were skilled workers: plumbers, railroad workers, skilled craftsmen, government employees, skilled factory workers, or farmers who were semi-successful or successful. There is, besides these, one other major source of students. This is the small town middle income grouping. From this source come the daughters of managers of small stores, dentists, doctors, ministers, and teachers, as well as from the group described above, in other words, from the top of the lower income group and the bottom of the middle grouping. Is it possible to make any significant generalizations about the culture patterns, the value systems and social experiences of this grouping?

Drawing upon my own research in these areas and leaning heavily upon the generalizations made by other students in the field of human relations, the following profile is presented. I could enlarge upon this to a considerable extent, but I am presenting only what I have pre-judged as the most salient features.

This is a group which is deeply concerned with the family and family life. The father is regarded as the head of the family, yet the mother rules in the kitchen and usually dominates the family decisions. This she seldom does openly, but rather uses continued suggestion, aggressive retreats, tears and hypochondriacal techniques to control the other members of the family. The father in the family pontificates at the dinner table and when there are visitors present, yet retreats behind his newspaper or goes to sleep in an effort to escape the conversation of his wife which seldom is of real interest to him. This creates some ill feeling on the part of the wife who feels life as something of a prison from which she escapes through romantic radio serials and the movies as well as her magazines. Her other and usual avenue of rebellion and escape is work, much of it "busy work." The male is but slightly concerned with politics but often has very rigorous identifications with one or the other of the political parties. He is seldom very conversant with the issues at stake and prefers to discuss politics in broad general terms. The woman is seldom very concerned with politics unless through her other associations (normally, religious and organizations concerned with the abolition of alcoholic beverages and gambling) she has developed a concern over a particular issue.

This is a church-going group. However, it is seldom very concerned with theological problems, being content that religion is a series of "do's," "don't's," and social gatherings. It places a very strong stress on morality and being moral. As one of my colleagues has suggested it is for this class that the Boy Scout Law might have been written. The dicta to be trustworthy, loyal, helpful, friendly, courteous, kind, obedient, cheerful, thrifty, brave, clean, and reverent are very meaningful as ideal patterns of behavior. To the ten commandments must be added an eleventh: "Thou shalt not stick out like a sore thumb."

The view of the world is a conservative one. Craft unionism is preferred to trade unionism and successful rugged individualism to both of these. They feel that education and the "breaks" or "luck" are the only requirements for social advancement. Although education is viewed with awe, it is also viewed with suspicion, for it tends to threaten the rigid personal social controls of this group. There is continual con-
flict between parents and children over this issue, the parents feeling that atheism, communism, and moral collapse are inherent in the ideas which the young child brings home from school. The child soon learns to keep the school and home world separate. At the same time, the parent is very concerned that the child get good grades and culture. With regard to the grades, the child finds that although the parents disapprove of what the child is learning, they still demand that the child get good grades. Bad grades, like immorality, reflect upon the parent, and the child soon learns that good grades bring love and bad grades, punishment. Reflecting his world view, the parent tells the child that there is nothing that hard work and sufficient interest can't achieve. Bad grades are thus the result of laziness or lack of interest. This latter is a state of mind without cause which one can overcome by will power.

Culture is strongly stressed in this group. "Culture" includes singing in the chorus, being in a play, playing an instrument in the school band or orchestra, and not saying "ain't." So strong is the concern with self-betterment that the parents of this group will make severe sacrifices in order that the child can learn to play the piano or violin. The child's interest in these instruments is of no importance to the decision that the lessons be taken.

Although the discussion of sex is avoided—in fact, the young must get information outside of the family except for the vaguest warnings about conception, and "what people will think"—this group is considerably concerned and anxious about sex. While children are wanted and no family is complete without them, there is considerable concern with limiting the size of the family and of not having too many.

Possibly the greatest single fear, which is always present in the minds of members of this class, is the fear that they will be regarded as having "bad breeding," or that they seem like lower class people whom they despise as lazy, immoral, and incompetent indigents. Thus, the strongest sanction to this group is gossip, and the fear "what people will think." Every child of this group hears day after day, "Do you want people to say that you're like that so and so girl or boy?"

The adolescent of this group is torn by two opposing ideas. One is escape and freedom—escape from the constant pressure of public opinion and parental sanction, and freedom "to do what I want to do." The other is a guilt at the at times not so vague hatred and rejection of the parent. Marriage, going away, or "making my own money" are the escapes most often dreamed of.

This is much easier for the boy of this group than it is for the girl. She is much more carefully watched than he is. Marriage is the expected pattern and the girl must be very careful to avoid any action which will reflect upon her character. She is caught in a rather difficult cross-current of forces in the home. Her mother lectures her about behaving properly and being "frisky" or "forward" and at the same time tells her to "have fun while you're young." If she does not follow to the letter her mother's wishes her mother tells her how much she has suffered and sacrificed for her and "now look how you act." The father is jealous of her and suspects every young man of the most immoral of predispositions. There is great conflict between the child and her parents. Usually, however, she can form a tacit alliance with one against the other. Inasmuch as her mother often reaches menopause at the same time that she reaches adolescence, this is a very uneasy alliance. Her mother is an uncertain ally at the best and her father, while often siding with her against the mother, will blame her for the mother's tearful outbursts.

Thus, the girl dreams of a quick marriage, of "getting away" or, often, even of suicide. Her literature is the "pulp magazine" or the Readers Digest, both of which romantically picture the nursing profession and its opportunities for freedom, respect, admiration, and romance, all of which are primary values to this unhappy child. (Often, this unhappiness is not realized but is suppressed into chronic illnesses, introspection, or romantic escape into "dating" and "popularity.")
Inasmuch as nursing is one of the professions or jobs which are included in the little girl’s “what are you going to be when you grow up?” she begins early in her dreaming and play-preparation for the role. Interest in the well-being of animals and an interest in sickness or death is supposed, in this culture, to indicate the proper attitude for undertaking a nursing career.

This description could be continued *ad infinitum* but I feel that this should be sufficient for the scope of this paper. Before we attempt any generalization upon these two sets of profiles, I should like to draw somewhat from nursing literature in order that we may more properly set our sights for the practical problems suggested by the comparison of the role and its occupant. I have taken these excerpts at random out of a book for nurses which was found in the personal libraries of nurses, in the public libraries, and in school libraries. I am not sufficiently conversant with nursing education to know whether or not it is used in all, many, or but a few nursing schools. However, the fact that the book has gone into its fifth printing would seem to indicate its widespread adoption.

From the flyleaf:

<table>
<thead>
<tr>
<th>To apologize</th>
<th>To keep on trying</th>
</tr>
</thead>
<tbody>
<tr>
<td>To begin over</td>
<td>To avoid mistakes</td>
</tr>
<tr>
<td>To admit error</td>
<td>To forgive and forget</td>
</tr>
<tr>
<td>To be unselfish</td>
<td>To keep out of the rut</td>
</tr>
<tr>
<td>To take advice</td>
<td>To make the most out of a little</td>
</tr>
<tr>
<td>To be charitable</td>
<td>To maintain a high standard</td>
</tr>
<tr>
<td>To be considerate</td>
<td>To recognize the silver lining</td>
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It is not easy

The foundation of all ethical and moral principles of our present civilization is found in the Bible.

... it is an unpardonable sin to lie to the doctor about a patient, but perfectly pardonable, and frequently very desirable, to lie to a patient. ...

Then a few paragraphs later:

A lie is morally, socially, and economically wrong, it is morally, socially, and economically dangerous and disruptive. ...

Lack of respect for authority is a sign of bad breeding. ...

The use of slang shows that the nurse is lacking in true culture.

After advising the nurse with a grievance to make sure it is a real grievance by writing it down and having a two or three day cooling off period before taking it to a responsible person in charge, the author advises:

... in a quiet, ladylike, dignified way go to a person in authority, who is in a position to correct the conditions complained of, and ask if something may not be done to improve matters. ...

If, after having done this, the grievance continues, what course should a nurse pursue? The old adage “Better endure the ills you have, than fly to those you know not of;” is a good one to remember.
This particular book on ethics gives but two pages to the problem of sex, at least one page of which is used in the discussion of divorce.

Before continuing to the comparative aspects of this paper, I should like to insert one parenthetical reflection. One of the strongest complaints of those in the last century who opposed the scientific examination of the working of the human body was that "it made it look ugly." Those who rose in righteous wrath against the preliminary findings of psychology and psychiatry complained that it made "human beings seem so terrible." I am sure that there are those who feel that the objective examination of the thought-ways and behavioral patterns of social beings is equally outrageous. Yet none could deny that the "profanities" of physiology, medicine, psychology and psychiatry have so broadened our abilities to cope with the problem of mankind that they have long justified their application. It is my hope that those who feel that the generalizations presented above are destructive will reflect momentarily upon the history of science and its applications.

To return to our material—it is obvious that the nurse in her day-to-day work is asked to adapt more rapidly and more efficiently than is a person in almost any other role in modern life. She must continue her work in a milieu which from patient to patient may vary almost as much as if she had moved from one moment to the next to a new society. There are significant differences between the value systems of these three groups described above. These are complicated to multifold proportions when we remember that the nurse also must meet a large number of members of ethnic communities with which she is equally unfamiliar—just to suggest a few, the Negro, the Jewish, the Polish, the Irish and the Italian—all of whom differ somewhat from each other in their conception of the "proper" behavior of a patient and of what the position and role of the nurse are. The psychological strain of such rapid adaptation is obvious, particularly when we recall that her own milieu, her own background, has so little prepared her for the conflicts inherent in these social relations. Hers has been an experience in an area of society which sees things as "black" or "white," "good" or "bad," "like us" or "not like us." Differences in behavior have been explained by primitive psychology; deviations from the rigid standards of behavior have always been reprehensible if not actually immoral. It might be added that she has been systematically taught that immorality is contagious, that is, if she is immoral in one area that that immorality is likely to spread to others. Thus, any behavioral deviation has been interpreted as symptomatic of immorality in all spheres of an individual's life.

It is not difficult to see the shock which comes to such a girl when she goes away to the demanding environment of the nursing school. Leaving home to escape authority, she comes face to face with what is probably the most authoritarian existence which is demanded of a woman in American life. Seeking love and romance she enters a milieu which, as a preliminary step, must (as it now operates) avoid emotional attachments between those
in charge and the student by sanctions of authority and a continuation of the familiar do's and don'ts. Smoking, drinking, swearing, sexual experimentation often become symbolic of the escape, the break with the humdrum existence, the conflict-filled existence of the past home life and its repetition in this new world.

The age-grading pattern of classes in the nursing school pushes her again toward association with age-mates with whom she is in competition. Posted ratings, grades, and consultation are often merely continuations of the old pattern whereby she found no real assurance of love, position, and importance.

She discovers too that although her parents want her to succeed in this world they feel that the nursing school is tearing down her morality and, from their point of view, stealing her away from them. Going home, looked forward to as an escape from the regimen of hospital life, becomes a nightmare of disappointment. Her parents complain that she is no longer interested in them, that when she has "dates" she just doesn't spend any time at home, that she regards home as "just a place to visit."

Thus the girl cannot find the "new world" which she has so sought. It should come as no surprise to find that the escape to a member of the opposite sex becomes of all-encompassing importance. She is thrown back to the old hope that marriage will cure all, marriage will give position, marriage will give freedom. This probably can give some further insight too into the number of nurses who find marriage so disappointing. (It just couldn't be that good.)

To return to nurse and patient, Sonnenthal has reported upon nurses and hysteria and malingering. His very excellent article may be expanded somewhat by the recognition that the girl, while growing up, learned that sickness is an efficient tool for gaining attention. It is also a very good weapon. Her mother and sisters had consistently gained or maintained control through ailments functional or organic. In her previous culture pattern, the menstrual period was a period in which a woman was forgiven for emotional outbursts and imposition. The headache and the backache were never-failing devices for gaining attention and for explaining failure. For her to continue to use these techniques as a nursing student and a nurse is predictable. Too, this must constantly color her definitions of sick people. They are imposing and malingering. On the other hand, she was taught that nursing was a technique of control. Repeatedly, she had seen her mother dominate by overcare. She had learned the technique whereby one could be denied privileges by the solicitous "You don't look good today, honey" or "Why don't you just rest tonight, and when you feel better, we'll talk about it again." Add to all of this the fact that sickness is regarded as somewhat immoral by this group and you have a serious impediment to objective nursing.

Once again, considerations of time force us to limit our generalizations.

Let us now turn to the more important part of this paper. I am sure that by this time all of you are saying, "All right, so we have a problem, that much we have known. We know that about one third of all nursing students never finish training, that a large number do not practice more than a year, and that our counselors are overworked. What are you going to suggest doing about it?"

I believe that, with the tentative analysis presented above and with the experience of other educational and indoctrination programs already in progress, it is possible to make some suggestions for consideration and action. This takes two general lines of approach which are fundamentally interrelated. The first of these includes the organization of generalized research upon the nurse and the community. From this should come material which would be invaluable both to the planners of nursing curricula and to the nurse counselor, a terribly overworked and underrated individual in most schools. I feel that this should not be a casual set of surveys or questionnaires, although these would obviously supply important hints. I am probably very prejudiced, but I feel that carefully organized interviewing, together with the actual examination of the nursing community in much the same way that the anthropologist examines any other community, would be the most fruitful approach. As this material is gathered and assessed it should be placed in the hands of those most able to implement its use. I think that such material should be carefully written with the idea that this material is to be used, not by social scientists, but by nursing educators and counselors. It should be written in such a way that it could be translated into action.²

On the other hand, I think that the nursing curricula should be broadened to include the mass of material which is already prevalent. The nurse must be educated in such a way that she can gain perspective both upon herself and her motivation and upon the various kinds of patients with whom she will come into contact. This would require that she be exposed to a generalized social science education. She should be shown the findings of social anthropology, psychology, sociology, and social psychology. Nursing educators are conscious of the fact that student nurses often resist if they do not actually resent academic courses. Such a course of study as we are discussing here must not be an academic course of definitions and memory work. It should start with the problems which the nurse herself feels and knows of. The student nurse should be encouraged by an ever-broadening knowledge to see that her problems are not peculiar ones. She should learn something about her own background and at the same time learn about her patients as members of society—not just as "sick people or healthy people" as one book for nurses demands. This is unrealistic if not nonsensical. Only a mechanical nurse could follow such an instruction. She is a member of society and she will act like one. To the extent that she has understanding will she be able to transcend her narrow past experience and become the understanding.

² I am confident that such programs now in operation will be extended.
warm, and sympathetic nurse which society so demands. The set of dicta about behavior which I excerpted above from the ethics text are demonstrations of training of the do and don't variety—dicta which do not prepare the nurse for any genuine understanding. Such dicta, because they sound so much like what mama or papa would say, pass along a path which had been about seventeen years in preparation—in one ear and out the other.

In conclusion, may I say that I hope that with this preliminary and often shallow treatment of this tremendously important problem, I have been able to demonstrate some of the culturally prepared pitfalls before the nurse and nursing education. If at times I have been overzealous in my characterizations, it has been with the hope of dramatically presenting some of the problems in bold relief. Finally, if I have not made precise enough suggestions for research or curriculum organization it is because I feel that more knowledge of the field and its personnel must be in the hands of the scientist before he can advise exacting courses of action.

**Morning Session**

**Thursday, May 5—9:00–11:30 a.m.**

**NEW PATTERNS FOR CLINICAL CURRICULAE**

*Presiding: Henrietta Doltz, R.N., Director, School of Nursing, University of Oregon Medical School, Portland, Oregon*

*Speakers:*

**Margaret Lindsey,** Coordinator of Professional Education, Indiana State Teachers College, Terre Haute, Indiana (Paper read by Ida Sommer Strieter, R.N.)

**Mable I. Darrington,** R.N., Associate Professor of Nursing, College of Nursing and Health, University of Cincinnati, Cincinnati, Ohio

**R. Louise McManus,** R.N., Director, Division of Nursing Education, Teachers College, Columbia University, New York, New York

**NEW PATTERNS FOR CLINICAL CURRICULAE**

*MARGARET LINDSEY*

It is doubtful that I am the one to approach this problem with a professional group made up of people as alert and dynamic and as intelligent as you and your colleagues. However, there are reasons why I am willing to take the risk of assuming the responsibility, even though I am uninformed about your particular problems.
I believe there are gains to be made when one from the outside "looks in." A few years ago I had the rich opportunity to teach a class in principles of education to a group of students in the Division of Nursing Education, Teachers College, Columbia University. During our discussion at the close of the course and when we were evaluating our experiences together, many individuals related their situation and understanding resulting from the fact that a person in training in nursing education had had opportunities in which she had been able to see a new light in her own profession.

I believe, secondly, that all citizens ought to be interested in their profession. This is particularly true of a member of a sister profession. We do have many things in common. We live in the same society—a dynamic one demanding that our professions take a second place in contributing to that society. We are similarly interested in the same ultimate goals in the recruitment program, in the status of our professions, and in the raising of professional standards.

Most important, we are all concerned with a program of education; particularly are we concerned with the improvement of teaching procedures and of the conditions and of the facilities affecting learning by the young people preparing to join our ranks. This presents you, as it presents us, with some very vital problems.

1. How can we best secure intelligent, wholesome and vigorous young people to prepare for our profession?
2. Once we have secured the right youth, how can we provide the best experience for them? How can we make the pre-service professional program more meaningful? How can we provide for better integration between so-called general education and the professional education?
3. How can we secure instructional personnel equipped with background and experience to guide young people through pre-service education?
4. How can we improve the methodology of college instruction so as to put into practice on the college level what we know to be sound in principle?
5. Where can the necessary facilities to provide for direct experience be secured?
6. How is the ambitious program we know to be essential in professional education going to be financed?

Of the goals and problems we have in common I propose to deal with one specific one—the improvement of the conditions for effective professional education. While what I have to say will be of a general nature, I am assuming that Miss Darrington will make more specific application of some of the ideas presented to your work in nursing education.

It seems that the first question we might ask ourselves is this—what is real learning? I should like to propose three possible answers to this question. Real learning is what happens to the individual as he engages in experience; that is to say, it is conceivable that a keen nurse in training, because of pres-
sure to make a specific grade on a content examination, may learn a variety of techniques for cheating. Because Billy got his hands slapped for picking up the nickel that didn't belong to him, Billy is likely to pass by the temptation the second time. He may change his behavior in the right direction as suggested; he may also change his behavior in the wrong direction—that is, he may experience that rebellious attitude and develop more ways of concealing his theft of the nickel. A third way to describe learning is to see that there is the residue from experience. It is our attitude on values, our ideas, our information and our skill which will be a part of us by reason of experience that we have had.

It is important to examine our concepts of learning. An attempt to confine what we mean by learning will most likely direct us into new and better ways of teaching and providing for us insight into the goals of both vicarious and direct experiences.

Assuming that we can agree that learning has changed behavior, let us move on to how learning takes place. While research in the area of the learning process is still in a developmental stage, we discover what we do from indisputable facts about the learning process. For the purpose of illustration, may I present two such facts? Learning is an active process. This is a principle which each of us can observe daily and which all of us experience. We do best and with less pressure those things in which we have active participation. This principle of learning has received wide recognition on the elementary school level and is being granted recognition as one observes the teaching process in college education and in professional education. Real learning takes place when the learner recognizes he has problems which are real to him, when he plans ways to solve that problem, when he engages in activity directed toward the solution, when he participates actively in evaluating the results, and when he actively reflects and draws generalizations on the basis of his experience.

To have effect, experience must have meaning to the learner. Now research has shown that learning occurs in direct proportion to the reality of the situation to the learner. This principle of learning has been established for many decades. The fact remains, however, that education has been very slow to put in practice and to prove this concept. For example, the social science program of the elementary institutions continues to be planned to include, almost exclusively, content which has to do with the long ago and far away. It has been extremely difficult to get classroom teachers to believe that parents and youth in our society need to deal with problems which are understood by them and are real to them, and to interest them in this aspect of the learning process, and to develop students into members of the profession who have gained sensitivity regarding social problems. You are concerned too, because this principle has significant implications for the kinds of experience provided in professional education.

And so we might ask the question "What do these two principles mean.
regarding conditions and learning in the school of nursing?" The implications are numerous and time does not permit dealing with more than a few examples:

1. If the learner must actively participate in the planning, executing, and evaluation of experience, the need of preparing for the experience must be the learner's and cannot be imposed upon him from the outside. I note in the Brown Study that leaders in the field "are concerned about the degree of efficiency" with which nurses use the English language. We too are concerned with this area. We hope that part of the difficulty is in the fact that our procedure for teaching does not always prepare individuals to communicate skills. It is essential, if we desire individuals to develop the communicative arts, that those individuals see a real purpose for spelling, reading, grammar, and punctuation.

2. The educational program designed to take advantage of what we know about the learning process must be a program of activity thoroughly experienced, dealing with real problems, and not one of pouring in information. This principle you have recognized in your professional education program for a long time. However, I note that with the trend toward raising standards both in general and professional education schools of nursing have fallen heir to the practices of so many other colleges, for example, the tendency to include direct experience in professional education alone. I note, with interest, that leaders in your profession are engaged in a study of this problem and that they are advocating a complete integration of these two areas.

To put this principle into operation for college work demands that the methodology of college instruction be completely revised. It demands that we place emphasis upon the process of obtaining, interpreting, and guiding knowledge rather than exclusively upon the knowledge itself. It demands that class experience be of such nature as to have individuals learn procedures for finding and using information. It demands that the subject matter dealt with consist of real problems in concrete situations.

A third question which we might well raise regarding our professional programs is this: What do we know about the learner himself? For an illustration, may I recall some of the most significant contributions of research in this area.

We individuals are not alike. No two humans have started on the path of life from identical points because of environmental conditions. Students in the professional school of nursing today present an array of individual problems which must be recognized in the program. This means that no set program of experience is of equal value to all students. Rather it implies that any curriculum must have flexibility and variety so as to make possible adjustment to individual needs, interests and abilities.

All human beings have a basic need for security. Somehow on the college level we seem to deny that such a need exists. Too often we place individuals in situations where standards are too difficult and degrade those people who
cannot meet them. Such procedure is a threat to the security of individuals. It is known that without security, individuals may engage in very destructive behavior. The professional program should be one which recognizes this need and provides ample opportunity for every individual to maintain and increase his security.

Among other accumulated knowledge in the field of human growth and development is an abundance of information regarding stages of growth and the characteristics of human beings in each of the various stages. Some very interesting facts are known. About adolescence—the particular stage of development with which you are directly concerned—is nursing education to be cognizant of the characteristics of adolescence which might be called "normal" and is it in every way designed to meet the growing pains and peculiarities of the adolescent stage?

The individual is the learner. He cannot be dissected into discreet parts. He is one organism having a variety of aspects—physical, mental, emotional and social. All parts of the individual are present in the learning situation. While the experience at hand may call for mental activity, the fact remains that emotional disturbance or a physical disability will greatly affect this mental activity. This fact calls for a very clear understanding of individuals on the part of those persons guiding their experiences. It is not enough for the college instructor and the supervisor to know the mental and the physical characteristics of a keen student. It is essential that such personnel be directly acquainted with his social and emotional problems as well.

Some specific recommendations would seem to be logical as result of this previous research in the learning process and human growth and development.

1. Direct experience is the best condition for learning. Vicarious experiences are good in proportion to the meaning they have to the learner.

2. Theory is most meaningful when arrived at by the learner on the basis of many interrelated experiences.

3. Things which belong together must go together and be directed toward a central goal and must be seen in relationship. Such integration must occur within the learner but must be facilitated by a variety of means: core courses; direct experience as an integral part of all courses; generalizing from experience.

4. In general, more direct experiences over longer periods of time are to be preferred to fewer experiences concentrated during a short period.

5. Every program must be flexible enough to meet individual needs, interests, and abilities.

6. Purposes must be within the learner.
Before we think together concerning nursing curricula, I wish to say that I have no single well-formulated answer to the problem of curriculum pattern, but perhaps I can serve a purpose similar to that of the father of a freshman high school girl studying algebra. When she told me that her father helped her with the difficult problems, of course I wondered if he worked them for her, so asked how he helped her. Her reply was: "It has been so long since Father did any algebra that he has forgotten practically everything, but he tries. We'll read it over and then he starts to set up the equation, but he just can't seem to remember that I don't know how to use two unknowns. But it is the funniest thing how it helps me to see him fumble with it; suddenly I get an idea and then I can set it up myself. Sometimes he doesn't understand my method either, and questions it. That kind of discussion helps me a great deal. We aren't either one very good, but he is remembering how to do it and I'm learning." Like papa, if I can suggest anything which will give you an idea so that you can set up your equation and solve the problem, I shall be satisfied.

The first important factor in establishing a curriculum pattern is the philosophy of the group; philosophy is goal-setting. Secondly, the way in which learning comes about, that is, the psychology of learning, determines the methods of teaching to be used in a program. Let us take a few examples in nursing to see what help it might give us today.

History tells us "when the women of a nation have been closely restricted by social convention to the home, and their energies limited to family life, nursing must have had almost wholly the character of a household art." The psychology of that day was a belief in instinct; they were "born nurses." They responded to the situation with common sense or with superstition.

The partial emancipation from conditions of subjection brought the woman in nursing to see her role as something other than a housekeeper, and she was the "one who personally cared for the sick and helpless patient, attended to his food and other physical needs, gave solace and comfort according to the prevailing degree of mentality or instinct, learned to apply simple remedies for the relief of pain, and was selected to assist the physician in his treatments." At the time that this was considered the function of the nurse, Ebbinghaus was staking his first claim in the field of psychology. His studies established such "laws of learning" as:

1. Each individual repetition of a series of words is equally effective in es-

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2 Ibid.
Establishing associative bonds. That is to say, the amount retained is directly proportional to the number of original repetitions.

2. Learning takes place more rapidly under the intent to learn.


Can't you see this psychology expressed in the method of learning of that day—if one wanted to learn, paid attention, and practiced over and over, learning would take place.

When nursing became separated from the home and was seen as a public service, experimental psychology had added new theories of learning. Stimulus-response, trial-and-error laboratory situations in the study of learning brought to the fore the problems of motivation, of rewards and of punishments. Out of this came the "law of effect." The clinical curriculum in nursing of that day was the apprentice system. It exemplified very well the accepted experimental work. The individual was placed in a trial-and-error situation and through her efforts of imitation she received the rewards and punishments.

Then the concept of nursing changed and it was felt that the nurse should have a definite body of knowledge and possess certain skills that could be produced in response to need. At that time we were thinking in terms of conditioned reflex and our psychology was from the standpoint of behaviorism. Certain stimuli lead regularly to reflex responses. Nursing took to the classroom and set up ward practice laboratories where more stimuli could be concentrated on the student to produce the desired behavior. We subscribed to the rule that we should practice in the precise form later to be demanded.

There are other examples such as memory exercises and transfer of training which affected our methods of teaching. Many of these concepts of discipline, that is, "it is good for one," or sometimes stated the other way, "it won't hurt you to get busy and learn that" still govern many faculty members today. It is not discipline that accomplishes learning. As faculty members we should be interested in experiences that result in meaningful learning which may be applied to new situations.

These illustrations are very brief and do not tell the complete story by any means, but they show the influence of psychology on methods of teaching in nursing. All through the development of modern nursing and up to the end of the first quarter of this century in America we were influenced by association psychology. Connectionism (that is, stimulus response), behaviorism, whether it is called systematic, descriptive or contiguous conditioning, and functionalism are all members of the association family. They all believe the behavior of organisms to be lawful and with some sort of cause-and-effect sequence, and thus use some physical model after which to design the law to be used in psychological explanation.


Because the past shows us that teaching patterns have been based upon theories of learning, it behooves us to examine the psychology of our time to see the implications for clinical curricula. Complete theory of learning must have something to say about reasoning, creative imagination, or inventiveness, in addition to what may be said about memorizing and retaining or about the acquisition of skill.  

For the present-day concept of what the professional nurse ought to be, let us turn to the opinion of the workshop group organized by the executive secretary of the National Nursing Council. To quote, "the professional nurse will be one who recognizes and understands the fundamental needs of a person, sick or well, and who knows how these needs can best be met. She will possess a body of scientific nursing knowledge which is based upon and keeps pace with general scientific advancement, and she will be able to apply this knowledge in meeting the nursing needs of a person and a community. She must possess that kind of discriminative judgment which will enable her to recognize those activities which fall within the area of professional nursing and those activities which have been identified with the fields of other professional or nonprofessional groups."  
This is quite a contrast to the household art we first mentioned as nursing. If this is what we think the professional nurse should be, then the next question is: what method of preparation should be used in order that we have a reasonably good chance that the nurse will fit this description? Since our cursory examination of the past shows us how dependent teaching method has been upon the accepted psychological theory of the day, let us examine the theories of our time and see what the implications may be for method.

Even though it might be more logical to examine the psychological theory and then set up the implications for the clinical curriculum, and I shall do that to a large extent, yet I am going to state the psychological theory and the method which I think it supports. My reason for doing it this way is that as we examine the theory you will make many applications of your own to method. I believe it is the field theory of psychology that gives us the integrated curriculum pattern with its integrated teaching method.

Although a member of the Gestalt group, Kurt Lewin has gone beyond that concept and has given us the field theory. His concept of behavioral dynamics is relevant to a theory of learning. When he was asked to discuss the field theory approach to the problems of learning, he said the following characteristics of this theory were important: the use of a constructive rather than a classificatory method; an interest in the dynamic aspects of events; a psychological rather than a physical approach; an analysis which starts with the

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situation as a whole; a distinction between systematic and historical problems. If we explore these characteristics a little more, the field theory becomes clearer.

The constructive method. Psychology is in a dilemma when it tries to develop "general" concepts and laws. If one makes generalities from "individual differences" there is no logical way back to making predictions for the individual case. The constructive method is to take an individual case and with the help of a few "elements" of construction recognize the effect of psychological "position" or psychological "force" on the individual case at a given time. It maintains individual differences.

The dynamic approach refers to change as a result of psychological forces; that is, behavior is the result of underlying psychological forces.

The psychological approach. One of the basic characteristics of field theory in psychology is the demand that the field which influences an individual should be described not in "objective physical" terms, but in the way in which it exists for that person at that time. The concept of life space is a plausible one. It signifies that each one of us has his own world which in many ways differs from every other person's. The life space is the space in which the individual lives psychologically, as seen from his own viewpoint. It corresponds in many ways to the world about him, to the world of things, of people, and of ideas, but it becomes his own world always in an edited and personalized form. The environment in life space is partly physical, partly social, and partly mental; that is, it reflects many features of the physical and social environment, but it is never to be identified strictly with the outside factors which condition it and influence it. Likewise, life space is not a strictly private affair open only to introspection. In fact, a person is not always able to introspect about the forces acting in his life space at a given moment.

Beginning with the situation as a whole. It has been said that field theory and Gestalt theory are against analysis. Lewin said, "nothing could be more erroneous. Instead of picking out one or another isolated element within a situation, the importance of which cannot be judged without consideration of the situation as a whole, field theory finds it advantageous, as a rule, to start with a characterization of the situation as a whole. After this first approximation, the various aspects and parts of the situation undergo a more and more specific and detailed analysis. Of course, such a method presupposes that there exists something like properties of the field as a whole—for instance, the field of gravity, the electrical field; this makes it a little less surprising to attach similar importance to atmosphere in psychology.

In fact, it is possible to determine and to measure psychological atmosphere

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7 Lewin, Kurt. *op. cit.*
8 *ibid.*
9 *ibid.*
10 *ibid.*
quite accurately. Every child is sensitive even to small changes in social atmosphere, for example, in the degree of friendliness or security."

Systematic structuring of the field. Most psychologists agree that events which have not yet occurred cannot affect behavior. "Field theory insists that the derivation of behavior from the past is not less metaphysical, because past events do not exist now and therefore cannot have effect now. The effect of the past on behavior can be only an indirect one; the past psychological field is one of the 'origins' of the present field and this in turn affects behavior. To link behavior with a past field therefore presupposes that one knows sufficiently how the past event changed the field at that time, and whether or not in the meantime other events have modified the field again."\textsuperscript{11}

Does not the application of the field concept of psychology to clinical curriculum point to the integrated method? Let us state what we mean by integration and then proceed to apply the theory to method. Integration may be thought of as a process or as a characteristic of an individual. To quote from Burton's \textit{The Guidance of Learning Activities},\textsuperscript{12} "the most important meaning for us relates to the process of integration in the person. The desired learning outcomes are acquired in such way as to be woven into the already existing system of understandings, attitudes, and abilities. The things learned become a part of the learner's personality." They have not merely been "added" to the "sum of knowledge possessed" to lie dormant until a need arises and then to be repeated. They are acquired functionally as dynamic factors which enter into the continuous determination of behavior. They truly constitute changes within the organism. Integration is continuous.

Integration means, in simple terms, learning things which are truly useful and meaningful to the learner at the time and which will continue to be useful in everyday behavior so far as we can see ahead. The product of integrating is an integrated person. The emphasis is on integrating, not integrated. It is an on-going, dynamic, interactive process. We should remember that humans are born physiologically integrated and continue to grow in an integrated fashion physically and mentally until parents, teachers, and other factors interfere. The point of great significance is that the school should maintain and promote the normal, primary integration of living organisms by providing learning experiences which are purposeful, continuous, and interactive.\textsuperscript{13}

Now then, what can we see in the characteristics of the field theory which apply to a purposeful, continuous, and interactive experience that contributes to the integrating process within the individual student? If we begin with the "Situation as a Whole" and realize the significance of psychological atmosphere, then the whole curriculum pattern must be based upon those

\textsuperscript{11}Ibid.


\textsuperscript{13}Ibid.
principles which promote integration. That is, in terms of the knowledges, attitudes, and abilities which it is desirable for each of us to integrate, we select interactive experiences. This factor of interaction is such an important one in promoting integration that it must function vertically as well as horizontally in the school. It applies to the administrative organization of the school, to the organized teaching, both classroom and clinical, and to the whole social structure of the school. From the standpoint of administration and teaching the best integration of individuals can only take place when provision is made for interaction, that is, a flow of ideas from the bottom up as well as the top down. This establishes the psychological atmosphere for the situation as a whole. Remember this can apply to other smaller wholes than the entire school; it applies to departments, to wards, to any give-and-take situation in which there are two or more persons.

Field psychology gives us good reason for organizing subject matter into units, into wholes that draw from many areas but have functional relationship. It is this psychological theory of life space that guides the offerings in an integrated plan. The benefits may not always be derived as we hope they will; in fact, we are pretty sure that not always will the experiences contribute to the person the particular concept he needs at that one time in his developmental process. But this gives us reason for organizing an integrated curriculum and for making every effort to offer learning opportunities that may serve his needs in his own particular life space.

Systematic structuring of the field is a psychological concept fundamental to the idea of integration. That is, we must realize that each student in her life space has a field of reference that exists for her at that particular time. Many things influence that field—the physical, mental and social forces within her and outside of her. Something so vital for us to remember is that it is her field—her life space. Failure to remember this leads to many frustrations on the part of both learner and teacher. Past events do not exist now, true; behavior in the present may be indirectly influenced by the past. Also it may not influence the behavior of someone else as you think it should—it is her life space. Influences of past events come as something fluid which may interact with the present, it is more like a drop of ink than a compact, rigid stone, dropped into the on-going stream of the present. For that reason it may markedly color one person’s life space as it is integrated into the present. On the other hand, it may not show at all as it becomes mixed into someone’s else blue stream, that is, another life space. That happens many times to the things we think we teach; some color, some don’t; some come out as a shade we never dreamed about, because we didn’t know with what it was to be integrated.

Then the constructive method of field psychology—that is, the consideration of individual cases, not making generalizations when applied to method

—will keep us aware that integration is an individual process. We must be aware of the forces—the influences that affect an individual. This gives us the basis for individual instruction, or rather, we should say individualized teaching.

Also we must remember that another characteristic of field psychology is the dynamic approach. This refers to the change that results from psychological forces. This is an important guide in planning integrating experiences.

There is much to be said about the organization as a whole, about the functioning of the plan and the curriculum pattern, but again I wish to say it is the method we use that may help the individual to become integrated. The most easily obtained and natural setting for effective integration is the nursing situation. To make clear what I mean by the nursing situation, I shall name but a few, such as, "caring for the personal needs of the patient," "dressing a wound," "giving an irrigation," or "giving immediate preoperative care." How is the learner going to meet any one of these nursing situations effectively? For example, the situation confronting the student nurse may be that of immediate preoperative care of the patient. In terms of field psychology we must recognize that the individual sets or accepts the problem as her own; it is to be approached as a whole. It can be analyzed into specific duties later, but both the learner and the patient will benefit if goals are set, the over-all atmosphere determined, and provision made for freeing the learner for intelligent activity.

If this is to be a learning, an integrating experience, how is the life space of the student structured? What cognitive factors—that is, what knowledges, attitudes, and abilities—does she bring to the situation? The life space is her world. To be sure, it will reflect many of the things which we believe to be there because of the previous experiences, but we never know in just what form; it has been interaction with her. If we are interested in the integrating process, then let us analyze carefully the knowledges, skills, habits, and attitudes which she may bring from each classroom course and then help her to utilize them in structuring her life space. First, what does Nursing Arts contribute? The student in that course with its ward laboratory experience has learned to consult the patient's chart for orders. Now she turns to it for preoperative orders concerning shaving of the part, the amount and kind of fluids, medications, and omission of diet. She also brings to this situation the ability to care for the personal needs of the patient: bath, mouth care, hair, nails, elimination and dressing the patient for operation. She may know but not yet have acquired the skill for caring for the personal belongings such as jewelry, money, prostheses—whether teeth or limbs. Likewise, the same may be true about putting the patient on a stretcher and providing for his identification as well as the information that is to be recorded on his chart.

What knowledge does she bring to this situation from Anatomy and Physiology? She knows the relationship between the mouth and respiratory
tract and between the mouth and parotid gland. And here is the place for integrating experience. She must have the opportunity and the necessary assistance in applying this information if it is to modify her behavior or influence her life space. It is not just mouth care; it must be undertaken with the understanding of these anatomical and physiological relationships in terms of omission of diet, organisms, and anesthesia.

Let us go on to the third classroom course of Microbiology and see what knowledge it can furnish in this practical application. From it the student may bring the knowledge of the organisms commonly found in the mouth and pharynx and on the skin. She may need help in organizing this material so that it affects her behavior, but, in addition to knowledge, this affords the opportunity for two additional kinds of learning—the acquisition of skill and a change in attitude.

Take another course such as Chemistry. What does it contribute to this situation? There are the antiseptics and cleansing agents as well as the anesthetics, each with its physical and chemical properties. Cleansing the skin and the mouth is undertaken not only for hygienic reasons, but it has added significance for the person about to be operated upon. Does she know the value of mechanical cleansing, the antiseptic effect of solutions used, and the effects of common organisms in that particular situation?

Then let us turn to Pharmacology. In that course the student gains information about the effect of preoperative medications: analgesics, cerebral depressants, basal narcotics, and secretory depressants. She brings her knowledge or facts concerning the effect of general anesthetics upon muscle, upon consciousness and pain. When she applies the theory of the relaxing effect of general anesthesia to muscle tissue, there is meaning to the removal of false teeth and to having the patient void. Now is the time to assist her in using this information and in applying it; in other words, the skill of preparing the patient is modified by understanding, and it becomes intelligent behavior. There is more than one type of change effected in the learner—this is the integrating process.

From the course in Diet Therapy, the learner may need help in recalling the importance of fluid balance and what she can do to help maintain it.

Lastly, let us consider the courses in Psychology, Sociology, and Health to see what she has had in theory so that we may assist her in bringing it to bear upon this situation. She has knowledge about the prevention of anxiety and appreciates in a measure its importance, but she probably does not have the voluntary control of the body musculature such as conversation, facial expression, body movements and manner to give all patients the necessary confidence. The social significance of a satisfactory exploration of the procedures, the importance of religious considerations and thoughtfulness of family may be understood by the student, but this is the time to modify her behavior in terms of her understanding. She needs guidance and help.

Provision should be made for her to become acquainted with the patient,
to talk to him, to learn something of his social background, to learn about his psychological outlook. If possible she should talk to the family, both to learn about her patient and to learn how to meet the psychological needs of the family. She can do much to establish confidence if she accepts this as her responsibility and is given the chance. She must have the opportunities to apply knowledge if it is going to become integrated. Also, if we believe in behavioral dynamics we will provide an opportunity for her to discuss her plan with the person teaching her—the head nurse or supervisor. One of the best devices for bringing about orderly arrangement of thought is the opportunity to express one's ideas. Let the student use the teacher "to talk out her plan." Give her freedom to express herself. We all know that sometimes when we are trying to express our thoughts on a subject, we get ideas, that is, thoughts pop to the surface that we were scarcely aware we had. Do that for the student; be a good listener and be helpful by manner and suggestion in a give-and-take atmosphere so that she may organize a plan for patient care that utilizes the very best in her. Give her freedom within her life space. To meet such a situation will call for an organization (a structuring) of knowledge, a weaving together of all these relevant factors into a desirable pattern of behavior in caring for that individual patient and his needs; this may be an integrating experience. This is something we cannot take hold of and shape. We cannot mold character or abilities, but we can provide experiences where the student may develop into an integrated person. The best measure of the success of such a plan is the way in which the product, that is the nurse, meets other situations.

This kind of clinical situation affords the opportunity for at least four kinds of learning: (1) a change in cognitive structure (knowledge); (2) a change in motivation (learning to like or to dislike); (3) a change in group belongingness (this is important in growing into the profession); (4) learning the meaning of voluntary control of the body musculature (acquiring skill).¹⁵

I realize that no set formula has come out of this discussion, but rather we are asking you to apply some of the fundamental concepts concerning the individual to your clinical teaching method. The "nursing situation" gives us the direct experience so valuable in assisting the student to derive meaningful learning on the basis of many interrelated experiences. This experience is a life situation that brings things together that belong together; it affords an opportunity to see them in their rightful relationship; generalizations may be made from experience; it favors integration. According to Lewin, integration is a pattern by which education links theory with reality.

In closing, let me say that we should concern ourselves with method but not just "how it is done"; let us go deeper into it and find out why we have any reason to expect certain methods to assist us in reaching our goal.

WHAT SHALL CONSTITUTE ADVANCED PREPARATION FOR NURSING?

R. LOUISE MCMANUS, R.N.

Fifty years ago the first university program for graduate nurses was established at Teachers College, Columbia University, because a group of pioneer nurses and a forward-looking dean of a school of education recognized the need for advanced preparation for positions of leadership in the rapidly growing profession of nursing. The question before us today—"What shall constitute advanced preparation for nursing?"—I am sure demanded serious consideration then too. Although the nature of our advanced programs in colleges and universities today may be markedly different from that first program, it is not unlikely that the purposes of our program are substantially the same—the preparation of graduate nurses for essential professional functions which are in advance of those required at the moment of the rank and file of the professional group and which help the profession as a whole more effectively to meet society's need.

The interpretation of the word "advanced" here assumed is exceedingly important, for it implies planned forward movement from one plane or status toward known and accepted goals. This is in contrast to other meanings of the term, which have primarily time and quantity connotations. Two points of reference always need to be made clear in discussing the term "advanced"—in advance of what and toward what?

The base line or starting point for an advanced program, the NLNE Committee on Postgraduate Nursing Education has said, should be the basic nursing program. I should like further to define this criterion by proposing that the point of departure be considered the level of the average basic preservice professional program and should advance the student toward a degree of professional competence beyond that expected of the average graduate nurse for new functions that are on the growing fringe where the profession is striving to meet changing social needs or for functions other than nursing but needed in specialized positions which nurses must hold. A program set up to provide opportunities for graduate nurses to supplement their preparation in those areas in which their basic nursing programs were partially or totally deficient does not meet this criterion. Even though the instruction and practice experiences provided are new to the nurse, the function of a supplementary program is to bring her up to an average basic nursing level competence only. A program which is concerned merely with an added period of study with more and more of the same kind of practice is not an advanced program either.

Many programs for graduate nurses have been, and unfortunately still are, of the added experience type; they provide merely for an extended period of repetitive practice, with few new learning experiences provided as a part of the planned program. Though we learn only through experience, it is true that not all experiences are educative, John Dewey has cautioned. Experi-
ences which are repetitive to the point of routine, which present no problems which demand thinking and reasoning, and which require only an almost automatic response not only are not educative but are miseducative. Research on the effect of experience on professional judgment in nursing clearly showed that professional practice or experience alone did not increase the graduate nurse's judgment. There was found no increment in judgment associated with years of experience. The emphasis in the basic program of the nurses studied had so concentrated on teaching and testing facts, that habits of memorizing facts had been fixed. Repetitive practice had provided for so much overlearning that the ability to recall factual information tended to increase with practice, rather than to drop off as might be expected from the curve of forgetting.

When the group who, as graduate nurses, had had some form of organized study interspersed with practice, was isolated and studied, there was found a measurable increase in judgment.

The second criterion proposed, therefore, is that advanced programs should provide new learning experiences, and these should include organized instruction which gives meaning to associated previous experience or concurrent practice, and should provide problems which demand solution by reasoning. The use of the term "nursing education program," as a synonym or general term for all advanced programs for graduate nurses, when "educational program for nurses" is meant, has caused considerable confusion. Many programs do prepare nurses for educational positions as teachers and administrators of nursing schools and directors of in-service educational programs for nursing service agencies; these are rightly nursing education programs.

Other educational programs prepare nurses not for educational positions but for nursing service positions, as head nurses, administrators of nursing service in hospitals and public health and other community health agencies. Still others prepare nurses for professional practice as specialists in clinical nursing fields. The fact that nurses who go into educational and administrative positions must forsake their practitional status is reflected in the kind of program offered to prepare them for their functions. Preparation for educational or faculty positions and for nursing service positions, while in advance of basic nursing, involves in reality an entirely new field of study, predominantly involved with principles and methods of teaching and/or administration, with sometimes little or no emphasis on advanced study of nursing practice. Doubts whether such programs are advanced nursing programs have been side-stepped at times by using the term "advanced programs for nurses." Similarly, doubts about the advanced nature of some of the advanced clinical programs have been side-stepped by calling them "programs of advanced study of clinical nursing." In any event, there is agreement that the positions prepared for are beyond those expected of the average professional nurse.

Advanced preparation in academic subjects or fields usually implies a con-
centration upon an ever-narrowing area of specialization, with the simultaneous acquisition of a greater depth of meaning or breadth of viewpoint in relation to the subject studied. This might be likened to digging deep into a mine to find a priceless jewel or new fact, or to climbing a cone-shaped mountain to achieve a vantage point of ever-wider vision. Professional education, however, differs from academic or general education. In professional education, the essential criteria for content is its utility, for it is concerned with whatever content is needed to prepare the worker to practice his profession. In contrast to the analogy for general education, professional education may be likened to drilling an oil well to establish a continuing supply of fuel for the work of the worker, as well as building high on the mountaintop a radio tower to disseminate knowledge. The function of professional education is to shape and sharpen the tools of service that the professional worker can precisely render the service needed. This necessitates a selection of content in relation to the specialized task to be performed and organization of content toward its use in professional practice, rather than content selected and organized for systematic study and exploration of the subject matter field.

Advanced programs in academic fields and professional fields alike have as prerequisites the completion of an acceptable program leading to a baccalaureate degree, and are offered in graduate schools in universities. Although less than 10 per cent of the schools of nursing preparing R.N.'s offer degree programs and the average status of graduate nurses is below this level, I should like to propose as a standard (in the sense of a banner or standard which leads us on and which we are willing to follow), that to the point of departure or base line for advanced programs we add the desirable standard of a baccalaureate degree which qualifies for admission with an advanced student status in universities. Increasingly, the majority of nurses will meet the prerequisite for advanced programs through basic professional collegiate programs, professional in their true sense as implied by Dr. Brown.\(^1\) For some time to come, however, many nurses must first prepare academically through undergraduate programs in general education, together with supplementary nursing programs, to bring themselves up to full professional status, that is, the level equivalent, in both areas of preparation, to the product of the average collegiate school of nursing. If this new standard is accepted, few of the programs which now prepare nurses for educational and administrative positions or clinical specializations will qualify as advanced programs, for they do not have as prerequisites full professional status including a baccalaureate degree.

Is it the standard that is too high? Or is the level of our programs too low?

There is considerable disagreement in many professional fields as to the

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unique qualities which characterize advanced content. I recently saw a graph prepared by and based upon an intensive study of developments in education made by Dr. Mort, Director of the Metropolitan School Council. This graph portrayed a time span extending from the first recognition of a need for fifty years up to the time when, after many trials and errors, a satisfactory way of meeting the need was invented or devised. It took the next fifteen years for the new method or educational principle to reach and be accepted and utilized by 3 per cent of the schools. During the next period of from fifteen to twenty years, there was an increasingly rapid diffusion of know-how, so that by the end of from thirty to forty years it had been accepted by all but a few backward schools.

Having this assignment in mind, I suddenly saw in his data what seemed to me to be a reasonable clue to the definition of advanced content in professional nursing, in fact in any professional field. Advanced content includes the facts that have been discovered, information, concepts and principles that have evolved, methods and know-how that have been invented and devised, which, although they have been proved successful and are known and accepted in a limited number of the research centers, have not yet reached the stage of more rapid diffusion to many other schools of nursing. Professional meetings and conferences and professional journals, books, and other publications, are tools of diffusion but the most strategic tool is likely to be the advanced programs for nursing. The main function of advanced programs for nursing, it appeared to me, was at once twofold: to do research to unearth new facts, to devise new methods to meet nursing needs, and to speed up the dissemination and diffusion of know-how as rapidly as possible, thus reducing the socially costly lag between invention and widespread use.

I tested my theory or idea on Dr. Mort, and he said that although he hadn’t thought of it in just that way, it was a logical inference from the data. In fact, he said, the very questions which were asked Ph.D. candidates five years ago to test their advanced knowledge of education, were now questions the answers to which we expect every bachelor’s or master’s degree candidate to know, and in a few years would expect every classroom teacher to know. If this theory is accepted, the lag between the discovery of the fact or the invention of an improved method and the application of the discovery so that the patient may have the benefit of it can be effectively reduced by the simultaneous extension of professional knowledge through research in nursing and the extension of opportunities for advanced study of nursing.

Advanced programs must prepare nurses for methods of research as well as for methods of teaching and administering educational programs in schools and nursing service agencies.

There is more agreement about the methods of advanced education than about content. The changing demands of people for services of professional nurses make it impossible to predict all of what the student will need to know after graduation. Educational methods should start the student on a
program of self-education by giving fundamental principles and insights and by establishing habits of thinking and reasoning about nursing problems that will enable her to continue to learn and to improve her judgment. In advanced programs emphasis on educational methods should be focused on the development of ability to solve professional problems, while emphasis on content should be focused on the social and human as well as the technical aspect about professional problems.

These then are the proposals in answer to "What shall constitute advanced preparation in nursing?" Advanced programs shall have as prerequisites graduation from an approved basic professional collegiate school of nursing or equivalent supplementary program. They shall be of a type and level equal to instruction in other graduate professional schools and they shall lead to an advanced degree. They shall provide for selected individuals learning experiences new to the student, and shall prepare her for a position in advance of any for which a graduate nurse can qualify without special preparation.

The content of advanced programs shall be concerned with whatever is needed to prepare professional nurses to perform their nursing functions with a higher degree of competence and expertness than is expected of every professional nurse, or for any added functions demanded of nurses in specialized educational and administrative positions in schools of nursing, nursing service, and other community service agencies. Advanced programs shall use methods which enable the student to be self-directing toward her own goals and establish habits of self-education, methods which equip her to continue to improve her own knowledge and practice and to add to the body of scientific professional knowledge essential to the improvement of nursing practice.

Both content and method in advanced programs shall be so related that they provide for the integration of humanistic and social, technical and professional content which will promote growth in professional and personal stature and prepare for leadership for constructive action on social and professional programs.

The purposes of advanced programs shall remain unchanged—the preparation of nurses for specialized functions which will enable them continually to promote the professional status of nursing while improving nursing and health services rendered to individuals, families, and communities.
MORNING AND AFTERNOON SESSIONS
Thursday, May 5—9:00 a.m.—4:30 p.m.

LEADERSHIP TECHNIQUES

Presiding: Frances H. Cunningham, R.N., President, Ohio State League of Nursing Education

Leaders:

Marjorie B. Davis, R.N.

Alvin P. Zander, Ph.D., Program Director, Research Center for Group Dynamics, University of Michigan, Ann Arbor, Michigan

Max Goodson, Ph.D., Assistant Dean and Coordinator of Research and Service, College of Education, Ohio State University, Columbus, Ohio

Participants:

"Actors" selected from the group in attendance to assume parts in the scenes

The setting for the session was introduced as a particular problem supposedly presented by a conscientious board member of a city hospital who had come to the group for help. It was a typical 300-bed general hospital and it had a typical board of trustees particularly proud of its course for practical nurses. How could the group help him? Why not try out various ways of meeting the problem—learn from experience in the situation without "playing for keeps"?

As a device for increasing audience participation during the session, it was suggested that three different kinds of spectacles should be worn by the three different sections of the audience. The center section was asked to look through spectacles centered on the practical nurse and to try to think and feel as the practical nurse did during the situations as they were developed. The right section was asked to focus attention on the board member in the same way and the left section on the director of nurses.

The succession of scenes developed throughout the morning may be briefly described. Roles were selected by the participants but the scenes moved spontaneously on the basis of the work experience of the role players. There was no script to follow.

Scene 1: To give background to the precipitating incident (which was the removal of weights applied to a leg fracture because the practical nurse was trying first and foremost to "make the patient comfortable"), it was necessary to go back into history a little.

The scene showed a class of practical nurse students with their instructor who was reviewing the points she had covered in previous sessions and
stressing the importance of ethical conduct and practical decorum. The place of the practical nurse in the hospital hierarchy was emphasized. She saw herself at the low rung on the ladder even though the team concept was introduced and her place made important. Her field of activity was reviewed and the importance of making the patient comfortable was hammered home. Questions and answers were exchanged between the instructor and the class members. Scene cut.

Scene II: Several weeks later and after some experience on the hospital wards we look in on the practical nurses as they are indulging in a typical dormitory "bull session." The comparison of different head nurses and their methods of leadership was an early topic. Remarks such as these were overheard:

"Miss So and So do this and do that—just one thing after another. No one knows who is to do what."

"That is not true on my ward. Miss X makes the assignments and we know just what to do."

"Why can't we do what we're taught? Why are we there at all if they can't trust us?"

"Why can't we know what's wrong with the patient? They think we're stupid. I was bawled out for picking up a chart. The student nurses are told these things."

Then came the precipitating event.

"Guess what happened to me! The patient asked me to take off the weights, so I took them off. She was terribly uncomfortable and that's all we hear—make the patient comfortable. She was crying and upset."

"How'd they find out about it?"

"Well Dr. . . . . . . came along just then and was he mad! But if a student nurse had done it they would have said, 'Oh, Miss So and So we don't do that. . . . .'"

A little thought about this session revealed a great deal. There were no inhibitions. Remarks flowed free and fast with considerable heat generated. Scene cut.

Scene III: This scene opened with a soliloquy by the director of nurses. She was worrying about the whole problem of the interrelating roles and the particular situation which had just been reported to her. This was one of a series of events, all very real, all pertinent to future relationships and progress in nursing service. "What should I do about it?"

The head nurse then appeared at the director's office to report the incident in detail. The director was reminded that this was not the first time the same practical nurse had been "too helpful." She was very well liked by the patients, however.
DIRECTOR: Did you explain why we don't do it?
HEAD NURSE: I didn't thoroughly. I didn't have time. Dr. ....... was very upset. The patient has been uncomfortable and very hard to please.
DIRECTOR: Do you wish me to talk with Miss .......? The matter of weights is important but there is a bigger problem than that. It has a deep and broad base. We find it easy to criticize the practical nurse but there must be some indication of a lack of understanding on our part. It is one thing to teach them in class and another to follow it through. It is the same with the student nurses.

Scene cut.

Scene IV: A woman board member who is also a member of the committee concerned with the practical nurse course drops in unexpectedly to pay her respects to the director of nursing. She is an understanding person and a source of help to the director. The moment is opportune and provides a chance for discussing the incident as well as the underlying causes.

DIRECTOR: We have to think of all that is involved. How can we help the graduate, student nurses and practical nurses to work together? The doctor is rightfully upset. We must consider the patient, her family and of course the hospital's liability. Would it be helpful to discuss it in a group?

BOARD MEMBER: This is a coincidence. I have been thinking a lot about the practical nurse and the team concept. It is close to my heart. How about having an informal group meeting? Get all the persons concerned together and get their ideas on how to handle it.

After further discussion the board member went on to her meeting.

Scene cut.

Scene V: True to reality the doctor then appeared.

DOCTOR: Have you heard about what happened to Mrs. .......? She has a mean fracture. It was all set up right. I spent a long time getting the weights adjusted. Traction has been on just two days and that practical nurse took them off. Can't they leave things alone?

DIRECTOR: Have you talked with her?

DOCTOR: Did I? I'll say I did.

DIRECTOR: This is a big problem. They are taught to do everything to make the patient comfortable. We don't want to lose the human touch, do we?

DOCTOR: You talk to her and have the head nurse do it too. Practical nurses mess up the treatments all the time.

DIRECTOR: Do you think we can work this out more successfully if we let the nurses work it out? Our problem is to teach them and help them
to understand. Doctors and nurses are striving toward the same goal. Commendation now and then might help.

**DOCTOR:** O.K. just so no more weights are taken off. Doctors are very busy and we work hard you know.

Scene cut.

**Scene VI:** Short soliloquy by the director as she thinks out loud about how to use the practical nurses to the best advantage. It is not just a problem of weights, uncomfortable patients, and irate doctors. She decides to go to the ward on the chance of seeing the practical nurse.

Scene cut.

**Scene VII:** On the ward. Practical nurse busy dusting a table.

**DIRECTOR:** Good morning, Miss ......... How are you getting along?
**PRACTICAL NURSE:** (very reticent) Oh, all right.
**DIRECTOR:** May I talk with you a few moments?
**P. N.:** Oh, I'll ask if I can be excused.
**DIRECTOR:** Do you like working with nurses?
**P. N.:** Most of them—I guess.
**DIRECTOR:** Don't you like all of them?
**P. N.:** No one can like everybody. Did I do something wrong, Miss .........
**DIRECTOR:** Miss ......... told me about yesterday's incident with Mrs. ......... I am not criticizing your motives and I know you have been taught to make the patient comfortable. That is very important.
**P. N.:** Yes. Mrs. ......... was crying. She was very upset and very uncomfortable. She felt so much better when I took off the weights.
**DIRECTOR:** You know that wasn't wise?
**P.N.:** Yes, Dr. ......... made that very clear.
**DIRECTOR:** Why didn't you go to the charge nurse and ask about it?
**P. N.:** I didn't think to. The patient was so upset and you can't always find the head nurse.
**DIRECTOR:** Try to think of the practical nurses as part of a whole team caring for the patient. Certain responsibilities are assigned to each member and we get into trouble when we go beyond that.

Scene cut.

These few scenes played off rather rapidly brought out many familiar and salient aspects which lie within the framework of the working relationships of the team. It was desirable now to learn what the three sections of the audience saw through their new spectacles as they watched the action unfold. Each section was asked to break up into informal groups formed by six or eight near-by persons and to discuss for about ten minutes what they thought
the real problem was. Each group was asked to elect a spokesman to report for it.

Group reports given verbally at the morning session were summarized and then mimeographed for the audience to have at the beginning of the afternoon session. This summary appears below.

Practical Nurse Viewpoint

1. She was not given an explanation as to why removing the weights was unwise.
2. She did not know what she could do and could not do.
3. She was not commended when she did what she was expected to do.
4. She needed help on specific practical problems when on the job after her training was completed.
5. She was stereotyped as a person of low intelligence.
6. Too many bosses.
7. Work load too heavy.
8. The function of the practical nurse is not really accepted in this hospital administration.
9. Lack of organization for communication.
10. Functions of student nurses and practical nurses overlap with no clarification of who does what.
11. Conflict in class teaching and ward practice.
12. Lack of opportunity for practice as a member of a team with other hospital personnel, including doctors.
13. Minority group position makes practical nurses feel insecure.

Director of Nursing Viewpoint

1. Director was more concerned with the channels of communication and proper steps in the hierarchy than with solution of the problem.
2. Practical nurse got in a jam because registered nurse did not take advantage of handling situation effectively and of teaching opportunity.
3. Head nurse not skilled in anticipating human relations.
4. Lack of common objectives and values among various levels in the hospital personnel.
5. Horse and buggy administration for supersonic age.
6. Lack of a personnel person back of personnel functions to handle personnel and human relations problems.

Board Member Viewpoint

1. Lack of machinery to take care of the fact that different people see the same problem differently.
2. What is the hospital’s legal responsibility for such mistakes?
3. Can we expand the personnel to help the whole situation—at what financial cost?
The afternoon session began with the team members discussing some of the perceptions that came out of the morning session. These points, condensed, are roughly as follows:

It seems necessary to improve the level of information to make certain that the information that is communicated is scientific and exact, but this alone will not solve the problem that arose in the morning session. That is only one part of it. There were factors within the practical nurse herself that were involved. She had to be helped in dealing with her own personal situation. It is the same in industry. Industry thinks more pay, better conditions and such will solve its problems. Labor frequently thinks likewise, and both avoid the fundamental problem.

What better transfer can we make from the classroom to the reality situation? Provide an opportunity to practice as a team. It is the old problem of getting people in different levels of a hierarchy to learn to work together. The practical nurse cannot learn to work with other members of the team when segregated with her own peers in the classroom. Psychology is the door to human relations, and all sides must be trained simultaneously. It is not just a matter of training the practical nurse but also of training the people with whom she will have to work.

How can we go about this business of training the team members? Many a promising young nurse has been lost to future usefulness because she was assigned to a person whose patterned behavior was not based on good working relationships. The younger nurse follows the wrong example. Can we not try out different ways of being a head nurse? Hospital administrators are running a social system and therefore must be prepared for all the problems inherent in the social system. In the "bull session" the practical nurse was talking with her peers. When she faced the director of nurses she was not able to hold up her end and demand a fair hearing of her problem. If the director had gone to the "bull session" the practical nurse would have had the backing of her group and would have expressed her thoughts and feelings with group support. The director would have had a different grasp of the problem and greater insight in relation to the whole problem. Instead of attending such a session it was suggested that the director could benefit from a suggestion box, from mixing informally at frequent teas and other gatherings in order to feel the pulse of the group.

Where does leadership really begin? Where along the line does leadership exist? It exists everywhere along the line. Every team member is a leader at some point varying with the situation. The potential group power in the "bull session" was impressive but it was not placed within the institution in such a way that it could be used. It is important to release this power so that potential leadership can be spread and thereby strengthen the team.

Does strategy thinking occur all along the way or should the director or administrator determine the goal? Can strategy thinking be spread and decentralized? Goals must be group-decided goals to be acceptable and thus effec-
tive. No one person can set up effective goals in a situation involving working relationships. Resistance is markedly lessened when the group as a group decides the goals to be achieved. The more the participants are involved in the discussion of how they will feel about a proposed change the more the opposition to change is reduced. Too many administrators are holding on to a certain kind of administrative pattern that does not lend itself to modern problems. The participants at the morning session felt sorry for the minority group as represented by the practical nurse.

How much does a person feel blocked? In the "bull session" the practical nurses were almost deliberately distorting the facts about the student nurses so as to make themselves more comfortable—one way of easing the blow to status which is precious to the individual.

The next step at the afternoon session was to take a look at the committee which the director got together to discuss the problem. This scene was one of a series of meetings of this committee. The problem: How to get everybody in the hospital to work together more effectively. Types of persons represented were: director of nurses, board member, practical nurse instructor, doctor, educational director for student nurses, two head nurses, two general staff nurses.

The audience seated on the left was asked to keep in mind: What surprises you as you watch and hear this meeting develop? Can you think of some things which you might expect to happen? The audience seated on the right was to try to determine: How do you think the decisions reached in this staff meeting will be supported by the entire staff? Is it just another group meeting or is there a possibility that it may really change some human relations?

The general tenor of the meeting was that of a typical group called together by the director of nurses who set the scene and for the most part dominated it.

The director called attention to the complexity of the problem. The board member tried unsuccessfully to have her idea accepted for publishing a pamphlet. This pamphlet would describe for the patient the functions of each member of the hospital personnel. Her idea was drowned in the details of the discussion but it served to loosen up the group. The doctor stressed the point that it was more important for the hospital personnel to know what the doctors expect of them than for the patient to know what he can expect of the hospital personnel.

**DIRECTOR OF NURSES:** What would you think of having groups of doctors and nurses meet and discuss some of these things?

**DOCTOR:** All right, but meetings take time.

**DIRECTOR OF NURSES:** Penicillin takes time too but we still use it. It might be worth-while in the end to have some small groups meet every so often.

The committee brought out that the knowledge acquired by the practical
nurse assigned to a nursery over a long period of time places her in a position to dictate to the new student nurse. Will this result in lesser prestige for the student nurse? How can this be handled successfully? Scene cut.

A few minutes was provided for a buzz session of small informal groups as was done in the morning. Group reports were then heard and can be summarized to cover the leading points.

They were surprised:

1. That the practical nurse was not in a position to teach.
2. That practical nurses were not represented in the meetings.
3. At the rapidity with which the graduate nurse accepted the practical nurse when she understood her function.
4. That the board member continued to participate when rebuffed so consistently.
5. That the hospital administrator was not represented at the meetings.
6. At the change of the director’s attitude toward the doctor since the morning session.
7. At the doctor’s ignorance about the situation and about the need for good relationships in general.
8. That the objectives were not well defined.
9. That the committee members lacked spontaneity even after several meetings together.
10. That the doctor stayed until the end of the meeting.

Will the conclusions reached be supported, and have the human relationships been improved? They thought:

1. There was definite group recognition of a real problem and an effort made to solve it.
2. The board member did not dictate. She only asked for group participation.
3. The conclusions were not clearly defined enough to gain support of the staff later.
4. There was a basic feeling for people as individuals.
5. There was a real desire to work together but they didn’t know how to get started.

Final random comments from members of working team:

Role playing in situations where it is not for keeps is an effective way of getting involvement. Deliberate retraining of people is needed before they can be good team members, and role playing is one way of doing it. How does it happen that we develop hierarchical systems and continue their support? Hostility develops when lines of communication fail between people and groups and misunderstandings are developed and nurtured. This creates a breach that continues to support itself because those involved frequently avoid each other. A chairman often unwittingly keeps people apart by inter-
jecting his own ideas. Statements such as "I felt dumb as the dickens" are symptoms of insecurity, and a way must be found to give people a feeling of their own worth. People do act pretty much as you expect them to and must have a chance to participate in making plans if they are expected to cooperate.

The problems of status, cohesiveness and social pressure brought out in these sessions are the same as those found everywhere in every group. Actually we had an experience in analyzing cause and effect. We took apart a problem in human relations and saw the basic principles come up startlingly.

**AFTERNOON SESSION**

**Thursday, May 5—2:00—4:30 p.m.**

**FEDERAL LEGISLATION**

*Presiding:* HAZELLE B. MACQUIN, R.N., Dean, College of Nursing, University of Utah, Salt Lake City, Utah

*Speakers:*

L. E. BURNEY, M.D., Secretary and State Health Officer, Indiana State Board of Health, Indianapolis, Indiana

EUGENIA K. SPALDING, R.N., Chairman, Committee to Consider Federal Legislation on Nursing Education

**FEDERAL LEGISLATION FOR NATIONAL HEALTH**

L. E. BURNEY, M.D.

Probably no previous American legislative body has been faced with more important decisions affecting the health and welfare of its constituents than is the 81st Congress. Not only must some disposition be made of the many new proposals and programs involving millions of people and millions of dollars, but also lying on the desks of present Congressmen are the printed symbols of problems and questions which have lain unanswered for as long as ten years. Some of them are highly controversial. Most of them are far-reaching in effect. Washington observers, in the main, seem to agree that the time for decision has come. The 81st Congress must say "Yea" or "Nay."

A long array of education, health, and welfare bills await action. Compulsory health insurance; subsidization of medical, dental, and nursing education; financial assistance to states and counties in formation of local public health units; creation of a Department of Human Resources, encompassing all federal health, education, and welfare activities; establishment of insti-
tutes for the study of cerebral palsy, multiple sclerosis, infantile paralysis, and perhaps other diseases just as the government now has institutes in cancer, heart disease, dental problems, and mental hygiene; prospective reorganization of the entire federal medical establishment, both military and civilian, along lines to be recommended by the Hoover Commission—these are a few of the issues with which the Senate and House will have to deal.

Not a few of these bills represent new or changing concepts of the role of government in the lives of all of us. Or, if the concepts themselves are not new, at least they represent extensions of old concepts, extensions of ideas tried out in one field into an adjacent or related area. Involved in many of them are these questions: To what extent am I singly, without assistance, responsible for my own health, education, and welfare? To what extent am I responsible for the health, education, and welfare of my neighbor? If in one or more of these areas I must help my neighbor and in turn ask his help, how far afield should I go? How broad must the organization be? Can the local community carry the burden alone? Do we need help from the state? Where and when should the federal government step in?

We are not here, of course, to come to a unanimous decision on all these points. We shall continue to make up our own minds on the basis of the facts as we become aware of them just as our representatives in Congress are trying to do. On one point we are probably agreed. And that is that no matter how you phrase it, the paramount question revolves about the role of government in health. On this issue hangs most of the debate.

Abraham Lincoln stated, "The legitimate object of government is to do for a community of people whatever they need to have done but cannot do at all or cannot do so well for themselves, in their separate and individual capacities."

Broader participation of the federal government on the state and local social scene has come to mean different things to different people. To some it means help. To others it bodes unwarranted interference. To the first group it means the ability to carry out programs previously impossible, or at least difficult, because of the lack of funds. To the second, it is synonymous with higher taxes. To the first, joint responsibility; to the second paternalism. Many feel that it is new and hence a little dangerous.

History

But let us try for a better perspective. Let us look at the history of grants-in-aid, for grants-in-aid are inseparable from government participation since it would be fruitless for government to recommend or suggest certain types of programs without taking into account some method of implementing those programs.

Federal aid to the states did not begin with the Social Security Act of 1935. Aside from land grants made by the federal government during the
first hundred years of its existence, the first federal aid came in 1879, fifty-six years before the Social Security Act. This was for health—for books and apparatus for the education of the blind. Eight years later the government adopted annually recurring grants to states for specialized programs. The following year, 1888, the State Soldiers’ Home Act was passed, an act which provided $100 per year per inmate for the care of disabled soldiers and sailors.

The first of such grants during the modern era came in 1916 with the passage of the Federal Aid Road Act in 1916 to be followed two years later by the Chamberlain-Kahn Act, which provided $1,000,000 to aid in the prevention and control of venereal diseases. We were engaged in the first World War by that time and were beginning to realize that our human resources—essential to national defense and a strong nation—were being sapped and wasted by the ravages of disease.

Very little in the way of federal aid to the states was added during the “Twenties.” Came the “Thirties” and an acceleration of the trend toward governmental underwriting of health and welfare programs, culminating in the Social Security Act of 1935. This act provided $8,000,000 for public health services, an unprecedented sum if not an unprecedented step. The Venereal Disease Act of 1938 authorized $3,000,000 for 1939, $7,000,000 for 1941, and “such sums as may be deemed necessary thereafter for venereal disease control.” It is interesting to note, I believe, that specific health problems, such as the control of venereal diseases and aid to the blind, were the first to receive attention. It is interesting particularly in light of the recommendations of the Hoover Commission which I shall mention in a moment. The policy of attacking public health problems as isolated from the broader aspects of public health has continued. Categorical grants in the amount of $20,000,000 were granted in 1944 to control venereal diseases and tuberculosis. These programs were to be developed in conjunction with the general health services. Mental health research and treatment received federal attention in 1946 when $10,000,000 was appropriated for those purposes. That same year Congress passed and the President signed the Hill-Burton Bill, which provided grants-in-aid to states for the construction and improvement of hospitals and health centers.

This brings us fairly well up-to-date. I have enumerated only those proposals which received favorable Congressional action. Introduced since the Social Security Act was first passed were many other proposals upon which no final decision has yet been made—voluntary health insurance, compulsory health insurance, aid to local health units, and so on.

**Philosophy**

Federal grants-in-aid then, if land grants are included, are as old as the nation. They comprise but one segment of the whole field of intergovern-
mental financial relationship. If we are startled by what appears at first sight as a veritable avalanche of federal grants, we have only to remember that they have grown as the nation has grown. The increasing complexity of our society increases interdependence. Rapid developments in communications and transportation, bringing us all closer together, have subjected us to the influence of our neighbors more than ever before. The weakness of our neighbor bears more heavily upon us because we are closer to him. We no longer live, speaking metaphorically from the health standpoint, in air-tight compartments, in our own private little isolation wards where time and distance may separate us from contagion. We are as close to an outbreak of smallpox in California as the fastest airliner.

Economically and industrially the idea of complete self-sufficiency is a fallacy. The industrial development of the northern extremity of my own state, Indiana, was dependent upon cheap and ready access to the ore mines of Minnesota and the coal of southern Indiana, Kentucky, and West Virginia. These are accidents of geography and not entirely of our own making, although we must admit that initiative and vision were necessary if the geographic potentialities were to be realized.

Advances in technology have necessitated new procedures and new breakdowns. Industrial provincialism is a thing of the past. The area which possesses the raw material, the natural resource, is dependent upon that area which possesses other advantages necessary to processing the particular raw material into one of a multitude of its final forms. The processing depends among other things upon a labor supply; the finished product needs a market, and the market today may be the entire world.

The philosophy of grants-in-aid is based upon this interdependence. We know that the imaginary lines separating states do not provide adequate quarantine guarantees in case of contagion. It is almost superfluous to say that our very way of life depends upon a high level of health and education throughout the land and not just in my neighborhood, my town, my state.

**Attitude Toward Grants-in-Aid**

What has been the effect of federal grants-in-aid in those areas where they have been applied? What do the people who have been responsible for administering grants-in-aid think?

The Council of State Governments sent questionnaires to state departments handling grants-in-aid. The council asked the following questions: (1) Has federal aid stimulated state activity? (2) Has it improved state standards of administration and service? In answer to the first question, 94 per cent stated that federal aid had stimulated state activity. Even more of them, 95 per cent, believed that in the field of public health federal aid had stimulated state activity. Seventy per cent believed that on the whole federal aid had improved state standards of administration and service. A higher per-
percentage, 78 per cent, believed that aid to public health had improved standards in this field.

These same two questions had been asked twenty years ago in a National Municipal League study of the opinions of 264 state officials cooperating with the federal government under provisions of seven federal aid statutes. Questions in both surveys were phrased identically. These answers given in 1948 were substantially the same as those I just quoted. During the twenty-year interval there has been no significant change in attitude. Slightly more than two thirds of the state officials believed in 1928, and continue to be of the same opinion, that federal aid has proved of value in improving state standards of administration and service.

The Council of State Governments' questionnaire contained this question: "Has federal aid led to federal interference in state affairs?" About 65 per cent replied in the negative. Eight and one-half per cent thought interference was small and probably unavoidable. Fifty-two per cent believed that the system of federal grants should be expanded. The majority preferred, however, that one grant for general health be given rather than a number of specific grants. Almost 70 per cent of those queried replied that federal aid does not tend to unbalance over-all state programs. Here again several health agencies suggested that many piecemeal grants for public health be replaced by one general grant. State agencies replying were overwhelmingly in favor of state budgeting and control of federal-aid funds.

**Hoover Recommendations**

Apparently some of the state officials completing the questionnaires anticipated the Hoover Commission on Organization of the Executive Branch of the Government. The Hoover Commission in its report to Congress on "Federal-State Relations" made the following recommendations:

We recommend that the grant-in-aid plan and program be clarified and systematized.

A system of grants should be established, based upon broad categories—such as highways, education, public assistance, and public health—as contrasted with the present system of extensive fragmentation. There are now at least 3 separate and distinct grants in the realm of education, at least 3 in public assistance, and 10 in public health. Grants for broader categories would do much to overcome the lack of balance now readily apparent.

**The Social Legislation Information Service Bulletin** of April 11, 1949, carries this story on the Hoover report:

In its appraisal of the grants-in-aid method, the Commission noted that it has stimulated states and localities to provide necessary public services; has decreased inequalities of service through some redistribution of resources from states that have superior means to those that lack them, and by providing standards to raise the level of all aided services; and has served to improve the administration of many state activities. In its list of liabilities, the Commission stated that grant programs have developed in a haphazard manner and are uncoordinated.
To correct these conditions, the Commission recommends that a federal agency on federal-state relations be created with primary responsibility for study, information, and guidance in the field of federal-state relations. This new agency would appraise our public needs, our resources, and ways and means for adjusting the one to the other in the interest of the American people.

I might add at this point that in 1915 federal aid totaled $5,488,000. Preliminary figures for 1947 totaled $1,208,200,000. Of that amount slightly over $33,000,000 went for public health. In the amount of federal aid, public health grants were considerably lower than those to highways, agriculture and forestry, old age assistance, aid to dependent children, unemployment compensation administration, employment service, and school lunches.

Local Public Health Services Bill

The Local Health Units Bill, as you may know, is sponsored by the National Congress of Parents and Teachers. It is endorsed by the American Medical Association, the Association of State and Territorial Health Officers, the American Public Health Association, and many other organizations.

Public health measures, by and large, are those which are taken to protect the people against health hazards that require systematized community-wide action. Senate Bill 522 would provide federal aid to encourage and assist each state in setting up and maintaining a system of local public health departments providing basic full-time public health services in all areas of the state. Assuming that basic public health services can be provided for $1.50 per capita per year, S. 522 calls for an appropriation of sufficient federal funds to meet the federal share of such cost. The federal share would vary according to the financial need of each state for assistance. Each state would be called upon to prepare and submit to the Surgeon General a plan to accomplish the objectives of the bill. This would be done in a similar manner as were the state plans for hospital construction under the Hill-Burton Act, which has proved that hit-and-miss expansion or construction can be avoided.

You are familiar with the public health scene and know that there, as well as in the medical, dental, and nursing professions, personnel shortages are crucial. S. 522 seeks to overcome this by providing for the training of needed personnel.

Briefly stated, then, the purposes of this bill are to help the states develop and maintain local public health units which will provide basic full-time public health services in all regions of the nation and to assist the states in training public health personnel.

The state plans which must be developed and approved before funds would become available must provide for allocation of federal funds to be received in accordance with methods assuring equitable distribution among local units. It has been estimated that if this bill were to pass today, it would entail an expenditure of about $25,000,000 in federal funds. Ultimately, when full coverage is achieved, it would cost about $77,000,000 annually.
School Health

Two bills have been introduced, one in the Senate and a companion bill in the House, which would provide federal aid for the development of school health services. Such services would include medical and dental examinations and possible treatment of physical and mental defects of children between the ages of five and seventeen. It has been estimated that there are approximately 29,000,000 children in these ages. Here again a state plan setting forth a school health program to accomplish the purposes of the bill must be drawn up by the states. In addition to the examinations for all children, treatment must be provided for those unable to pay in whole or in part. Treatment may be provided without regard to the ability to pay, but, in any case, whatever services are offered must be offered without regard to race, creed, color, nationality, or the location or character of the school. The bill would provide $33,000,000 for the fiscal year ending June 30, 1950, and a like sum for each fiscal year thereafter to be distributed among the states which submit plans complying with the provisions of this bill. Allotments to the states will be determined on a formula considering factors of child population and relative per capita income. No state will receive more than 75 per cent of the total cost of its program nor less than 35 per cent.

Hospital Construction

Since passage of the Hill-Burton Act of 1946 more than 650 hospital units have been planned or placed under construction. H.R. 4126, introduced by Mr. Lemke of North Dakota, would amend the Public Health Service Act to increase federal payments for the construction of hospitals and for other purposes. It would increase the federal minimum contribution from 33⅓ per cent to 50 per cent and appropriates such sums as may be necessary to increase the allotment to each state.

A Senate bill, S. 614, asks for an extension of the Hill-Burton Hospital Survey and Construction Act and for twice the financial aid granted during the past three years. Among other things, the bill specifically provides: (1) an extension of the Hill-Burton Act six years beyond the first three years, and (2) an increase in federal appropriations from $75,000,000 to $150,000,000 a year.

It would seem now, from the many efforts to expand and extend its provisions, that the Hill-Burton Act, or the Hospital Survey and Construction Act, has thus far been highly successful.

Aid to Medical Education

Another approach toward solving the nation's health problems is being made by Representative George A. Smathers of Florida. He has introduced H.R. 2045 which would appropriate over a three-year period $60,000,000 for structural expansion of medical schools and construction of new ones.
The program would be administered by the Office of Education, Federal Security Agency. Representative Smathers has also introduced H.R. 1779, a bill to provide federal loans to medical students covering tuition, books, subsistence, and other necessary expenses and which would be repaid in installments beginning ten years after graduation.

Science Foundation

The objectives of such a foundation would be to permit the federal government to keep abreast of modern scientific developments, to provide for stimulation and coordination of medical research, and to encourage scientific education through the award of scholarships and fellowships for research work.

Murray-Wagner-Dingell Bill

The most controversial of all proposed health legislation, the Murray-Wagner-Dingell Bill, has been proposed in each Congress since 1938. Designed by its authors to provide health insurance by a payroll deduction plan, the bill during its various experiences in Congress has been changed only slightly. Introduced as the "National Health Insurance and Public Health Act of 1949" and sponsored by Mr. Wagner, Mr. Pepper, Mr. Chavez, Mr. Taylor, and Mr. McGrath, S. 5 provides medical, dental, home-nursing, hospital, and auxiliary services to all covered by the plan. Participation of the public in the plan is determined on a basis somewhat similar to that set up for social security. For those of the general public whom the bill is designed to cover, participation is compulsory. Physicians and dentists are free to participate or to practice outside the plan as they desire. A patient who is eligible, that is, one covered by the plan, may select the physician, dentist, nurse, medical group, hospital or other person of his choice to render services and may change his selection, "provided, that the practitioner, medical group, hospital or other person has agreed . . . to furnish the class of services required and consents to furnish such services to the individual." (Sec. 203)

New Compulsory Health Insurance Bill

Approximately two weeks ago the successor to the Murray-Wagner-Dingell Bill, S. 1679, was introduced. This is the administration's omnibus health bill containing provisions for aid to additional institutions, students in medicine, dentistry, and the health sciences, hospitals and the states. The chief sponsor is Senator Elbert D. Thomas of Utah. Co-sponsors are Senators Murray, Wagner, Pepper, Chavez, Taylor, McGrath, and Humphrey.

It has been announced that hearings by the Senate Labor and Public Welfare Committee on compulsory health insurance and the three voluntary program bills will begin May 16.
Voluntary Health Insurance

In an effort to correct the inadequacies recognized to exist, Senators Hill, O'Connor, Withers, Aiken, and Morse have joined to sponsor what is known as the Voluntary Health Insurance Bill. This is S. 1456 and it authorizes grants to enable the states to survey, coordinate, supplement, and strengthen their existing health resources. The bill proposes the allocation of federal funds to states so that state authorities may secure voluntary hospitalization and sickness insurance for persons unable to pay the costs of medical care in whole or in part. It is designed to make hospital and medical care available to all by:

1. Providing protection to persons financially unable to pay all or part of subscription charges for prepayment of hospital and medical care;
2. Stimulating voluntary enrollment in prepayment plans for hospital and medical care emphasizing:
   a. employer participation in transmission of subscription charges
   b. enrollment in rural areas;
3. Strengthening and coordinating existing health resources.

At the federal level the program would be administered by the Surgeon General of the Public Health Service.

A Federal Hospital and Medical Care Council of 10 persons (2 doctors, 2 hospital administrators, 2 prepayment plan executives, 4 consumer representatives) will share responsibility with the Surgeon General in developing these broad policies of the program.

At the local level the program is to be administered by a state agency which may be the same agency now administering the Hill-Burton Hospital Survey and Construction program in the state. This agency is to have a council with representation similar to that of the Federal Hospital Care Council. In addition, the states are to be divided into regions in which complete hospital and medical services are available. Within each region a Hospital and Medical Care Authority will operate as a unit of the state agency. The authority will be composed of persons residing within the region including representatives from as broad a segment of the population as possible.

To finance the program, federal funds are to be matched on a variable percentage by funds from within the states. The same formula is used as in the Hill-Burton Hospital Survey and Construction Act, which provides that a higher percentage of federal funds will be available to states with lower per capita income. The state plan must provide that the state itself will put up at least 50 per cent of the matching funds so that half or less than half of the matching percentages will come from the local communities.

National Health Bill

As to American government, we recognize that the primary responsibility in the field of health, welfare, education, and housing rests with the state governments,
and that there is no direct grant of power to the federal government in the Constitution to deal with these questions. On the other hand, the federal government does have an extensive spending power arising out of the provisions of Article I, Section 8 of the Constitution, giving the Congress power "to lay and collect taxes, duties, imposts and excises . . . to provide for the general welfare." The extent to which a state desires to provide health and welfare services to its people is a matter for such state to determine. When the states in general fail to meet any basic health or welfare problem, however, because of inability to finance a satisfactory method of dealing with it, the secondary obligation of the federal government comes into play, and it is the right of Congress to relieve the deficiencies of the states. This is a long way from proposing a "welfare state," in which government undertakes to supply all the wants of the people. We do not feel that there is either a duty or a power to undertake such a program. In general, our constitutional form of government and the danger of centralization forces a clear distinction between federal participation and over-all federal control.¹

A National Health Agency is created, to be under the direction of an administrator appointed by the President with the consent of the Senate. The administrator must be a doctor of medicine, outstanding in medicine and administration.

Five million dollars are authorized for surveys by states of their existing medical, dental, and hospital services. State plans are required based upon findings of the survey.

These plans must present a five-year program for broadening the distribution of medical and hospital services so that the services are available to all individuals and families unable to pay the entire cost of such services. Dental care may be included in the plan.

Seventy-five per cent of the funds must be used for the development of the medical and dental aspects of the plan. These services may be carried out through voluntary health insurance plans or other public or private agencies in the form of insurance premiums or otherwise. Partial charges may be collected from beneficiaries able to make partial payments for the services provided.

State plans must be administered by the state health departments. Compliance with minimum standards—merit system for personnel and other minor requirements—is mandatory.

Title III of the bill is similar to S. 1411, the School Health Services Bill. Title IV is similar to S. 614, the "Hospital Survey and Construction Amendments of 1949." This proposes an increase in authorization for construction from $75,000,000 to $150,000,000 and provides a more flexible matching formula.

Title V is adapted from S. 522, the Local Public Health Unit Bill.

Title VI provides for studies and grants for increasing available health man power. This authorizes the payment to medical schools of $500 per student for each enrolled student up to the average enrollment of the past three years and $750 for each student above that average.

¹From a speech by Robert A. Taft, U. S. Senator from Ohio.
Education of Professional Health Personnel (S. 1453 - H.R. 3894)

Federal funds would be provided in this bill for the fulfillment of three programs:

(1) Direct aid to schools for cost of construction.
(2) Appropriations for grants for construction and equipment.
(3) Aid through the states to students for scholarships, including students of medicine, dentistry, nursing, dental hygiene, sanitary engineering and other public health fields.

Under direct aid to schools, funds are included for establishing, maintaining, and enlarging their teaching staffs and for operating their facilities. The formula for allotment is determined from enrollment.

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<td>Sanitary Engineering</td>
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<td>1,200 each</td>
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</tbody>
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Fifty million dollars would be appropriated for scholarships for 1950, the number of scholarships to each state to be apportioned according to a formula.

Fifteen million are included for paying the cost of a practical nurse training program.

Conclusion

Quite obviously the members of our Congress are aware of our health needs. That awareness, undoubtedly, is a reflection of the thinking and expressions of their constituents back home. The multitude and variety of bills introduced indicate an increased interest on the part of the public and an awakened awareness and desire for health protection superior even to what we now have. The steps taken in 1879 when aid to the blind was granted are not being retraced. They are leading on.

The assumption by the government of greater responsibility for the health and welfare of the citizenry will not be laid aside lightly. On the contrary, it is here to stay and is likely to increase.

Federal assistance to the states has definitely opened new vistas in public health. It has permitted research that could not otherwise have been undertaken. It has given us techniques which would have been much longer in coming were it not for such aid. This assistance has provided the means for securing and training personnel to achieve many of the goals which we would not otherwise have won.
The principles underlying grant-in-aid programs are sound. They are the principles of joint responsibility, of interdependence. However sound the principle, the method of application must be equally sound. No statement, no generalization would cover every eventuality. When considering programs for the future, we shall be betraying ourselves and our trust if we blindly consign the solution of all our problems to a benevolent government. The principle of grants-in-aid, let me repeat, is the principle of joint responsibility. That means that the individual, the local community, and the state are not bystanders—they are partners with the federal government. In addition, I am sure that none of us can blandly say that all problems with which we are beset are amenable to solution simply by the acquisition of additional funds from Washington. We must solve our problems issue by issue. We must examine them carefully, determine their nature, decide where responsibility lies, and then try to find a workable solution. If we can solve them ourselves, by all means let us do so. If we have to go outside our immediate borders for help, let us not shy away for fear of a word.

**FEDERAL FINANCIAL AID FOR NURSING EDUCATION**

**EUGENIA K. SPALDING, R.N.**

**Historical Aspects**

Federal financial aid for nursing education is a serious subject. The problems involved are such that they require the best thinking of all of us if we are to make wise decisions.

In general, I hope to review briefly certain historical aspects of this subject which has been assigned to me. Then I will discuss certain steps taken by the profession during the last three years in attempting to clarify its thinking, so as to arrive at generalizations that could be used as guides in studying or preparing federal legislation providing financial assistance for nursing education. This will be followed by a brief review of past and current pertinent legislation, and a comparison of such legislation with the profession’s stated principles. I shall merely mention some other federal legislation that affects nursing education and nurse educators.

Federal aid to general education is not a new idea. The federal government, almost since its establishment, has given assistance of one kind or another to education. However, the Smith-Hughes Act, passed in 1917, seems to be the first federal legislation which has had a bearing on nursing education. This Act provided for agricultural and industrial courses in secondary schools. Some nursing schools, especially in the southwestern part of this country, used funds from this source through their use of facilities and personnel in secondary schools. The use of Smith-Hughes funds was frowned upon by the nursing profession in the beginning because it was
said that this placed nursing on the level of secondary education instead of on the level of higher education.

The first definite federal legislation that provided funds for nursing education purposes was the Social Security Act of 1935. In the beginning, funds appropriated under this Act were used only for the preparation of public health nurses through sponsorship of the U. S. Public Health Service and the U. S. Children's Bureau.\(^1\) Later, especially through the U. S. Children's Bureau, funds provided through the Social Security Act have been used to prepare nurses for educational positions in maternity and pediatric nursing.

No federal legislation of much significance for nursing education was in effect until 1941, when the Training for Nurses Act was passed. The origin of this particular legislation shows the relationship of one activity to another.

In 1940 the Committee on Educational Policies and Resources of the National Nursing Council on National Defense, which later became the National Nursing Council for War Service, made a survey of nursing educational needs and resources. Isabel Maitland Stewart was chairman of this committee. This committee presented nursing education needs to the U. S. Office of Education so convincingly that a bill was introduced into the Congress for the purpose of securing federal funds for nursing education. The Training for Nurses (National Defense) Act was passed by the Congress on July 1, 1941. Under this Act, as you know, the sum of $1,200,000 was appropriated, under certain conditions, for refresher courses, for postgraduate education in special fields for graduate nurses, and to increase enrollment in nursing schools offering basic curricula. This Act was administered by the U. S. Public Health Service.

In 1943 the Bolton Act was passed. This Act provided larger sums for nursing education than had previously been allotted. The purpose of the Bolton Act was to prepare more nurses for civilian and military needs, this purpose to be achieved by condensing essential instruction and experience in the basic nursing curricula, usually requiring 24 to 30 months, and by adding a supervised practice period during which students should gain experience similar to that of graduate nurses in civilian and military institutions. Young women, as you all know, who were recruited through the Bolton Act became the U. S. Cadet Nurse Corps.

The increased enrollment in schools offering basic curricula stimulated by the Bolton Act called for additional faculty members. Funds were therefore allotted for postgraduate programs and refresher courses. Altogether up to March 31, 1949, a sum of approximately 160 million dollars\(^2\) was spent by the federal government on the Bolton Act program.

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\(^1\)Both of the agencies are now units within the Federal Security Agency.

\(^2\)This represents net disbursements as of March 31, 1949. This information was secured from a letter under date of April 22, 1949, from Lucile Petry, Chief, Division of Nursing, Federal Security Agency, Public Health Service.
Public Law 346 (G.I. Bill of Rights) passed June 22, 1944, and Public Law 16 passed March 24, 1943, giving educational and other assistance to veterans, have provided large sums of money. Nursing has profited through the G.I. Bill of Rights. Out of a total of 11,877 nurse enrollees in 1947, 3,757 received benefits. From a total of 11,586 enrollees in 1948, a total of 3,120 nurses were benefited.

The Smith-Hughes and George-Barden Acts (1946) have in recent years provided appropriations for practical nurse training.

Furthermore, such measures as the Mental Hygiene Act and other similar acts now incorporated into the Public Health Service Act and the Maternal and Child Health Acts have made it possible for many graduate nurses to continue their education.

Federal funds have also been spent for research in nursing service and nursing education. For example, in February 1948 a $10,000 grant was given by the Public Health Service to the National League of Nursing Education and the National Organization for Public Health Nursing for a study to develop criteria for the evaluation of advanced psychiatric nursing curricula.

Now we will take a look at the present situation.

Current Legislation and Related Phases

You will recall that in 1947 the National League of Nursing Education Committee (representative of the American Nurses' Association, the Association of Collegiate Schools of Nursing, the National League of Nursing Education, and the National Organization for Public Health Nursing) which had as its purpose the preparation of a Statement of Objectives Concerning Federal Aid for Nursing Education submitted its report in which were set forth certain facts and fundamental principles. Some of these as conceived by that committee in 1947 I would like to review now.

Purposes of Professional Nursing Education. The purposes of professional nursing education as expressed by this committee are as follows:

1. Provision of professional nursing personnel qualified to render a high quality of service in the curative, preventive, and health fields of nursing.

2. Provision of a sufficient number and qualified administrative and instructional personnel for broad training of such professional nursing personnel just described.

Fulfilling the Nursing Needs of Society. In order to fulfill the nursing needs of society the following type of education was considered essential by the committee:

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1. Broad general education and experience, including social science and the physical and biological sciences with great emphasis on the humanities and especially on nursing arts.

2. Preparation of nurses for all types of community nursing service and for administrative and instructional responsibilities in conducting nursing education programs, basic and advanced. It should be noted that this committee did not concern itself with the practical nurse.

It was further stated by this committee in 1947 that in order to prepare nursing personnel as just described, nursing instruction should be coordinate with general education, public and private.

The Public’s Stake in Nursing Education. It was said that the public should assume some responsibility for the cost of nursing education, both in private and public institutions, since the welfare of the public is affected by the quality and quantity of nursing service rendered.

Proposed Purpose of Federal Aid. Emphasis was placed in the stated general purpose of federal aid for nursing education on improvement of professional nursing service through the improvement of programs of professional nursing education, basic and advanced. This committee did not at that time (1947) believe that practical nurse training should be considered in any plan for securing federal financial assistance for the professional nurse group.

Proposed Uses of Federal Aid. The specific proposed uses of financial federal assistance listed by this first Federal Aid “Objective” Committee were for:

1. National studies to determine qualitative and quantitative nursing needs.
2. Preparation of skilled nurses for general staff positions in hospitals and other community agencies and for private practice.
3. Preparation of educational, administrative, and instructional personnel for nursing service in hospitals and other community agencies and for institutions offering basic and advanced nursing education.
4. Provision of educational equipment.
5. Temporary demonstrations, intensive courses, and workshops in nursing education.
6. General research and experimentation in nursing service and nursing education, and research in administration of the program with publication of findings.

Other items emphasized by the “Objectives” Committee in 1947 are the following:

It was emphasized that both privately and publicly supported institutions offering nursing education programs be eligible for receiving federal funds.

The committee believed that federal assistance should be sought for basic
and advanced professional nursing curricula, regardless of sex, color, race, or creed of the officers of administration or students in the controlling institution.

At the time the original objectives were outlined, it was believed that scholarship aid should be sought only for students in advanced nursing education programs. The committee believed that it is imperative to strengthen curricula for preparation of executive hospital nursing service, public health nursing service, and school of nursing personnel, if we are ever to hope to improve basic nursing education.

The committee believed it was not within its province to name the federal agency for administration of the proposed federal funds. It was the consensus, however, that such agency or organizational unit thereof should be one whose purpose is the advancement of higher education.

In regard to the regulation and policy-forming group for administration of the proposed fund, it was suggested that a civilian commission be appointed to include members of the nursing profession. Approximately two thirds of the commission, it was said, should be professional nurses nominated by the six national professional nursing organizations participating in the national structure study. Proposed functions of the commission were listed as follows:

1. To serve as a regulation and policy-forming body.
2. To act in an advisory capacity to the nursing and other technical personnel responsible for administering the funds.

In regard to the proposed distribution of federal funds, it was thought that such funds should go directly to approved institutions from the federal agency administering the federal funds. The reason for this recommendation was because there did not seem to be one appropriate state agency, and also because of the facility in handling funds in this way. The committee was not opposed to the use of a state agency if an appropriate one could be used.

General principles concerning federal aid to nursing education proposed by the 1947 committee, and approved by the national nursing organizations represented on the committee, included such statements as these:

Provision of financial assistance for nursing education must not result in direct federal control of any nursing educational program. The federal statute should state plainly the purposes for which funds are to be used and also that the only federal interest is to see that the money is used for these purposes.

The role of federal aid should be secondary and supplementary to aid from private sources and states.

Regulations and policies set up by the proposed commission should not interfere with educational and nursing service experimentation in individual institutions.

The role of national nursing organizations relative to federal assistance for nursing education was designated by the committee as follows:
1. Suggest policies to guide legislators in drafting federal legislation for nursing education.

2. Develop and publish nursing service and nursing education standards to guide in developing or checking regulations and in solving problems in the administration of federal funds.

3. Study and influence passage or defeat of federal legislation for nursing education.

4. Nominate members for commissions and advisory and technical committees for federal nursing education programs.

5. Keep their memberships informed on matters pertaining to federal legislation.

The role of the state nursing organizations was designated by the following stated objectives:

1. Point out local and state nursing educational needs and make suggestions to national nursing organizations concerning educational policies and standards.

2. Keep members informed on federal legislation concerned with nursing education.

3. Inform U. S. Senators and Congressmen representing their respective states of desirable and undesirable legislation for nursing education.

Upon conclusion of the work early in January 1948 of the National League of Nursing Education Committee to Prepare a Statement of Objectives Concerning Federal Aid for Nursing Education, the League appointed a second committee representative of the six national professional nursing organizations, whose function was to prepare essentials to be included in a proposed bill for federal financial assistance for nursing education. The work of this second committee was completed in January 1948 just before the annual meetings of the national nursing organizations. I urge you to study the essentials proposed by this committee, if you have not done so. A complete report can be found on pages 223-226 of the Fifty-fourth Annual Report of the National League of Nursing Education, 1948.

After the Essentials Report was approved in January 1948 by the six national professional nursing organizations concerned, the American Nurses' Association began preparing a bill based upon them. After the American Nurses' Association began its preparation of this bill a bill to provide federal aid for nursing education, S. 2588, a bill to amend the Public Health Service Act, to provide scholarships for medical education and grants for dental, nursing and public health education and for other purposes, was introduced by Senator Thomas of Utah. This was on April 30, 1948.

On May 30, 1948, a meeting of the American Nurses' Association Special Committee on Federal Legislation was held in Washington, D. C. The Chair-
man of the League's Committee to Consider Federal Legislation on Nursing Education attended this meeting. At this time a comparison of Mr. Thomas' Bill S. 2588 was made with the League's published Essentials on Federal Aid for Nursing Education.

This comparative study showed that the most outstanding advantage of Mr. Thomas' bill was its coverage for the several health professions. This was approved by the several national nursing organizations concerned although it had not been proposed in the Essentials.

This comparison of the American Nurses' Association Special Committee on Federal Legislation also brought out a number of differences between S. 2588 and the "Proposed Essentials for a Bill for Federal Aid for Nursing Education." A statement outlining these differences was sent to each state nurses' association by the ANA Special Committee on Federal Legislation for study.

The 80th Congress (1948) adjourned without S. 2588 coming up for hearing, and the nursing profession did not introduce the bill which had been prepared.

In November 1948 it was learned that the Federal Security Agency was thinking of preparing another bill that might provide federal aid for nursing education along with the other professions in the health field. Representatives of the National League of Nursing Education Committee to Consider Federal Legislation on Nursing Education and other representatives of the nursing profession, the medical profession, and hospital administration, met with Mr. Oscar Ewing, Federal Security Administrator, and members of his staff from the Public Health Service and the Office of Education to consider the problem of federal financial assistance for nursing education. Before listing some of the major items discussed at the meeting with Mr. Ewing, I wish to point out that, although these items were discussed, it does not necessarily follow that there was complete agreement on them by all present. In the course of the two-day session (December 30-31, 1948) the following were pointed out:

1. The national needs for nursing personnel have increased beyond the present national facilities for preparing such personnel.
2. The needs for nursing personnel include both professional nurses and trained practical nurses.
3. The professional nursing personnel needed are:
   a. Those functioning in nursing service positions in hospitals, other institutions, public health agencies, and private practice. Some positions named were administrators, supervisors, head nurses, and clinical nursing specialists.
   b. Those functioning in nursing education positions. Some positions named were administrators of nursing education programs, including basic and advanced professional curricula, and programs in
schools of practical nursing; teachers of the different curriculum subjects for each type of school; supervisors of practical nurse training in vocational education on national, state, and local levels; and research workers for nursing research and experimentation.

Much discussion at the meeting with Mr. Ewing last December centered also about ways and means for increasing both the quality and quantity of nursing personnel. Among the suggestions made were:

1. Stimulate the development of regional school centers. It was said that these centers might be in a university or in a large teaching hospital. The small hospital either in urban or rural areas now conducting a school might then serve as a clinical practice field for the students from the central regional school. Many hospital schools are small schools which are costly to administer if a good program is operated. Such hospitals, by giving up their own schools and serving as practice fields in a large school center, would be relieved of that large proportion of instruction which is given during the first year.

2. Promote the development and expansion of university schools of nursing, both those conducting basic programs and those conducting advanced programs.

3. Give help to hospital schools that either now prepare their students to meet community needs or will improve their programs to effect such preparation.

4. Organize an increasing number of schools of practical nursing under vocational education.

5. Provide ways and means for recruiting large numbers of qualified students to each type of school herein named.

In considering federal aid for nursing education some general points discussed at the meeting with Mr. Ewing were:

1. The function of the federal government. The statement was made that the function of the federal government is to provide financial aid to expand personnel and that it should keep out of any plan to regulate the program of schools.

2. The desirability of having the nurses express themselves as to whether they favor a bill which would provide federal aid to the several disciplines (health professions). It seemed to be the consensus that financial assistance for nursing education should be a part of this type of omnibus bill.

3. The placement of the unit administering federal funds for nursing education and the manner of its operation. An opinion expressed was that if legislation which carried aid to the several disciplines were enacted, the administration of funds should be in one over-all administrative unit with an advisory committee for the total program, and
sub-advisory committees for the administrative subdivisions dealing with the respective disciplines. Another statement made was that while advice from the professions was essential in the operation of technical programs, advising groups should not tie the hands of the Federal Security Administrator. It was further stated that the safest thing to say was that the unit would be in the Federal Security Agency.

4. The desirability of granting funds directly to the schools or through the states. The opinion was expressed that state administration might slow up the program, especially in relation to grants to institutions.

During this conference with Mr. Ewing in December considerable time was given to legislation to aid practical nursing education. This conference included the following expressions:

1. Practical nursing education is at present carried on in the Federal Security Agency in the Office of Education, Division of Vocational Education, and largely centered in the Trade and Industrial Service.

2. Vocational education programs at present must comply with the provisions of the Smith-Hughes Act (1917), supplemented by the Vocational-Educational (George-Barden) Act (1946), in order to receive federal funds for programs of less than college grade.

3. State divisions of vocational education are the state authorities for securing and administering federal funds for occupational (vocational) education in their respective states.

4. The question was asked whether federal funds could be used by private high schools if they desired to sponsor practical nurse education programs. It was stated that federal funds could not be so used since the law provides that funds can be made available only to publicly controlled schools. Private hospitals, it was said, however, may be used for practice fields.

5. Because of the urgency of training large numbers of practical nurses, the desirability of enacting legislation for an emergency period was considered as an alternative to the use of the Smith-Hughes and George-Barden funds.

6. The most serious obstacle in producing large numbers of practical nurses, it was pointed out, is the lack of qualified persons to guide the operational program.

7. The desirability was discussed of having a professional nurse educator in the Division of Vocational Education, Office of Education, and also in the offices of state divisions of vocational education.

8. The question was asked whether it would be possible to have a separate service for practical nurse education in the Division of Vocational Education similar to other existing services in the Office of Education.

9. The need for funds for the training of teachers for schools of practical nursing as well as for the operation of programs was emphasized.
10. It was thought that effort and provision should be made to produce 10,000 practical nurses annually.

This finishes the list of major items discussed by the profession with Mr. Ewing last December.

In January 1949 it was learned that the Federal Security Agency was preparing a bill which would provide for federal aid for nursing education. This bill, S. 1453, to amend the Public Health Service Act to provide grants and scholarships for education to the medical, dental, dental hygiene, public health, nursing and sanitary engineering professions, and for other purposes, was introduced on March 29, 1949, by senators Claude Pepper, Democrat, Florida; James E. Murray, Democrat, Montana; Hubert H. Humphrey, Democrat, Minnesota; and Matthew M. Neely, Democrat, West Virginia. A corresponding bill, H.R. 3894, has also been introduced.

The bill S. 1453 has five principal features as follows:

1. Federal grants to those schools to help finance the cost of instruction on the basis of an amount for the present average student enrollment, based on the fiscal years 1947 through 1949, and a higher amount for the additional number of students enrolled in future years above these averages. For example, a medical school would get $300 per student for the present average enrollment, and $1,700 per new student. The difference between these two amounts is based on the fact that the schools would need much more money to hire new instructors for additional students than they need for their present enrollment.

Nursing schools which provide basic or advanced training leading to a degree in nursing would get $200 for each student enrolled, and $1,200 for each student enrolled in excess of its average past enrollment. Schools which provide basic training leading to a diploma (hospital schools) and which provide tuition, books, and other facilities, such as board and room, would get $200 for each enrolled student in the first year, $150 for each student in the second year, and $50 for each student in the third year.

2. Federal grants to finance the cost of construction and equipment of schools up to 50 per cent of such cost.

3. The establishment of state scholarship programs under a state agency. The federal government would furnish the financial assistance through a system of grants throughout the nation, based upon the proportion of the population of each state to the total population of the United States. The bill would provide $50,000,000 for the fiscal year ending June 30, 1951, and thereafter such sums as the Congress may appropriate. Normally these scholarships will cover the cost of tuition, educational fees and supplies. If the Surgeon General of the U. S. Public Health Service so determines, they may include maintenance money not to exceed $125 per month for a student with no dependents, $150 per
month for a student with one dependent, and $175 per month for a
student with two or more dependents.

4. The establishment of a National Council of Education for the health
professions, consisting of the Surgeon General as chairman, the chief
medical officer of the Veterans Administration, a medical representative
of the Secretary of Defense, and twenty public leaders of medical science,
education, or public affairs, ten of whom must be from the fields of
health education covered by the bill. The Surgeon General of the Public
Health Service and the Council would have jurisdiction over the first
three features of the program.

5. The establishment of a program financed by the federal government
at a cost of $15,000,000 a year in the various states for the training of
practical nurses, for persons sixteen years of age and over. The federal
aspect of this program would be under the jurisdiction of the Com-

The most important differences between S. 1453 and the "Proposed Essentials to be included in a Bill for Federal Aid for Nursing Education" adopted by the American Nurses' Association, the National League of Nursing Edu-
cation, and other professional nursing organizations, seem to be these:

1. S. 1453 covers not only nursing education, but also medical, dental,
dental hygiene, public health, and sanitary engineering education. This
is believed to be a good difference because it creates a situation that
would permit all those in the health professions to progress together
in working out health problems and in providing desirable health
planning for the individual and the nation.

2. The emphasis in S. 1453 seems to be chiefly on quantity of nursing
education, not quality, as in the "Proposed Essentials." Thus, S. 1453
seems to make no provision for research, experimental work, demon-
strations, or workshops, except surveys concerning costs. Encouragement
is given to degree programs by payment to schools of $1,200 for each
student in excess of a school's average past enrollment (based upon
July 1, 1946, to June 30, 1949), whereas the maximum payment to
schools for diploma courses is $400 for each student. The bill also pro-
vides that schools must be public or nonprofit institutions and must be
approved or accredited.

3. S. 1453 makes no provision for a unit of nursing education under the
Surgeon General or for any director of such unit.

4. S. 1453 makes no provision for a Commission on Policies and Regula-
tions. The Surgeon General has full power to prescribe all regulations
after consultation with the National Council on Education for health
professions. This council would appear to be merely advisory in
character.
5. **S. 1453** provides that schools shall be approved or accredited by a body or bodies approved for such purposes by the Surgeon General, after consultation with the National Council on Education for Health Professions.

6. **S. 1453** provides that scholarships shall be paid to the states rather than directly to students.

7. **S. 1453** contains certain provisions not in the "Proposed Essentials" to the effect that any person receiving a scholarship under the proposed law would be obligated to practice nursing for five years, and that, if she failed to do so or voluntarily failed to complete the program, she must repay the scholarship unless there was "good cause" for her failure. Repayment would be reduced pro rata in recognition of practice for less than five years, that is, if the nurse practiced for two years, she would presumably be required to refund only three fifths of the scholarship.

8. Part B of **S. 1453** provides for federal aid to state plans for practical nurse training. This subject is not treated in the "Proposed Essentials." It should be pointed out, however, that since the "Essentials" have been approved there has been considerable discussion of the advisability of considering legislation concerning financial assistance for practical nursing education.

On April 18-19, 1949, the National League of Nursing Education Committee (which is representative of the six national professional nursing organizations) to Study Federal Legislation on Nursing Education and the American Nurses' Association's Special Committee on Federal Legislation met in New York and studied very carefully **S. 1453**. The recommendations of these two committees have been considered by the Board of Directors of the National League of Nursing Education. The Board made some revisions of the committees' recommendations. I will now attempt to point out some of the highlights of the discussions of these two committees and the Board.

The principle of securing financial assistance for nursing education through an Act providing such assistance for the other health professions was approved.

It was pointed out that **S. 1453** does not provide for the greatly needed nursing service and nursing education research and experiments on such basic studies as:

1. The determination of the qualitative and quantitative nursing service personnel needs;
2. The study of the type of nursing service that will provide nursing situations where students in basic and advanced nursing curricula can see and learn good nursing, and
3. The basic curriculum studies needed for improvement of basic and advanced nursing curricula.
It was agreed that shortages in nursing personnel should be explained in terms of quality which is now lacking in nursing and demands which are calling for more nurses, for example, in the fields of psychiatric and tuberculosis nursing.

It was agreed in order to insure that schools training men nurses might receive benefits provided in the bill the word "sex" should be inserted in the section relative to provisions as they affect race, creed, color or national origin of students.

It was agreed that the wording in the bill concerning grants to institutions offering basic and advanced training in nursing for which it grants a baccalaureate or higher degree, should be clarified so that funds would be given to those institutions in this category that are truly college- or university-controlled. The committee proposed a statement for such clarification. The reason for this recommendation is that there are some hospital-controlled schools of nursing operating basic nursing programs which have very loose arrangements with colleges or universities, whereby the colleges or universities grant credit for the hospital school's programs toward a degree, although such programs are not controlled by the colleges or universities. Such schools properly fall under the section dealing with hospital schools of nursing. This revision was suggested also to insure appropriate designation of degrees.

The clause in the bill which was discussed for almost half a day related to the proposed grant of $400 to the school of nursing (hospital school) which provides basic training leading to a diploma as a professional nurse. Although such a school is to receive $200 for each student enrolled in the first year of training, $150 for each student enrolled in the second year of training, and $50 for each student enrolled in the third year, the school or hospital would be required to provide each student's "tuition, books and other facilities needed in such training, and board and lodging during such training without charge therefor." Since the reasoning back of this part of the bill was not clearly understood by the two committees, it was decided to ask the authors of the bill for clarification. We have not received a report on this to date. However, the legal adviser of the American Nurses' Association told me over the telephone last Sunday that a communication under date of April 26, 1949, asking for clarification has gone to Senator Pepper.

The question as to why grants to schools of public health is higher than to the other professions was raised, but no definite statement made.

The bill proposed that enrollment averages upon which grants were based would be determined on consideration of number of full-time students in first semesters. It was agreed that this calculation should be on the basis of consideration of the first regular term so as to provide for the different types of programs, whether operated by semester or quarter.

The bill limits benefits to schools within the continental United States exempt from income tax. It was agreed that the legal counsel seek clarifi-
cation of this to learn why it does not provide coverage, for example, for Hawaii and Puerto Rico.

The part of the bill which probably raises a problem is concerned with the provision for the Surgeon General's approval of the body or bodies by which the approved or accredited list of schools of nursing for receiving federal funds will be made. It is not clear as to whether or not professional groups will be asked to name such body or bodies except through their possible representation on the National Council on Education for Health Professions. It has been said the profession could be assured that its advice would be sought on this item. No change has been suggested in the wording in the bill. It was not considered advisable to have the names of accrediting bodies appear in the bill.

It was not clear to the study groups if there would be specified grants earmarked for construction and equipment for each profession covered in the bill. It was therefore thought this section needed clarification.

The section relative to state units' approval of applications for funds for construction and equipment did not seem to point out clearly what state unit is responsible for the administration of the funds. The legal adviser for the American Nurses' Association was therefore asked to prepare a statement of interpretation of that section. I do not have that statement at this time because he is attempting to secure clarification.

An amendment was suggested to the statement on the apportionment of scholarships so that it would be clearly understood that there would be at least two scholarships provided in each state for each profession mentioned in the bill.

In the section providing for funds for administration of the scholarship funds under a state agency, an amendment to omit the word "educational" when referring to such a state agency was suggested. This was suggested because the state agency might be an agency other than the State Board of Education.

The bill provides that the applicant for a scholarship, among other items, shall submit the name and location of the educational institution he expects to attend. It has been suggested by our committees that the applicant be required to submit, when making application, the information on the name and location of the educational institution by which he has been accepted for admission. The reason for this recommendation is that it is believed that the applicant should have been accepted for admission before submitting application for scholarship, the inference being that his qualifications are satisfactory for admission to the particular school.

It was suggested that provision be made with reference to state scholarship awards for state advisory committees from each profession—medical, nursing, dental, dental hygiene, sanitary engineering and public health.

It was agreed to suggest an amendment to provide for at least two leading authorities in each of the fields of medical, dental, nursing, sanitary engineer-
ing and public health education on the proposed National Council on Edu-
cation for Health Professions, which would act in an advisory capacity to
the Surgeon General. The proposed Council would then consist of the fol-
lowing: the Surgeon General who would serve as chairman, the Commissioner
of Education or his representative, the Chief Medical Officer of the Veterans
Administration or his representative, a medical representative designated
by the Secretary of Defense, all of whom would be ex officio members, and
twenty appointed members, ten of whom would be represented by two each
from the professions covered in the bill and ten others. The bill at present
does not specify a specific number from each of the health professions.

In the section on practical nurse education several suggestions were made
by the committees of the American Nurses’ Association and the National
League of Nursing Education dealing with federal legislation.

In relation to the supervision of vocational educational divisions in states,
the bill provides: "(1) the availability of professional education courses
necessary for the certification of teachers, supervisors and directors of prac-
tical nurse training, and (2) that such training leading to the certification
of teachers, supervisors, and directors, shall be given under the auspices
of the State Board of Education. . . ." It was thought by the League and
the American Nurses’ Association committees that these items should be
deleted so as to safeguard nursing education supervision by the profession.
It was also thought that funds for the preparation of administrative and
instructional personnel in practical nurse education should be provided
through section 372 of S. 1453. When this was brought to the attention of
the League Board, it was decided that no suggestion on deleting these
items be made if these provisions do not prohibit the allotting of funds to
privately supported institutions for the training of personnel referred to
and if this does not mean that the nursing profession would lose direction
of professional courses for such nursing personnel. The American Nurses’
Association has been asked to secure clarification on these items.

Other suggestions on practical nurse education included these:

1. The bill provides for one registered nurse on the state advisory coun-
cil for practical nurse education. It is proposed that representation be
included also from the practical nurse group. This part as now pro-
posed would then read as follows: "An advisory council composed of
not more than ten or less than six persons, including a registered pro-
fessional nurse, a practical nurse (who shall be a licensed practical
nurse if the state in which she practices shall have provided for the
licensure of practical nurses), a physician, an educator, a hospital ad-
ministrator, and such other persons the state may desire. . . ." This
recommendation is made in the belief that practical nurses should be
represented on a state advisory council on practical nurse training,
inasmuch as a qualified practical nurse could make a valuable contribution to the work of such a council.

2. The bill does not now specifically provide for nurse supervisors in state departments of education. Therefore, a suggestion was made for the provision for nurse supervisors in state departments of education to administer the proposed program.

3. There is no specific provision for nurse direction of the practical nurse program in the Office of Education of the Federal Security Agency. It was suggested, therefore, that some reference be made to the hope that the activities concerning practical nurse training and professional nursing education as administered in the Federal Security Agency could be coordinated and that nurse direction be provided for this program in the Office of Education.

It is understood that a recommendation was made last week at the Conference of State Boards of Nurse Examiners relative to the sections on practical nurse training. The bill provides that such training shall be less than college grade. The State Board Conference has suggested that "technical" be substituted for "less than college" in this part.

Testimony (pro and con) is now being prepared based upon suggestions of the two committees which met in New York April 18-19, 1949, concerning S. 1453. Hearings may start soon, within a few weeks or not at all.

It was also decided that the American Nurses' Association should learn from the other professions covered in the bill what their stand is—wherein there is agreement and disagreement.

We have received in the last few days copies of S. 1679 which is the administration's bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional personnel and other health personnel. This bill was introduced April 11, 1949, by Mr. Thomas of Utah (for himself, Mr. Murray, Mr. Wagner, Mr. Pepper, Mr. Chavez, Mr. Taylor, Mr. McGrath, and Mr. Humphrey).

This bill (S. 1679) covers all phases of health planning on a national scale. In Title I it contains provisions for the education of health personnel.

The League committee has not had an opportunity to study the bill nor have we had an analysis from the legal advisers of the American Nurses' Association. However, it appears that the provisions in Title I differ very little from those in S. 1453.

Some of the main differences seem to be these:

1. S. 1679 provides for the hospital administration group and S. 1453 does not.

2. S. 1453 provides for specific appropriations and S. 1679 provides that such sums, as deemed necessary, be determined by the Congress.

3. S. 1679 omits the provision of the scholarships for refresher training
as provided for in S. 1453, that is, persons taking such training seem not to be eligible for scholarships.

4. S. 1679 specifies that students of each type of professional school may enter a school to be eligible for scholarships. This is not spelled out in S. 1453. Schools of nursing in which students must enter for eligibility for scholarships are those providing basic or advanced training leading to a degree in nursing.

5. In S. 1679 selection of scholarship appointees are made on the basis of ability and such other factors as the state may find necessary and reasonable. In S. 1453 appointees are identified and certified for scholarships solely on the basis of ability.

6. In S. 1679 a scholarship is conditioned upon acceptance by a school of the applicant's choice which is accredited by a body or bodies appointed by the Surgeon General. This condition is not specifically stated in the corresponding section in S. 1453.

7. In S. 1679 a scholarship appointee must practice in the state which selected him or in an area designated by the state agency as one in need of additional personnel trained in such profession or, with the approval of the state agency, in full-time active duty in a medical agency or unit of the United States government. This section undoubtedly needs considerable clarification.

8. In the section providing for a state advisory council on practical nurse training S. 1679 provides for two registered nurses. S. 1453 provides for one registered nurse.

9. There are other items in S. 1679 which are different from S. 1453. These will be brought out in the analysis by the legal advisers of the American Nurses' Association and the professional staff working on this analysis at Headquarters.

All of you are urged to review Title I of S. 1679 and to send your comments to the National League of Nursing Education Headquarters at once.

There seems to be little difference between Title I of S. 1679 and S. 1453. Practically the same testimony could be used for both bills relative to instruction, construction, and scholarships pertaining to nursing education with a few exceptions of major importance. Since S. 1679 contains the very controversial provisions relative to a program of national health insurance and other items, any over-all statement by the nursing profession must be very carefully considered and presented at hearings.

Since I reported to the membership on Monday, I have learned that hearings on national health insurance bills S. 1679, S. 1581, S. 1456 and S. 1106 are scheduled to begin Monday, May 16, 1949.

It would appear, for many reasons, that it would be advisable to try to get S. 1453 out of committee (Labor and Public Welfare) for hearings and that efforts be concentrated on that bill instead of S. 1679. I do not know if
this is possible. If this is what you desire, it is urged that you write your senators and representatives to bring S. 1453 out of committee for hearings.

Before leaving this discussion on financial assistance to nursing education, I believe it is important to point out that the controversy and confusion over the provisions for a national health plan are over the cost and method of securing medical and other health protection. It is not on the recognition of the lack of institutional facilities (educational and service) and professional personnel required. There is general agreement on this need. A sound national health plan should provide for the elimination of both obstacles.

**Legislation Indirectly Affecting Nursing Education**

So far we have been discussing federal legislation directly affecting nursing education, relative to instruction, construction, and scholarships. Almost all health and public welfare legislation has implications for nursing education, but there is some legislation that has more direct implications.

The first I should like to call attention to is Social Security coverage for nursing education personnel. At present this group is not covered for federal old-age and survivors' insurance nor for unemployment insurance under the Social Security Act. Nurse educators have very irregular or no opportunity to build basic retirement and disability incomes. The mobility of such employed nurses often requires forfeiting of basic retirement provisions which have been started in either nonprofit private or public institutions, if there was any provision at all for such plans. The economic insecurity in the nursing profession is one persistent problem among the many others which prevents the recruitment of nurses in sufficient numbers.

The American Nurses' Association presented testimony on April 21, 1949, which went on record as "favoring the broadening of the Social Security Act to provide protection for the self-employed private duty nurses and for nurses employed in nonprofit agencies and institutions who are not now covered by the old-age and survivors' insurance program. Such extension would be of great benefit not only to private duty nurses (a self-employed group) but also to nurses employed in voluntary hospitals, visiting nurses' associations, schools of nursing, and other nonprofit agencies and institutions."^4

This whole problem needs serious consideration by the nurse educators so as to determine what stand should be taken on Social Security legislation. The following questions were raised on this at the afternoon business session on Monday:

1. Should nurse educators employed in public institutions, whether or not included in some type of retirement plan, be included under the federal old-age and survivors' insurance system?

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^4Statement of American Nurses' Association on H.R. 2893 by Edith M. Beattie, R.N., Chairman, ANA Special Committee on Federal Legislation before the Ways and Means Committee of the House of Representatives, April 21, 1949.
(2) Should all nurses, including nurse educators, be included under unemployment provisions of the Social Security Act?

It appeared from the raising of hands at that time that the answer is "Yes" to the first question. The answer to the second question could not be determined from the raising of hands on Monday. You may desire to discuss these questions further today.

Perhaps we need a special committee in the National League of Nursing Education to study intensively federal legislation on Social Security as it relates to nurse educators.

Other federal legislation I want to touch upon briefly is that relating to full-time local health units. If we are to have proper training field centers for practice for all health personnel, including public health nurses, we must take interest in seeing that we get local health units that provide practically prepared personnel in all of the health programs. I will not discuss this further because Dr. Burney covered this so very clearly in his discussion.

It is significant that three national Catholic groups (Catholic National Welfare Conference, the National Conference of Catholic Charities, and the Catholic Hospital Association) in attacking the administration's compulsory health insurance plan are offering a program. So is the American Medical Association in its twelve-point plan. In addition to a prepayment of costs of sickness plan, other items are proposed in the plan of the Catholic group, including the provision of federal funds for nurse training programs for both professional and practical nurses. This plan is described in a pamphlet entitled *A Voluntary Approach to a National Health Program*. It can be secured from the Catholic Hospital Association, St. Louis, Missouri.

**Summary and Conclusion**

In conclusion, I should like to reiterate that I have not tried to answer questions but have attempted to show step-by-step what the nursing profession under the leadership of the National League of Nursing Education has done to state principles underlying the securing of financial assistance for nursing education, and the use of those principles in preparing and studying such legislation. I have also attempted to point up some other types of federal legislation which have a bearing on nurse education or nurse educators.

If we desire federal financial assistance for nursing education, the whole profession needs to study federal legislation that is being promoted and let the League Headquarters staff know what it thinks about it. League Headquarters wants you to write to them about what you are thinking.

We need to safeguard our nursing education programs so that progress in the improvement of nursing service is assured all the way along the line—in practical nurse education and in professional nurse education, basic and advanced. We need to safeguard the spirit of nursing and the individual and social nature of the nurse which is so important in this confused world.
To this end, the several League committees concerned with federal legislation affecting nursing education have worked, but all of us need to keep alert to what is happening locally and nationally and to make ourselves heard if we want to change what we do not desire to have happen and to make happen whatever will improve nursing service in all its aspects—spiritual, professional and social—and to promote such service where needed, in the home or hospital, in rural or urban areas, and in the world at large.

**GENERAL SESSION**

**Thursday, May 5—8:00 p.m.**

**HOME CARE OF THE SICK**

*Presiding: Elizabeth S. Bixler, R.N., President, Association of Collegiate Schools of Nursing*

*Speakers:*

**Martin Cherkaskey, M.D.**, Home Care Executive, Montefiore Hospital, New York, New York

**Marian G. Randall, R.N.,** Executive Director, Visiting Nurse Service of New York

**A HOSPITAL'S HOME CARE PROGRAM**

**Martin Cherkaskey, M.D.**

Home care is a subject in which everyone has become interested. This interest is so widespread that the reason is almost obvious. Prolonged (chronic or long-term) illness is the compelling problem facing society today. The acute problems, apart from acute surgery, are becoming relatively less important if only because they are adequately covered as a result of their relative urgency. The extent of the problem of prolonged illness and its destructive effects on human beings, physically, emotionally and socially, are of such magnitude that, if we marshal all of our resources, direct all our best efforts, and abandon all of our petty organizational jealousies, we may still not be able to accomplish our objective to the full which is "all of the care needed for all who need it."

A study in 1936 uncovered some startling facts about chronic diseases. More than 23 million Americans were suffering from these illnesses. One and one half million were permanently disabled. These figures are huge and yet I doubt if they approximate the actual problem today. Since the time the study was made, there have been great advances in medicine. The sulfa drugs,
penicillin, streptomycin, aureomycin and other anti-biotic drugs have helped to control many acute illnesses while the non-acute linger for greater periods of time. Pneumonia was one of the commonest immediate causes of death in patients with long-term illnesses. No longer is this so. Through the curative effect of these drugs and other advances in medicine and surgery, the span of life is increasing and, while old age and long-term illnesses are not always coexistent, it is a fact that most of the illnesses occurring in the older age group are resistant to such dramatic treatment and fall into the long-term category. There has also been a great and destructive war, and we in the United States have our share of the helpless and crippled who represent part of the price of that war.

These are some of the factors which have served to change the chronic disease picture since 1936. There are now many more people suffering from prolonged illness, and the prospect is that the problem will continue to grow if we do not attack and circumscribe it to the very best of our ability.

By outlining this huge task, I do not mean to frighten you. We have faced greater tasks, such as the defense of democracy on the battlefield, and this effort, like war against any enemy, will require the highest form of grand strategy, teamwork, and united effort for the common good.

During the past few decades we have developed the erroneous concept that the place for all sick people is in a hospital. Even if I were to accept such a concept, which I do not, it would be impossible for us to create or maintain enough institutional facilities for the care of all patients suffering from prolonged illness. It costs about $20,000 to build a hospital bed, and between $12 and $25 a day to maintain it. The latest figures reveal a shortage of 248,000 "chronic" hospital beds. There is also a great shortage of highly trained professional personnel. The task from this point of view is getting more impossible by the day to accomplish, but we in this country have been able to accomplish the impossible before.

Even if we could build all these beds and maintain them, would we really be doing the best possible job? Hospitals are pleasant enough places for those of us who work in them. They may even be tolerable for the patient who is receiving a great deal of attention and who expects a rapid favorable termination to his illness. For the patient with prolonged illness however, where the weeks may drag into months and the months into years, the hospital may well be regarded as an isolated prison or a place of social as well as medical exile. It is in the best interests of such patients to provide care for them in an environment which is more nearly like their normal way of life. This method of care is indeed forced on us not only by the progressive economic difficulty of providing institutional care, but also by the more important stimulus of the patient's well-being.

The home care program at Montefiore Hospital, New York, was begun in January 1947 with funds from the New York Cancer Committee and the Greater New York Fund. Since that time generous contributions have been
made by the United Hospital Fund, the New York Heart Association, and
the Commonwealth Fund. Home care is not absolutely new with Montefiore
Hospital. It has been practiced throughout the ages. What is new is that the
hospital has integrated its facilities with those of the community for the
benefit of the patient. This program is a further extension of the philosophy
of social medicine which Dr. E. M. Bluestone, the director of Montefiore
Hospital, has been teaching for almost three decades.

A patient in the wards of our hospital, or one who applies to us for home
care from the community, is first checked medically by one of our doctors
so that we may determine whether he can be given in the home the sort of
medical care that he sought in the hospital. A social evaluation is then made
by the medical social worker. This is probably the most important phase of
the program. Illnesses of all sorts cause some emotional and social dislocation,
and this is particularly true of prolonged illness. Any program of medical
care for the sick that does not take notice of, and try to cure social compli-
cations will not be complete. These dislocations may have a more important
bearing on the well-being of a patient than his organic illness. It is this ap-
proach to prolonged illness which has made it essential that the team caring
for the patient in his home has as its nucleus the doctor, the public health
nurse, and the medical social worker.

The social worker plays her part in determining whether the patient and
the patient’s family are prepared for his return to their midst. It may sound
sentimental to say that the social worker is on the lookout for love and
affection in the family which can be applied for the benefit of the patient,
yet this is her earliest task.

When we have satisfied ourselves that the patient is medically and socially
suitable for home care, he is returned to his home and may receive any or all
of the following services: medical care, social service, nursing care, house-
keeping service, occupational therapy, diatherapy, physical therapy, X-ray
service, and laboratory examinations.

Doctors see the patients at regular intervals and are on call around the
clock seven days a week besides. All the specialties and departments of our
hospital are available for consultation. Surgeons, orthopedists, dentists, and
other specialists go into the home and give their expert opinion and help
as needed.

The social worker follows the patient into his home and provides the care
and help that fall within her field. The public health nurse (we have a con-
tract with the Visiting Nurse Service of New York) goes into the home and
provides nursing care, or what is more important, instructs and supervises
members of the family in the care of the patient.

Housekeeping aid is provided where necessary up to ten hours a week.
Occupational therapy and physical therapy are carried out in the home by
trained personnel. Laboratory studies are performed either in the home or
in the hospital, for, when the facility can not be brought to the patient, the
patient is brought to the facility. It is not difficult to bring a patient to the hospital for an X-ray examination where an ambulance is available. All medications and hospital equipment such as beds, wheel chairs, oxygen, and the like are provided in the home when necessary.

The program has been functioning for over two-and-a-half years. During this time we have provided over 30,000 days of patient care to something over 400 patients. We have taken care of people in all stages of cancer, heart disease, peripheral vascular disease, diabetes, kidney disease, tuberculosis, and colitis. There seems to be no illness to which home care could not be adapted.

During 1948, the cost per patient day was $2.88. This includes every cost. It is comforting to know that the program is not an expensive one, at least in money, but we would have no interest in the program were it not for the primary fact that for a suitable patient there is no better type of care than home care, regardless of comparative cost. We have found that patients who are medically and socially suitable do very well in their homes. Frequently the best therapy for a patient is to be returned to the atmosphere of his home and family. There have been many triumphs in the way our patients have responded to the "tender loving care" which we have prescribed successfully.

Of greater significance in the problem of medical care than just the care we have rendered to a relatively modest number of patients, is the concept of integration of all community services for the benefit of the patient. The hospital has, in this program, encompassed a much larger area and many more people than its traditional walls could hold. A hospital is only one of many facilities available to the community for the care of the patient. In this great struggle against illness, the combined efforts of all the health services and of all community facilities, institutional and noninstitutional, public and private, will be needed if we are to do the job adequately.

**Planning for Home Care of the Sick**

MARIAN G. RANDALL, R.N.

The topic for discussion for this meeting is listed as "Planning for Home Care of the Sick." May I use these same words in four different groupings to outline my remarks:

The Sick  
Care of the Sick  
Home Care of the Sick  
Planning for Home Care of the Sick

*The Sick* are the words first cited to emphasize that the patient must be the center of all our discussions and considerations. Many chapters of the
Bible give us exhortation to help the sick, and down through the ages the sick have been designated as those who need assistance from their neighbors. On the subject of the good neighbor—neighborliness, Jan Christian Smuts said, "It is not only an ethical concept but an economic, political and social concept and standard of behavior which we violate at our peril." The sick call for our compassion, our help, our skill, and all of our scientific knowledge.

The Care of the Sick. That the sick need care is unqualifiedly accepted by society, but the use or application of all our scientific knowledge presents many complications. The increased tempo of scientific medical discovery presents great pressure for rapid acceptance and application of such knowledge. There is also the ever-growing conscience of humanity which refuses to accept the anachronistic distinctions which are translated into medical selectivity when men are sick.

But we have to recognize also that there is resistance to the widespread use of all scientific medical knowledge for all people. Restraining influences relate to inflationary money values, the high cost of progress which makes diagnostic and therapeutic procedures very expensive, vested interests, the shortage of all trained personnel for all specialized services, and community inertia often due to unawareness of the trends in health and medical care.

The direct and indirect results of the interaction of these phenomena are responsible for the current trends in public health and medical practice. But above all we are sure that there is an ever-increasing awareness of the need to use what may be called "the combined specialties" which considers the whole man in relation to his environment and to the spirit which animates him.

There is no need to review for this audience historical events in the care of the sick, nor is it necessary to describe different kinds of modern hospitals which provide all kinds of services for the care of the sick. It is significant to mention, however, that as time is measured it was only a short time ago that all sick persons were cared for at home. And now both in and out of hospitals there is the goal and ideal to be attained of unification of general and special services in medical care practice.

The concept of group practice should not be limited to a few doctors joining forces, but rather should encompass a group composed of all the professions concerned with the care of the sick really practicing together with mutual respect for each others' abilities, knowledge, and skills.

Home Care of the Sick. As a participant in this kind of group practice, it would be all too easy when considering home care of the sick, for visiting nurse organizations to assume superior attitudes because of being in the business of home care for approximately sixty years. I know of two visiting nurse associations which have for over twenty years had printed on all their literature the slogan, "A Hospital without Walls." The origin of the visiting nurse stemmed from the impulse to give care at home to the sick who were
without any care. The nurse who learned her skill in a hospital attempted
to carry the standards of nursing care into homes bare of the necessities and
into homes where hospital cleanliness was unknown, into homes where love
and affection were nonexistent. Many a public health nurse in the past as in
the present has been shocked by her first visit to a kind of home she never
knew existed. But we believe that out of these sixty years of experience have
come not a superior attitude but an understanding and humility and respect
for the family. We believe that our best lessons, social and medical, have been
learned at the bedside and in the intimate surroundings in the place the fam-
ily calls home. To be a member of a larger professional group, practicing
together, gives the visiting nurse the realization that there is an increased
possibility of considering the sick person in relation to where he lives, with
whom he lives, what he does, and what is his life picture.

As is well known, or it should be well known, the visiting nurse gives
service in the home only if the patient is under the care and supervision of a
physician. Planning for home care in a community, therefore, requires, first,
provision for physicians' services. Many an otherwise good plan has failed
because adequate provision was not made for a doctor to see and direct
the patient's care in the home situation.

Look at annual reports for several years from visiting nurse associations
throughout the country and you can read not only the number of patients
cared for at home, classified by type of illness or service rendered, but you
can read the source of referral of these patients. The records of the Visiting
Nurse Service of New York for the past ten years show that an average of
20 per cent of our patients were referred from hospitals. "Discharged from
the hospital" has been the general idea, but in many instances when the
patient could afford to pay for his medical care the same doctor continued
to care for the patient and recommended treatment and care which the visit-
ing nurse should give during the patient's period of convalescence. For
patients who could not afford to pay for it, however, this same continuity of
care was not so easily arranged.

To the credit of a few public health nursing leaders it can be said here
that several years ago, in some cities, conferences with hospital authorities
were initiated to discuss a plan for indigent patients whereby nursing care
could be continued in the home by the visiting nurse with the hospital
continuing medical supervision at less expense to the community than long
hospitalization. We have memoranda of such conferences in the files of the
Visiting Nurse Service of New York. But at that time there were sufficient
hospital beds available and sufficient nurses both in hospitals and in outside
agencies. Frankly, it had to wait until hospitals were overcrowded before other
plans were sought. And now there is a shortage of nurses which makes it
difficult to plan for the amount of home service we might wish to give! This
illustrates what kind of pressures make society try new things. It must be
more than the idea, and to put it across requires more group discussion, more
group planning, and far wider distribution of the ideas to encourage citizen participation and citizen demand for the best possible medical care for all people.

All professional groups included in the broader concept of medical care can be accused of "hiding their lights under a bushel" when you consider the potential power of the public for getting things accomplished. And referring again for a moment to the broader concept of group practice which means the working together of all professions included in this broader concept of medical care, I believe that no one profession, if its members feel secure, needs to hesitate to work and exchange ideas with other professions.

Planning for the Home Care of the Sick. Frequent discussion among the professional groups concerned is the secret of success of a community home care program. The much publicized Montefiore Hospital Home Care Program has emphasized this point in the written and spoken word and I should like here to give acknowledgment and praise to the director and staff of the Montefiore Home Care Program for the way in which they have made this cooperative spirit function. It has been a privilege to work with this group. Planning discussions both for the over-all program and for the care of each individual patient are essential.

The Visiting Nurse Service of New York has a written contract with Montefiore Hospital to provide home nursing service for selected patients in accordance with the policies of the home care department of the hospital and the policies of the Visiting Nurse Service. The hospital pays for these nursing visits at the prevailing rate of the cost per visit based on an annual cost accounting. To bring about such a contract, several meetings were necessary. As a public health nursing agency we needed to learn about the hospital's plan and the details of the service given in the hospital. As workers in the hospital, the hospital staff needed to know the policies of a public health nursing agency concerning such details as hours of work, services the nurses were permitted to undertake, relationships with other agencies, and all the numerous items which those of you who are public health nurses know so well. It's a good experience to have such an exchange of fundamental ideas. In such planning conferences all groups should be included—hospital administrator, physicians in charge of the program and physicians giving the service, the nursing director, and from the hospital personnel, representatives of the ward nursing supervisors and staff groups, medical social workers, physical therapists, nutritionists, occupational therapists and others, and from the public health nursing agency or any other agency with which contracts for service are arranged, the director of the agency and representatives of the supervisory and staff group. This may seem like a lot of people, a lot of work and time and perhaps money involved, but in the long run it pays in time and money and does more to insure success than any other one procedure. As the program progresses, meetings of the same nature, even if attended by fewer people, make case conferences of real value.
Once the program is established, the decision about a patient's transfer home is made following the same idea of group conference. Obviously the physicians' recommendations head such a conference. The suitability of the home and the willingness and ability of the patient's family to have the patient at home are discussed by the social workers and others on the hospital staff according to the problem. A visit to the home by the visiting nurse before the patient leaves the hospital is considered essential, and it is recommended that such a visit be made for every patient regardless of his immediate need for nursing care. No one person's opinion determines the procedure but joint judgment is used. The circumstances of the case determine the amount of time and service from each professional worker. It is not the same for all patients and does not need to be, but it is the principle involved which is important, that all professional services are available. Just saying this does not make it so, and frequent check-ups on what is happening are indicated. But if it works, and it can work, this is truly planning for home care of the sick.

When all conferences are completed, there is still needed a tool for exchange of written information. Modern hospital records are made up of information from all departments, but when services from outside the hospital are utilized the additional referral form is needed. In New York we call this the Greater New York Interagency Referral Form. The words Greater New York are used because the same form is used in all five boroughs by many hospitals and social agencies. It is not a product of a specific home care program, but rather an outgrowth of a group of social workers and public health nurses and others working together to devise a record form to provide a space for all professional personnel inside and outside of hospitals to record data about a patient and thus facilitate continuity of care. When properly used these forms are very satisfactory, but experience tells us that it is necessary to both write and talk about the use of these forms. Written instructions were made available.

In Montefiore, the voluntary hospital you have heard about in connection with the home care program, these interagency referral forms go through the home care department, and a special medical social worker assigned to the home care program assumes the responsibility for collecting all the necessary data. The public health nurse sends her information back to the home care department.

In the New York City Department of Hospitals where a home care program has recently been initiated and with which we have the same kind of written contract to provide home nursing service, a nursing coordinator has been assigned to each of the city hospitals participating in the plan and she assumes the responsibility for assembling the necessary data. The same referral form record is used in both programs. The method used depends somewhat

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1Copies of these forms may be secured from the United Hospital Fund, 8 East 41st Street, New York 17, N. Y.
on the organization within the hospital and also the size and complications within the hospital plant and in the city where such a program is undertaken. It is the willingness on the part of the people concerned to make a plan work which is one of its greatest assets.

And how does this newer concept of the home care program actually work out in practice? If the hospital staff continues to be responsible, does that mean the doctor, the medical social worker, the occupational therapist, the dietitian, and all the various people visit in the home? In the Montefiore plan the answer at present is "Yes."

We expect many different workers to serve the patient while he is in the hospital but there is something about so many different people visiting the same home which raises questions. First we should be willing to experiment, but not haphazardly.

With the shortages of all professional personnel, however, it is extravagant even for experiments to duplicate services and superimpose one worker's service upon another's to the point that all topples over because of the weight. Selection of services based on the individual patient's needs is the answer, but one most difficult to carry out unless each worker recognizes the functions of each member of the team and entirely surmounts any "small" notions that we cannot occasionally carry a message for each other or even report certain conditions which will help all members of the team to do a better job.

For example, I know of a child with rheumatic fever who, while he was in the hospital, presented a great problem because he would not stay in bed. It was decided that the home situation could be advantageous. All plans were made. The reports sent to the visiting nurse included comments from physician, psychiatrist, psychiatric social worker, ward nursing supervisor, play therapist and visiting teacher, dietitian, and perhaps others. Well supplied with information, the nurse visited the home, taught the mother, who seemed very cooperative, to give nursing care to the child, to make the bed comfortable and convenient with a table and shelves for the child to play, cut pictures, read, and engage in other activities. The child's bed was moved from a front bedroom to a room off the kitchen so he could be nearer to where the mother was working and not feel so away from things. Many devices for simplifying care at home were taught to the mother and for the first week all seemed to go very well. The child stayed in bed and seemed to respond well to the nurse's suggestions. Suddenly the child reverted to his former behavior and reports went back to the hospital that the child was not only getting out of bed but running up and down the stairs! A conference was held and it was decided that only the psychiatric social worker would visit the home for awhile. This decision was based on the psychiatrist's work previously with the father and mother. The social worker had all the information the nurse could give her, and it was the joint judgment that all nursing care needed had been well learned by the mother and that for the present nursing service would be discontinued. It was recommended, however, that
nursing as well as any other services would be resumed when needed. You see, that means that all workers must be willing and able to recognize the need for services from other professional workers.

Another patient, a woman recovering from radical surgery for cancer, needed the skilled techniques for changing dressings, but she also responded to the nurses’s instruction and encouragement regarding exercises of the arm and plans for complete rehabilitation. In this instance it was decided that only the doctor and nurse would visit in the home for a period of time even though there were some other problems which needed attention at a later date.

An opportunity to make such selection of workers for home service does not exist in many communities because of shortages of personnel in all professions. But perhaps a better utilization of limited personnel can result in group practice. In our special experiments in New York we hope very much that we can be wise enough to learn some lessons of value.

I sometimes think that if a home care program such as the one we have been discussing can be carried out in New York City with its multiplicity of complicated problems, it can be done anywhere. But I was quite set back on my heels recently when a health officer of no mean ability, in a southern state, told me of a plan whereby a clerk went into the hospital each day and looked at the records of the patients about to be discharged and on her own judgment made referrals to the visiting nurse. When I questioned the educational opportunity lost to the hospital staff, the chance that a patient’s needs were overlooked, and the possible lack of good continuity of care, he replied, "Oh, it’s easier that way and occasionally we go over the records so everybody knows what is going on.” His added comment was, “You make things too complicated in New York.” Perhaps we do, and perhaps the New York situation makes it so.

But in the long run it seems as if better service will result if there is early and continuous planning in a community to utilize all available services in the most economical and efficient way possible. Changes take place so rapidly today.

Just this spring we analyzed a week’s experience in the Visiting Nurse Service of New York and found that of 6,500 home visits made, 40 per cent included some hypodermic service. We knew there was a change taking place because of the increased number of requests from physicians to give mercurydrin, streptomycin, and several other of the newer drugs, to say nothing of the constant request to teach people to give insulin, but we did not realize that the change in medical practice had taken place so fast that 40 per cent of our home visits included hypodermics. These new medications make it possible to “manage patient care at home” for many persons who formerly were cared for in hospitals.

From the standpoint of planning for home nursing service, can some of these hypodermics be assigned to practical nurses under supervision of the public health nurse who will assume more responsibility for the social impli-
ations of the service and for teaching? Again it will not be the same for every patient or in every community. But change is here and it may be our most valuable asset if we learn that the only thing worth considering permanent is our ability to change.

This discussion cannot end without reference to the theme of your fifty-third convention, namely, "Systematic Investigation and Planning for Nursing." I heard it said recently that what this country needs is no longer a good 5 cent cigar but a good 5 cent statement of the deepest things in which we believe. Have we been more vocal about what we don't want in nursing than what we do want?

Today, nursing and nursing education are receiving the kind of analysis and examination which take place only when a profession becomes established and secure. You have to be grown up to acknowledge your own shortcomings, but you also have to be grown up to do something about making changes. In our planning for nursing there are standards which we violate at our own peril. We dare not fail to recognize that health and disease in all their manifestations must be seen together, that the complicated cause and effect of today's health problems can be solved only if all groups are willing to work together, and that as a profession nursing must take its place in the highest level of social statesmanship.

**CLOSING BUSINESS SESSION**

**Friday, May 6—9:00-10:30 a.m.**

The closing business session was called to order by the president, Agnes Gelines, at 9:15 a.m. The roll call indicated that representatives of 42 state leagues were present.

**REVISION OF THE BYLAWS**

The president stated that several members had suggested that the discussion of the revision of the Bylaws, which took place at the opening business session on May 2, be reopened. A motion to this effect was then voted upon and not carried. The parliamentarian, however, suggested that such a vote would not be necessary in order for a member to present a proposed amendment to the Bylaws, and that, according to the League Bylaws and Robert's Rules of Order Revised, such an amendment could be presented at that time if it were in writing and signed by two persons. Such a proposed amendment would require a unanimous vote for passage.

Emma E. Brown (New Jersey) then presented the following motion in writing, signed by herself and Margaret B. Allen (New Jersey): "I move to amend Article IV, Section 2-a, by adding "except the Nominating Com-
mittee." This amendment, if passed, would restrict the ex officio membership of the president to all committees other than the Committee on Nominations.

In the discussion which followed, Adelaide A. Mayo, the executive director, stated that although, according to the Bylaws, the president and executive director are members ex officio of all committees, at the national level, at least, they have taken particular pains not to participate in the work of the Committee on Nominations; all correspondence from the chairman of the Committee on Nominations passes directly to the secretary of the organization. Louise E. Knapp, a former chairman of the Committee on Nominations, stated that in her opinion it would be helpful if the knowledge and experience of the president could be available to the Committee on Nominations in the course of its work. Ruth Sleeper, as a former president, stated that she would have preferred not to have been a member of the Committee on Nominations but to have been able to stand by and have the committee consult her if it so wished. She further stated: "The fact that the president is not a member of the committee does not in any way prohibit her from giving whatever assistance the committee wants, but it is much better not to have any possibility of influence in such a committee as the Committee on Nominations. The League has never, to my knowledge, had any politics, and may it go on without politics!"

Upon questioning by several of the members, the parliamentarian stated that, since the League operates under Robert's Rules of Order Revised which states that the president is not a member of the Committee on Nominations, the president of the League is not a member of the Committee on Nominations even though the limitation is not specified in the Bylaws.

A vote was then taken on the motion which was lost, since there were seven negative votes and a unanimous vote was needed. Following this vote, the secretary explained that, regardless of the fact that the proposed amendment failed to be carried, the president was not a member of the Committee on Nominations.

It was then moved by Miss Brown and seconded by Miss Allen that Article IV, Section 6-g be similarly amended so that the executive director would not be an ex officio member of the Committee on Nominations. The parliamentarian stated that this point is not covered in Robert's Rules of Order Revised and that, therefore, under the present Bylaws, the executive director was an ex officio member of the Committee on Nominations. This motion was also lost, there being seven negative votes. The president reminded the membership that it would be possible to amend the Bylaws at the 1950 Convention.

It was then moved by Margaret B. Allen (New Jersey), seconded by Frances Lewis (New Jersey) that Article IV, Section 1-g be amended to read: "The Board of Directors shall select an executive director and give her adequate authority to manage and direct activities of the National League of Nursing Education in accordance with established policies and programs,
whose term of office shall be at the discretion of the Board of Directors."
(Proposed addition in italics.)

In the discussion which followed this motion, Agnes Salisbury (Connecticut) pointed out that such an amendment was unnecessary; that, since the Board has the power to appoint the executive director, the Board can remove the executive director at will. Ruth Sleeper (Massachusetts), however, expressed the opinion that if the membership felt that there might be some misunderstanding with regard to the Bylaws, it would be wise to make the Bylaws more explicit.

Clara F. Brouse (Ohio) suggested that the phrase "at the discretion of the Board" was too vague and that provision might be made for reconsideration of the executive director's appointment at specified intervals of time. Miss Allen stated that, in her opinion, anyone applying for the position of executive director would not feel secure if her name were to come up for consideration at set intervals of time. Miss Sleeper, on the other hand, stated that the very fact that she was reappointed annually to her position gave her a feeling of greater security; that a person with an indefinite period of appointment might tend to wonder how well she was doing and how long she would be retained. Miss Mayo, the executive director, stated that she agreed with Miss Sleeper that an annual reappointment of the executive director would provide a means whereby the executive director would know definitely whether her work had met with the approval of the Board and would thus give her a feeling of more security than if she continued on indefinitely, not knowing how her efforts were being evaluated. She stated that she herself in the past had had to raise the question as to whether the Board would like her resignation and that it would have been easier for her had the question been automatically raised by virtue of a specific term of appointment.

Kathryn T. Burke (California) pointed out that many employees have a tenure clause in their contracts. She further stated, "Our executive director has contributed much to the success of this organization, and I would like to pay tribute to her."

Several members suggested that the problem of a term of appointment for the executive director might well be studied by the Committee on Revision and the recommendations of the committee brought before the membership at the 1950 Convention.

The motion to amend the Bylaws in respect to the executive director's term of office was lost.

REPORT OF THE COMMITTEE ON RESOLUTIONS

The Committee on Resolutions recommends that the following resolutions be adopted by the members of the National League of Nursing Education at its Fifty-third Convention.
Be it resolved that:

1. We express to Miss Mary M. Roberts our grateful and sincere appreciation for her contribution to the progress of nursing through her inspirational leadership and untiring efforts as editor-in-chief of the \textit{American Journal of Nursing} for the past twenty-eight years.

2. We express to Miss Blanche Pfefferkorn, retiring director of the Department of Studies of the National League of Nursing Education, our grateful and sincere appreciation for her contribution to the progress of nursing through her many careful, analytical studies during her years of service.

3. We express our appreciation for the time and leadership given by the retiring officers and members of the Board of Directors of the National League of Nursing Education.

4. We express our appreciation for the valuable contributions of the non-member participants in our programs.

Further be it resolved, that:

5. We express our sincere thanks for the arrangements, comforts, and many courtesies that have been extended to us by the Ohio State League of Nursing Education, Cleveland League of Nursing Education, and each of their active committees and all other organizations and groups that cooperated with them.

And be it further resolved that:

6. We express to Mrs. Marian Woodbury Hall, Director of St. Luke's Hospital School of Nursing, and her staff, and also to the Greater Cleveland Chapter of the American Red Cross our thanks for the delightful teas given for the League members.

Be it further resolved that:

7. A copy of these resolutions be presented to those individuals and groups specifically mentioned in these resolutions.

Respectfully submitted,

\textit{Marjorie Bartholf, Chairman}
\textit{Carol Randall}
\textit{Margaret B. Allen}

This report was adopted by vote of the membership.

\textbf{IN MEMORIAM}

The president announced that, during the past year, two outstanding leaders in nursing had passed away, and requested the secretary to read the two editorials which had appeared in the \textit{American Journal of Nursing} on Mary Adelaide Nutting and Julia Catherine Stimson. Following the reading
of each editorial, the assemblage rose in silent acknowledgment. It was then voted that these expressions be spread on the minutes of the meeting.

MARY ADELAIDE NUTTING—1858-1948

Because of her long years of invalidism, Miss Nutting, like Miss Nightingale, became almost a legendary figure in her lifetime. Like Miss Nightingale, she possessed the keen intelligence to analyze situations and the imaginative courage to recommend changes which she was indefatigable in following up. When Miss Nutting retired in 1923, she had been cited by Yale University as "one of the most useful women in the world."

Those who had the privilege of working with Miss Nutting, or of being her students, quickly learned that her blazing zeal for the improvement of educational methods and the advancement of nursing was supported by a persistent search for specific information. This led to her collaboration with Lavinia L. Dock in the preparation of the first two volumes of the authoritative History of Nursing. It also took her to the U. S. Bureau of Education to find out why that agency was not producing data on the education of nurses. That self-imposed task resulted in the first comprehensive studies of nursing in the United States and the publication by the government of monographs on nursing in 1904, 1907, and 1912. Miss Nutting's classic Educational Status of Nursing merits re-reading today. It is significant that the Commissioner of Education, in his letter transmitting this study to higher authority with a recommendation that it be published, said, "This work of nursing has rapidly advanced to the position of a profession requiring careful preparation for admission."

A number of other "firsts" should be credited to Miss Nutting. At Johns Hopkins she established the first preclinical course in this country. She was the first nurse in the world to become a member of a university faculty with professional rank. Her scholarly characteristics made her a very acceptable member of a faculty which had little knowledge of the place of nursing in society. As head of what is now the Division of Nursing Education at Teachers College, Miss Nutting made it a Mecca for nurse leaders from all quarters of the globe who returned to their own countries determined to improve the preparation and status of nurses. Her influence on the development of both basic and advanced education for nurses is incalculable.

It was Miss Nutting who suggested, at an ICN meeting in 1912, that the proposed memorial to Miss Nightingale should be educational in character. She was honorary president of the Florence Nightingale International Foundation from its inauguration in 1934 until her death. Many honors came to her.

As chairman of the Committee on Nursing of the Council on National Defense, appointed by President Wilson for World War I, Miss Nutting's erudition and statesmanship were brought into effective action.

Miss Nutting was a very influential member of that group of dynamic leaders who, in the nineties, established the NLNE, the ANA, and the Journal. She was president of what was then the Society of Superintendents of Training Schools for two terms, and its secretary for many years. To her, more than any one other member of that distinguished group, the profession owes a debt of gratitude for the excellence of its records.

Her penetrating intelligence made Miss Nutting a scholar by instinct as her education had prepared her for a very different sort of life. Demanding the best of herself, she expected no less from others. This characteristic was, however, happily combined with a warmly human interest in people and events that extended far beyond the immediate scope of nursing. Miss Nutting acquired international fame as nurse, historian, and educator. To those who knew her she was, however, not a personage but a wise and friendly counselor and a deeply loyal and inspiring friend.

1American Journal of Nursing, 49:675, Nov. 1948
JULIA CATHERINE STIMSON—1881-1948

To thousands of nurses, familiar with Colonel Stimson's dynamic personality, the news of her sudden death has been received with a sense of bewildering shock. It seems but yesterday, that as president of the ANA, she was making herself one with the audiences she addressed in many parts of the country. Julia C. Stimson was a gifted and a fortunate person. After her graduation from Vassar several years went by before, through the influence of Annie W. Goodrich (as the Colonel liked to remind us), she entered the New York Hospital School of Nursing.

An independent thinker and deeply sympathetic with the underprivileged, Julia Stimson's earlier professional years were spent at Harlem Hospital in New York and in social service in St. Louis. Passionately patriotic, she responded promptly to the call for volunteers in World War I. Her brilliant work overseas and long association with Miss Goodrich made her the logical successor to the creator of the Army School of Nursing and the superintendent of the Army Nurse Corps. Always interested in the work of the ANA and the NLNE, retirement from the Corps released her energies for more intensive participation in organization work.

As president of the ANA, she had a desk at national headquarters and devoted a major part of her time to the service of the organization. That task completed, she "retired" as dynamically as she had done everything else and promptly became a useful and influential citizen of her chosen home, Briarcliff Manor, near New York. There, at the time of her death, Colonel Stimson was a member of the boards of trustees of the library and of her church. She was chairman of the music committee of the church and had devoted much time to the training of the choir. Other committees, philanthropic organizations, and civic groups frequently turned to her for counsel and found in her an energetic and enthusiastic co-worker. Colonel Stimson will be greatly missed both within and without the profession.

APPRECIATION TO THE STAFF

The president then stated, "At this time, before we leave our very pleasant meeting, I would like to give very special recognition for the contribution of the staff at Headquarters to the work of the Board and the League. Under the outstanding leadership of our executive director, Miss Mayo, we have been able to proceed with a fair amount of speed, I think, and certainly with a great deal of support and encouragement from the staff." She then asked Miss Mayo, as a representative of the staff, to stand.

The president also asked Blanche Pfefferkorn, director of the Department of Studies, to stand, saying, "On Monday we did not have Miss Blanche Pfefferkorn with us. I think Miss Pfefferkorn deserves a special note of recognition." Miss Pfefferkorn replied, "I would like to say that for many years I think I have had the very best job there is in nursing in the National League of Nursing Education." The president remarked that if Miss Pfefferkorn had had the best job it was because she had made it the best job.

REPORT ON ATTENDANCE

The executive director reported that 1,557 persons had registered at the convention of which 353 had been students.

The meeting adjourned at 10:30 a.m.

MEETING OF THE COUNCIL OF STATE LEAGUES

Friday, May 6—11:00 a.m.—12:45 p.m.

The post-convention meeting of the Council of State Leagues was held in the Ohio Room of the Hotel Statler in Cleveland, Ohio, on Friday, May 6, 1949. The chairman, Agnes Gelinas, called the meeting to order at 11:00 a.m.

The secretary, Henrietta A. Loughran, called the roll to which the presidents or representatives of thirty-three state leagues responded. Also present were the four officer-members of the Council, other members of the Board of Directors, and other members of the League.

The chairman stated that the present meeting provided an opportunity for the state presidents and the Board of Directors of the national organization to plan together in the light of the information and knowledge which had been gained and the actions which had been taken at the recently concluded convention. Since some of the planning should be done in the light of the needs felt by the state leagues, she reviewed the needs which had been expressed by the state league presidents at the meeting of the Council of State Leagues on May 1, 1949. These included ways of developing closer cooperation with communities; the curriculum; the values of League membership to nurses and eligible non-nurses; implementation of the Brown Report; ways of reducing the number of committees; financing of programs; and more efficient methods of intercommunication between the state leagues and the national organization.

Miss Gelinas then added some questions which she and the members of the Board thought might be considered by the state league presidents. Can you suggest new policies for the National League of Nursing Education? How can joint planning by the National League and state leagues be developed? What suggestions have you for the National League program for 1949 and 1950? What departments should be established at Headquarters to give greater service to the state leagues? Can the American Journal of Nursing be used more effectively? Do you want a representative from National Headquarters to visit your league, and, if so, when?

REGIONAL COUNCILS

Florence Wilson (North Carolina) expressed appreciation for the visit of Gladys S. Benz of National Headquarters to the Regional Conference of State League Representatives held in Atlanta in April. At the request of some of those present, Alma E. Gault (Tennessee) further described the formation and purposes of this Regional Conference.

The Southern Regional Conference of State League Representatives, Miss Gault stated, had been inspired by the formation of the Southern Regional Council on Education, composed of the governor and two appointed persons
from each participating state. The purpose of the Council is to promote planning for educational facilities on the regional rather than the state level. For example, the Southern need for education in forestry can be met by two or three schools, and four schools of veterinary medicine are deemed sufficient for the entire Southern area. It would, therefore, be extravagant for each state to establish a school of forestry and one of veterinary medicine; instead, it would be financially practicable for the states to join together in supporting the necessary schools. Because of the financial implications of this joint planning, it is necessary for the participating states to become members of the Regional Council by vote of their legislatures.

In the discussion which followed concerning the desirability of having regional planning for nursing education, Sister Mary Anthony (Kentucky) pointed out that care must be taken that regional thinking should not replace national thinking. Miss Wilson explained that the Southern Regional Conference of State League Representatives had tried to circumvent this danger by stipulating in its constitution and bylaws that the organization would disband as soon as it had served its purpose and by keeping the National League thoroughly informed of its activities. Deborah M. Jensen (Missouri) expressed the opinion that some areas of the country are ready for regional planning while others are not even yet ready for state planning; that such factors as the geography of the state or region, the population, the centralization of educational facilities, and the cultural dominance of certain areas would all have a bearing on the level at which planning for nursing education could best take place. She stated that, although the Missouri league has no formal contracts with other state leagues, whenever it sponsors an institute which would be of interest to League members in nearby states it lets the leagues in these states know it. This, in a sense, might be considered the beginning of regional thinking. Miss Benz pointed out that regional planning need not cover the whole field of nursing education but might be undertaken with regard to certain specific activities; for example, regional work conferences on accrediting were being planned and the possibility of regional conferences on the Structure Study had been discussed.

Further discussion brought out the fact that a definition of regional areas would be a necessary precursor to regional planning. Henrietta A. Loughran (Colorado) stated that, historically speaking, regional councils such as the Southern Regional Council for Education sprang from a Regional Council of Governors which, in turn, developed from the National Council of Governors. She urged that nursing education make a place for itself on all such councils on education, pointing out that "if we are really going to turn to educational institutions we must fit somewhere within the pattern of general educational programs." She further stressed the need for nurse educators to get together for discussion of the problems coming before councils on education so that their representatives on the councils would speak not as individuals but as true representatives of nurse educators.
R. Louise McManus (New York) stated that at the Battle Creek Conference the advantages of having nursing educators work with regional groups of college interests had been stressed.

Miss Benz stated that another type of planning group in which nurse educators should participate is the group dealing with hospital construction. Miss Wilson stated that a nurse had been appointed to the Hospital Planning Commission in North Carolina and had finally, after three years, succeeded in getting a good deal accomplished. The representative from the Mississippi league stated that the study made by the Mississippi Commission on Hospital Care was largely responsible for the legislative appropriations for graduate nurse education and for a university school of nursing in Mississippi in 1948, and suggested that members of the Council of State Leagues might write for copies of this study.

SURVEYS OF NURSING NEEDS AND RESOURCES

Miss Gault stated that in seven of the fourteen states participating in the Southern Regional Conference of State League Representatives state-wide surveys of the resources, facilities, and needs of nursing and nursing education were being made or planned. Eugenia K. Spalding, Chairman of the Committee to Consider Federal Legislation on Nursing Education, and Blanche Pfefferkorn, director of the Department of Studies, then showed in what ways the information collected on a state or regional basis would be useful in the preparation of testimony for Congressional hearings on bills providing aid to nursing education.

Miss Pfefferkorn spoke of some of the sources of information which she had tapped in assembling facts about the number and qualifications of nurses who are available and the number and qualifications of those who are or will be needed to serve the health needs of the country. Among these sources were the Journal of the American Medical Association, such placement services as those conducted by Teachers College, Columbia University, and the Department of Studies itself which had collected statistics with regard to the preparation of trained practical nurses, the postgraduate education of professional nurses in advanced programs, and the education of nurses in colleges and universities at both the basic and the advanced level. Mrs. Spalding urged that state leagues add to this information which Miss Pfefferkorn had collected by sending in data from their states regarding: (1) the number of nurses needed in different areas of nursing practice; (2) the quality as well as the quantity of nursing; (3) reasons why prospective students are not entering schools of nursing and reasons why student nurses are dropping out of nursing schools; (4) limitations of facilities for basic or advanced nursing education, and (5) any studies dealing with the preparation of nurses in such different fields as hospital nursing, public health nursing, industrial nursing, and nursing education.
It was further brought out that states which were planning surveys of nursing needs and resources might well include the collection of data of this kind in their plans, since it would be of help in presenting testimony both to state legislatures and to Congress. It was also pointed out that information collected by the National League might be of considerable assistance to the state and regional groups.

COMMUNITY INTEREST

There was considerable discussion as to ways in which community interest in and help for nursing education was being aroused. Nina Mae Basham (Alabama) spoke of the citizens' committees being sponsored by the Alabama league; these committees were supporting the league's program particularly with respect to the securing of financial support for nursing education from the state legislature.

Ruth Johnson (Pennsylvania) stated that a similar project was being started by the Pittsburgh League of Nursing Education which was shortly going to have a workshop to orient citizens to the league's program. These citizens, whose names were being secured from physicians and schools of nursing, would then be asked to speak before other groups with regard to the problems and needs of nursing education.

Frances H. Cunningham (Ohio) pointed out that citizen cooperation in Cleveland was forthcoming through the Cleveland Community Nursing Council. Gertrude Nathe (Michigan) commented on the fine assistance given by the community nursing councils in the larger cities of Michigan, particularly as regards student recruitment, and told of a workshop arranged for representatives from these councils by the Michigan Nursing Center Association.

Eugenia K. Spalding (Indiana) described the work of a state-wide committee in Indiana which had been formed to carry out the recommendations of a workshop on the implications of the Brown Report participated in by educators, hospital administrators, and other citizens. She stated that the chairman of this committee was a dean of a college of arts and sciences and the committee membership included three college presidents, the publisher of one of the big newspapers in the state, the State Commissioner of Health, a representative of the State Department of Hospital and Institutional Services, a representative of the Commissioner of Education, the executive secretary of the State Board of Nurse Examiners, directors of nursing service and nursing education programs, and the presidents of the state league and Indiana Nurses' Association. This committee, Mrs. Spalding reported, had first concerned itself with problems of nursing service but the matter of improving nursing education had soon evolved as one of the paramount issues. At present the committee was making a list of all graduate nurses working in the state and was compiling a bibliography on any studies that relate to the supply of and need for nurses, from both the
quantitative and the qualitative points of view, and on any studies which might aid in a functional analysis of nursing. Next, the committee hoped to outline some needed projects and raise funds for the carrying out of these projects.

Cooperation with Practical Nurses

R. Louise McManus, a member of the NLNE Board of Directors, spoke of the Board's discussion concerning the desirability of recognizing that the practical nurse group is a group that is prepared to give service and, through the cooperation of professional nurses, can give better service. She stated that it was the Board's hope that the practical nurse groups throughout the country could be helped in their endeavors by state and local leagues; wherever the practical nurses wish to organize a state association, state leagues should help in the formation of such an organization to the end that practical nurses, like professional nurses, would be able to work together for their common goals, improve their conditions of work, and render better service to the community.

Lois Austin (Virginia) told how the professional nurses in Virginia had been instrumental in promoting the passage of legislation providing for the licensure of practical nurses and stated that the practical nurses had asked that professional nurses serve in an advisory capacity to the practical nurse associations which had been formed in various areas throughout the state.

Adelaide A. Mayo, executive director, spoke of the manual for state and local leagues on Practical Nurse Education which had been prepared by the NLNE Committee on Practical Nurse Education, stating that the second part of this manual which gave guidance in curriculum-making would shortly be distributed to the state and local leagues. She pointed out that schools of practical nursing were mushrooming up all over the country and stressed the need for nurse educators, through state and local leagues and the national organization, to work together more closely in setting up general policies in order to avoid the turmoil which might result from widely different developments in relation to the use of educational and hospital facilities and from a conglomeration of curricula. She suggested that the NLNE Board of Directors might well think in terms of providing some type of counseling service to aid in the development of practical nurse schools.

Ruth Henry (Georgia), Ruth Johnson (Pennsylvania), and Margaret B. Allen (New Jersey) expressed enthusiasm concerning Miss Mayo's suggestion, pointing out that the time was a strategic one for joint thinking on practical nurse education. Considerable interest was expressed in the manual for state and local leagues, and the executive director pointed out that the state leagues would be the channels through which knowledge about this pamphlet would be disseminated to vocational counselors and others interested in practical nurse education.
STATE LEAGUE PUBLICATIONS

Various members of the Council then told of materials available in their states that might be helpful in planning programs for practical nurses and gave as sources of these materials the New Jersey Board of Nurse Examiners, Newark, New Jersey; Helen Marchant, State Department of Education, Hartford, Connecticut; Nina E. Wootten, Secretary of the Committee on Nursing Education and Nursing Practice in Tennessee, Warner Building, Nashville, Tennessee; and the Michigan Nursing Center Association, Lansing, Michigan.

The chairman suggested that at the next convention it would be valuable to have an exhibit of publications by state leagues and asked that during the year the state leagues inform the National League of any publications which they had produced and could distribute to others, giving the price and place where these publications could be ordered, so that the national organization could keep League members informed of available materials.

FUTURE MEETINGS OF COUNCIL

The chairman then asked for a discussion as to the desirability of holding another post-convention meeting of the Council of State Leagues at the 1950 Biennial Convention in San Francisco in addition to the usual pre-convention meeting. There were many expressions of approval for such a meeting on the part of both state league presidents and NLNE Board members, it being decided, by a show of hands, that a two-hour meeting following the closing business meeting would be desirable.

DEPARTMENT OF ADVISORY SERVICE TO STATE LEAGUES

The secretary suggested that the representative of the new NLNE Department of Advisory Service to State Leagues of Nursing Education might well receive from the state leagues suggestions as to the program of the post-convention meeting of the Council. Gladys S. Benz, the director of this new department, then told of her tentative plans for visiting the state leagues during the coming year and stated that the five visits she had made during the past spring had been extremely helpful to her.

Upon motion of Agnes Salisbury (Connecticut) there was a vote of thanks for the "gracious leadership of our president." The meeting then adjourned at 12:45 p.m.
NATIONAL LEAGUE OF NURSING EDUCATION

THE AMERICAN SOCIETY OF SUPERINTENDENTS WAS REGISTERED APRIL 26, 1907, AND ON CHANGE OF NAME THE NATIONAL LEAGUE OF NURSING EDUCATION WAS REGISTERED JULY 22, 1914, IN NEW YORK COUNTY.


Bylaws 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; May 17, 1940; May 19, 1942; June 19, 1943; September 23, 1946; September 8 and 11, 1947; May 2, 1949.

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 questions relating to nursing education; to advance educational aims and standards in nursing; to assist in furthering the development of public health; to aid in measures for public good by co-operating with other bodies, educational, philanthropic, and social; to promote helpful and cordial professional relationships, and 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)

Robert E. P. Kreiter as to .......................................................... Jane A. Delano (Seal)
[.................................] Georgia Nevins (Seal)
[.................................] Clara D. Noyes (Seal)

*As amended; amended September 23, 1946, by vote of the League membership in convention; amendment recorded October 18, 1946.
BYLAWS

ARTICLE I

MEMBERSHIP

SECTION 1. Members in the National League of Nursing Education shall be classified as follows:

A. Nurse members with qualifications as set forth in Sections 2 and 3:
   Active, including sustaining

B. Lay members with qualifications as stated under Section 4:
   Active, including sustaining

C. Honorary members as defined in Section 5

SEC. 2. An applicant for nurse membership shall, after October 1, 1949, qualify by:

a. (1) Having been graduated from a school of nursing accredited by the legally authorized state accrediting agency 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 from a school of nursing accredited by the legally authorized state accrediting agency 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 or affiliations of not less than six months in a state-accredited school of nursing connected with a hospital having a minimum daily average of 100 patients, or having completed satisfactorily, after graduation, a course or courses of not less than six months; or
   (3) Having been graduated from 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. (1) Holding a position carrying administrative or teaching responsibilities in a school of nursing or educational organization or health agency or in a government service employing nurses; or
   (2) Holding a position as director of nursing service in a hospital without a school of nursing; or
   (3) Holding a position as administrator or instructor in a school of practical nursing approved by the legally authorized state accrediting agency or the National Association for Practical Nurse Education.

e. (1) Being approved for active membership by a state or local league; or
   (2) Being approved for active individual membership by the executive director.

SEC. 3. A sustaining member is an active member interested in furthering the financial welfare of the League, who has paid the dues required of such membership.

SEC. 4. An applicant for lay membership shall qualify for active or sustaining membership by:

a. (1) Having been or being a member of a board of trustees of a hospital conducting a school of nursing; or
   (2) Having been or being a member of a school of nursing committee; or
   (3) Having been or being a member of a board of trustees or of a faculty of a college or university concerned with nursing education; or
(4) Having been or being a member of a board or a committee member of a public health agency concerned with nursing education for student or graduate nurses; or
(5) Having been or being a member of the administrative or teaching staff of a school of nursing; or
(6) Having made or making important surveys or studies or other recognized contributions to nursing education.

b. (1) Being approved for lay membership by a state or local league; or
(2) Being approved for lay individual membership by the executive director.

SEC. 5. Honorary membership may be conferred by a unanimous vote of the voting body at the annual convention or business meeting 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. Honorary members do not pay dues.

SEC. 6. a. An applicant for active membership in the National League of Nursing Education shall be accepted in one of four ways:

(1) As a member of a local league of nursing education, which gives automatic membership in state leagues and the National League of Nursing Education; or
(2) As a member of a state league where there is no local league, which gives automatic membership in the National League of Nursing Education; or
(3) As an individual member if residing in a state which has no state league, or upon special action of the Board of Directors; or
(4) As an individual member if residing in a state where Negro nurses are not eligible for membership in the state league. Membership in the National Association of Colored Graduate Nurses will be accepted in lieu of membership in the American Nurses' Association.

b. An applicant desiring to join the National League of Nursing Education as an individual member shall make application on a form furnished by the executive director. The form, after being properly filled in, shall be sent with the required dues to the executive director.

SEC. 7. An active member in good standing in any state league who changes her residence to another state may be admitted by transfer, upon request to the executive director of the National League of Nursing Education who will notify the treasurers of both state leagues of such transfer. A member who has paid her dues for the current year before transferring to another state league will receive a membership card from and be granted full membership privileges by the state league to which she has transferred without further payment of dues for the current year. A member who transfers to another state league before she has paid her current dues will pay such dues to the state (or local) league to which she is transferring. A member living in one state and working in another or temporarily located in a state may be permitted to continue her membership in the state of her choice.

SEC. 8. An active member who is not permanently located may retain her membership on an individual basis by paying dues directly to the National League of Nursing Education.

SEC. 9. An active member who has withdrawn from the National League of Nursing Education or whose membership has lapsed on account of nonpayment of dues may be reinstated by paying the regular annual dues for the current year to the state in which she is a resident, except as provided in Section 7 or in Section 8.
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, all of whom shall be nurses. These four officers, and eight directors, one of whom shall always be a lay member, and, as ex officio members, the president of the American Nurses' Association, the president of the National Organization for Public Health Nursing, the editor of the American Journal of Nursing, and the executive director, 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 and three members of the Committee on Nominations referred to in Article V, Section 2. a. shall be held by mail within two months preceding the annual convention or business meeting. All elections shall be by ballot. All elections shall be had by plurality vote.

SEC. 3. The president shall appoint the necessary tellers of election.

SEC. 4. All members whose dues have been received at Headquarters by the first day of the month preceding the month of the annual convention or business meeting shall receive ballots. Ballots, enclosed in special envelopes, shall be returned to Headquarters by the date indicated annually.

SEC. 5. Tellers shall count and record all votes, and all records shall be checked by an auditor, and a certified and sealed report shall be given to the secretary.

SEC. 6. Each officer shall hold office until the adjournment of the annual meeting at which her successor has been elected.

SEC. 7. In the event of a vacancy in the Board membership, the Board of Directors shall fill the vacancy until the next election.

ARTICLE IV

DUTIES OF THE BOARD OF DIRECTORS AND OFFICERS

SECTION 1. The Board of Directors shall:

a. Act as trustees of the nursing profession for the advancement of nursing education.

b. Establish broad objectives to be achieved by the National League of Nursing Education.

c. Determine basic policies to be followed in achieving the broad objectives.

d. Develop programs outlining general methods to be used by operating staff in executing the approved policies.

e. Select members of the Board to serve on its advisory committees.

f. Review and approve annual budgets.
g. Select an executive director and give her adequate authority to manage and direct activities of the National League of Nursing Education in accordance with established policies and programs.

b. Review progress being made by the executive director in executing her responsibilities.

i. Hold an annual meeting and meet at other times at the call of the president or request of five or more members of the Board.

j. Appoint committees as provided for in Article V.

SEC. 2. The president shall:

a. Preside at conventions and at all meetings of the Board of Directors, Executive Committee, and the Council of State Leagues and be a member ex officio of all committees.

b. Report to the Board of Directors at its meetings and to the membership at the annual convention or business meeting.

c. Perform all duties 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 or business meeting and of the meetings of the Board of Directors and of the Council of State Leagues.

b. Report at each annual convention or upon request the policies established and action taken at all business meetings of the membership.

c. Send a notice of the annual convention to each member at least one month in advance.

d. 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.

SEC. 5. The treasurer shall:

a. Serve as chairman of the Committee on Finance.

b. Report to the membership the financial standing of the League at each annual convention and upon request.

SEC. 6. The executive director shall:

a. Be chief operating executive of all National League of Nursing Education activities.

b. Formulate and recommend policies and programs to the Board of Directors.

c. Carry out policies and programs approved by the Board of Directors.

d. Administer, coordinate, and control the activities of the Headquarters staff.

e. Develop a basic organization plan and select executive personnel.

f. Direct the development of financial budgets for all activities.

g. Be an ex officio member of all committees.

h. Represent the National League of Nursing Education in planning and checking the results of activities entered into as joint projects with other organizations.

i. Administer programs of the Joint Board of the Six National Nursing Organizations assigned to the League.

j. Appoint members of any committee requested by a department to assist it in carrying out a designated function. She shall select these members from names submitted by the executive officer of the department requesting the committee. She shall dissolve the committee after consultation with the executive officer.
SECTION 1. Committees of the Board.

a. The Executive Committee shall:
   (1) Consist of five Board members, two of whom shall be the president and executive director.
   (2) Transact Board business that arises between Board meetings except the establishment of policy.

b. The Committee on Finance shall:
   (1) Consist of four Board members, two of whom shall be the treasurer and executive director.
   (2) Act as general financial advisers to the Board of Directors.
   (3) Review the annual budget submitted by the executive director.
   (4) Present the budget, with recommendations, to the Board of Directors.
   (5) Establish general financial policies concerning the handling of funds and the designation of banks in which funds are deposited.
   (6) Determine and supervise the making of investments.
   (7) Review and approve major expenditures before they are made.
   (8) Provide for the annual audit and review the report with the auditor.
   (9) Act in advisory capacity to the executive director.

c. Advisory committees as needed shall:
   (1) Consist of at least two or three Board members. A Board member shall be chairman of each committee.
   (2) Act in advisory capacity to the Board on problems and policies pertaining to any of its functions.

SEC. 2. Committees of the National League of Nursing Education. Committees of the National League of Nursing Education shall be appointed as needed by the Board except as herein provided.

a. The Committee on Nominations. The committee shall consist of five members. The chairman and one other member shall be appointed by the president and three members shall be elected by ballot as provided in Article III, Section 2.

On or about 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 and one for the Committee on Nominations. This form 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, eight names for the office of directors, and six names for the Committee on Nominations. 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 and the ticket published in the American Journal of Nursing when approved by the Board of Directors.
SEC. 3. Each committee shall present a written report of its activities to the annual convention and to the Board of Directors as requested, and keep the executive director informed of its work, as may be indicated, during the year.

ARTICLE VI

DUES

SECTION 1. The annual dues for all active members of the National League of Nursing Education shall be $5.00.

a. In states where there is a state league, dues ($5.00) for all active members shall be paid through the state league on the basis of membership as of March 1 of each year, except for 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 ($5.00) shall be paid directly to the National League of Nursing Education. Dues shall accompany application.

SEC. 2. The annual dues for sustaining members shall be $13.00, which shall entitle the members to receive pamphlets published by the League during the year, not to exceed $2.50 in value.

a. In states where there is a state league, dues ($13.00) for all sustaining members shall be paid through the state league on the basis of membership as of 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 ($13.00) shall be paid directly to the National League of Nursing Education. Dues shall accompany application.

SEC. 3. Any state leagues or individual members 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 forfeit all privileges of membership. Active members having forfeited their membership may be reinstated upon the payment of dues for the fiscal year.

ARTICLE VII

MEETINGS

SECTION 1. A convention or business meeting 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 business at each convention shall include:

a. Reading of the minutes
b. Annual reports of secretary, treasurer, and executive director
c. Annual reports of presidents of all state leagues of nursing education
d. Annual reports of committees
e. Address by the president
f. Miscellaneous business
g. Announcement of election of officers and directors and members of the Committee on Nominations
ARTICLE VIII

REPRESENTATION

SECTION 1. The voting body at the annual convention of the National League of Nursing Education shall consist of active and sustaining members of state leagues in good standing, and individual active and sustaining members in good standing.

ARTICLE IX

QUORUM

SECTION 1. A quorum of the Board of Directors shall be eight members.
SEC. 2. A quorum of the Executive Committee shall be three members.
SEC. 3. A quorum of the Council of State Leagues shall be ten members other than the officers.
SEC. 4. Members from fifteen states shall constitute a quorum for the transaction of business at any annual convention.

ARTICLE X

FISCAL YEAR

SECTION 1. The fiscal year of this association shall be the calendar year.

ARTICLE XI

COUNCIL OF STATE LEAGUES

SECTION 1. The officers of the National League of Nursing Education and the presidents of the state leagues shall constitute a Council of State Leagues.
SEC. 2. The duties of the Council of State Leagues shall be to keep the National League informed of the progress of nursing education in the states represented and promote programs of the National League of Nursing Education.
SEC. 3. Meetings of the Council of State Leagues shall be held in connection with each annual convention or business meeting and at any other time as called by the Board of Directors. The members shall 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 Council of State Leagues by an alternate appointed by the state league.

ARTICLE XII

STATE LEAGUES

SECTION 1. Where the term "state league" is used in these Bylaws, the word "state" shall be understood to apply equally to any state of the United States of America, to the District 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 members in the states, the District of Columbia, the territories, possessions, or dependencies shall be the same. (See Article 1, Sec. 5, Bylaws, American Nurses' Association.)
SEC. 2. A group of League members desiring to form a state league of nursing education shall make application on the form furnished by the executive director. This form shall be properly filled in and, with a copy of the proposed constitution and bylaws, shall be sent to the executive director and shall be referred by her to the Board of Directors for final approval.

ARTICLE XIII
DUTIES OF STATE LEAGUES

SECTION 1. 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 executive director 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 the 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 promote within the state league activities the policies and programs of the National League of Nursing Education.

f. To confer with the executive director regarding changes in the state constitution and bylaws. All proposed changes shall be sent for approval to the executive director in duplicate, together with two copies of the old constitution and bylaws. Upon the adoption of any changes, the state league shall send one copy of the revised bylaws to the executive director.

g. To help organize local leagues, when desired.

h. To provide official representation, as a member of the Council of State Leagues, at each annual convention.

ARTICLE XIV
PARLIAMENTARY AUTHORITY

SECTION 1. Deliberations of all meetings of the National League shall be governed by Robert's Rules of Order Revised.

ARTICLE XV
THE OFFICIAL ORGAN

SECTION 1. The American Journal of Nursing shall be the official organ of the National League of Nursing Education.
SECTION 1. These Bylaws 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 Bylaws may be amended at any annual convention by the unanimous vote of the active members present and voting, without previous notice.

ISABEL HAMPTON ROBB MEMORIAL FUND, INC.

*MRS. R. LOUISE McMANUS, Chairman
Teachers College, Columbia University
New York 27, N. Y.

*ELEANOR HALL, Vice Chairman
Yale University
School of Nursing
New Haven, Conn.

*VIRGINIA M. DUNBAR
1520 York Avenue
New York 21, N. Y.

BLANCHE E. EDWARDS
440 East 26th Street
New York 10, N. Y.

AGNES GELINAS
303 East 20th Street
New York 3, N. Y.

LUCY HARRIS
Harris Methodist Memorial Hospital
Fort Worth, Tex.

HELEN J. LEADER
Presbyterian Hospital
Philadelphia 4, Pa.

MADELEINE McCONNELL
1439 South Michigan Avenue
Chicago 5, Ill.

*ELEANOR MOLE
Brooklyn Visiting Nurse Service
138 South Oxford Street
Brooklyn, N. Y.

MILDRED MONTAG
46 Kilburn Road
Garden City, N. Y.

EDNA S. NEWMAN
1900 West Polk Street
Chicago 12, Ill.

*MRS. MARGARET W. EGBERT, Secretary-Treasurer
252 Deems Avenue
Staten Island, N. Y.

*Members of Executive Committee.
ROBB MEMORIAL FUND

REPORT OF THE ISABEL HAMPTON ROBB MEMORIAL FUND, INC.
(McIsaac Loan Fund and Isabel Hampton Robb Scholarship Fund)

SECRETARY’S REPORT FOR 1948

Applications for scholarships received .......................................................... 10
Scholarships awarded—$400.00 each ............................................................... 2

  Graduate of Frances Payne Bolton School of Nursing, Western Reserve University
  Field of work: Administration, School of Nursing
  School of choice: Western Reserve University

(Massachusetts) Miss Frances Theresa Tomasunas—27 Suffield Street, Worcester, Mass.
  Graduate of Massachusetts General Hospital
  Field of work: Nursing Education
  School of choice: Boston University

Alternate, Miss Hilda C. Burnham, 3308 Westfield Avenue, Baltimore, Md.
  Graduate of Johns Hopkins Hospital School of Nursing
  Field of work: Teaching Nursing Arts
  School of choice: Louisiana State University

Since Miss Dalrymple was unable to secure leave of absence for the year she was promised a scholarship in 1949-1950 and Miss Burnham received the $400.00 scholarship.

McIsaac Loans awarded ................................................................. 2

(Tennessee) Mrs. Mary Raines Scott, 706 Jackson Avenue, Memphis, Tenn.
  Loan $200.00
    Graduate: Memorial Hospital, Worcester, Mass.
    Field of work: Teaching and Supervision in Schools of Nursing
    School of choice: Teachers College

(Massachusetts) Miss E. Claire Voyer, 721 Huntington Ave., Boston, Mass.
  Loan $200.00
    Graduate: Peter Bent Brigham Hospital, Boston, Mass.
    Field of work: General Nursing
    School of choice: Boston University

Loans paid in full during 1948
  #266 Dora Harris White, $200.00 awarded in 1941
  #286 Miriam A. Dailey, $150.00 awarded in 1946
  #290 Evelyn Ryer, $200.00 awarded in 1946
  #291 Phyllis Gray, $200.00 awarded in 1946
  #294 Gertrude Humm, $250.00 awarded in 1947

Outstanding Loans
  Notices of payments due have been sent to all loans over a year old.

Outlawed Loans:
  The following loans were written off the books in accordance with the resolution dated February 11, 1948:
    #11 Mary Helen Hankins, Balance of $195.00 due in 1924
    #31 Julian Lindsley Johnson, $200.00 due in 1927
    #48 Mary Salisbury Iglett, Balance of $10.00 due in 1929
  No reply to communications.
CONTRIBUTIONS RECEIVED IN 1948

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<th>Institution</th>
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<th>Mclsaac</th>
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ROBB SCHOLARSHIP FUND

Financial Statement as of December 31, 1948

Assets

Cash:
First National Bank, Ossining, N. Y. .............................................. $675.32
Bank for Savings, Ossining, N. Y. ............................................... 219.21
U. S. Government Bonds ..................................................... 35,200.00
Prepaid Expense .............................................................. 20.83

$36,115.36

Principal, Surplus and Reserves

Principal ................................................................. $35,593.16
Surplus ........................................................................... 322.20
Reserve for Scholarships Already Granted .................................. 200.00

$36,115.36

Statement of Income and Expense

Income
Interest on Bank Balance .................................................. $4.33
Interest on U. S. Government Bonds ..................................... 1,030.00

$1,034.33
ROBB MEMORIAL FUND

Expenses

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Net income for Year

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<td>$ 894.92</td>
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McISAAC LOAN FUND

Financial Statement as of December 31, 1948

Assets

Cash:
- First National Bank, Ossining, N. Y. $ 2,286.96
- Bank for Savings, Ossining, N. Y. 4,403.39
- U. S. Government Bonds 13,000.00
- Loans Receivable 3,945.05
- Prepaid Expense 20.83

**Total Assets** $23,656.23

Principal and Surplus

Principal $23,336.29
Surplus 319.94

**Total Principal and Surplus** $23,656.23

Statement of Income and Expense

Income

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<td>Interest on Loans</td>
<td>26.83</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>$ 438.81</strong></td>
</tr>
</tbody>
</table>

Expenses

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Secretarial service</td>
<td>$ 6.19</td>
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<tr>
<td>Stationery and printing</td>
<td>47.40</td>
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<tr>
<td>Postage</td>
<td>5.00</td>
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<tr>
<td>Accounting and financial services</td>
<td>100.00</td>
</tr>
<tr>
<td>Treasurer's bond</td>
<td>10.42</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>7.75</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$ 176.76</strong></td>
</tr>
</tbody>
</table>

Net Income for Year $ 262.05

Respectfully submitted,

MARGARET W. EGBERT, R.N., Secretary-Treasurer*

*Julia C. Stimson served as Secretary-Treasurer up to her death in October, 1948.
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† Lay member
‡ No state league

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GRAF, KATHERINE J. Veterans Administration Hospital, Montgomery 10

1This list includes those members whose 1949 dues reached NLNE Headquarters by September 15, 1949.
2Bylaws (revised by vote of the membership September 23, 1946), Article I, Sec. 3: "A sustaining member is an active member interested in furthering the financial welfare of the League, who has paid the dues required of such membership." Article VIII, Sec. 2: "The annual dues for sustaining members shall be $15.00, which shall entitle the members to receive pamphlets published by the League during the year, not to exceed $2.50 in value."
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<td>Bowen, Bessie L.</td>
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<tr>
<td>Bowen, Vera L.</td>
<td>Veterans Administration Hospital, Chambless</td>
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<tr>
<td>Brackett, Ida A.</td>
<td>Veterans Administration Hospital, Chambless</td>
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<tr>
<td>Bradley, Martha M.</td>
<td>Veterans Administration Hospital, Augusta</td>
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<tr>
<td>Branch, Elizabeth</td>
<td>Macon City Hospital, Macon</td>
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<tr>
<td>Brandiner, Hilda A.</td>
<td>Veterans Administration Hospital, Chambless</td>
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<tr>
<td>Briggs, Mrs. Willie G.</td>
<td>Veterans Administration Hospital, Chambless</td>
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<tr>
<td>Burch, Mary</td>
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<td>Burpee, Mrs. Margaret Mcl.</td>
<td>University Hospital, Augusta</td>
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<td>Burum, Mrs. Frances R.</td>
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<td>Happy Hollow Rd., Doraville</td>
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<td>Florida Sanitarium &amp; Hospital, Orlando</td>
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<td>Doty, Florence J.</td>
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<td>Duncan, Emma</td>
<td>Dearing</td>
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<td>Edenfield, Minna</td>
<td>Georgia Baptist Hospital, Atlanta</td>
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<td>Etheridge, Mattie</td>
<td>Veterans Administration Hospital, Chambless</td>
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<td>Ethridge, Mrs. Mamie C.</td>
<td>Piedmont Hospital, Atlanta</td>
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<td>Falls, Ruby</td>
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<td>Fountain, Annie P.</td>
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<td>Georgia—184</td>
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<thead>
<tr>
<th>Members</th>
<th>Kentucky—Louisiana</th>
</tr>
</thead>
</table>
| Nelson, Anna | Sister Mary Benigna  
St. Joseph Infirmary, Louisville 8  |
| Noel, Betty S. | Sister Mary Leonis  
St. Anthony Hospital, Louisville  |
| Nooner, Dorothy | Sister Mary Phus  
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| O’Brien, Bernice E.* | Sister Robert Ann  
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| Painter, Ruby H. | Specie, Florence A.  
Somerset General Hospital, Somerset  |
| Norton Memorial Infirmary, Louisville 3 | Stacy, Frances  
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| Ponder, Nellie | Stanley, Ruth  
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| St. Joseph Hospital, Lexington |  |
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| Nazareth College, Louisville 3 |  |
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| Sister Mary Anthony |  |
| St. Elizabeth Hospital, Covington |  |
| Sister M. Assumpta |  |
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Louisiana—192

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<thead>
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<th>Address</th>
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</thead>
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<tr>
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<td>Our Lady of the Lake Sanitarium, Baton Rouge</td>
</tr>
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IERVALINO, ISABELLA C.
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<td>IGOR, MARGARET</td>
<td>2965 Marion Ave., New York 58</td>
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<td>ILLING, FLORENCE L.</td>
<td>82 Chestnut St., Albany 6</td>
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<td>INGRAM, MADELINE E.</td>
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<td>East Loop Rd., Staten Island 4</td>
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<td>JAKOBY, GERARD</td>
<td>Sea View Hospital, Staten Island 14</td>
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<td>Kings County Hospital, Brooklyn 3</td>
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<td>Samaritan Hospital, Troy</td>
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<td>Rensselaer County Dept. of Health, Troy</td>
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<td>477 St. John's Pl., Brooklyn 16</td>
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<td>Mercy Hospital, Watertown</td>
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<td>KNOCHE, MRS. LAZELLE S.</td>
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<td>KOCHER, ELSIE B.</td>
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<td>KONNIWISER, MRS. EVELYN S.</td>
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<td>KOPSCHE, GERTRUDE</td>
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<td>1001 Inwood Pl., Brooklyn 13</td>
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LEWIS, GERTRÜDE E.  
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<thead>
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<th>City</th>
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<td>Briggs, Mrs. Eva W.</td>
<td>5013 Nassau St., Philadelphia 31</td>
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<tr>
<td>Brown, Barbara L.</td>
<td>20 Keystone Ave., Upper Darby</td>
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<td>Brown, Gertrude M.</td>
<td>Danville State Hospital, Danville</td>
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<td>Hahnemann Hospital, Scranton</td>
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<td>Brown, Mrs. Leona G.</td>
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<td>Brown, Mary E.</td>
<td>51 N. 39 St., Philadelphia 4</td>
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<td>Brumbaugh, Olga L.</td>
<td>St. Christopher's Hospital for Children, Philadelphia 33</td>
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<td>Bryant, Mrs. Kathryn P.</td>
<td>Allegheny Valley Hospital, Tarentum</td>
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<td>Buckingham, Mrs. Gertrude S.</td>
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<td>Burhenn, Ruth</td>
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<td>Burroughs, Mrs. Beatrice W.</td>
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<td>Butler, Miriam C.</td>
<td>Philadelphia General Hospital, Philadelphia 4</td>
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<td>Byler, Sara E.</td>
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<td>Calabro, Frances M.</td>
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<td>Cann, Mary T.</td>
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<td>Cantwell, Elsie B.</td>
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<td>Carey, Margaret A.</td>
<td>Veterans Administration Hospital, Lebanon</td>
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<td>Carlson, Louise M.</td>
<td>Allegheny General Hospital, Pittsburgh 12</td>
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<td>Carlson, Marjorie E.</td>
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<td>Carney, Mary H.</td>
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<td>Carpenter, Rose M.</td>
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<td>Carroll, Eileen P.</td>
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<td>Carroll, Mary A.</td>
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<td>Chalfant, Mrs. Henry C.</td>
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<td>Chilcott, Ruth E.</td>
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<td>Childs, Katherine</td>
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<td>Christie, Anna M.</td>
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<td>Clyde, Frances K.</td>
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<td>Coble, E. Arabella</td>
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<td>Cochran, Mary L.</td>
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<tr>
<td>Cohen, Mary A.</td>
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<td>Coleman, Grace E.</td>
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FLETCHER, LILA B.,
Wisconsin General Hospital, Madison 6

FLYNN, MARY
416 McKinley, Eau Claire

FULWILER, IRENE M.
St. Joseph’s Hospital, Marshfield

GEYER, ANNE M.
223 W. Washington Ave., Madison

GIERHAIN, OLGA L.
2912 S. Wentworth Ave., Milwaukee 7
GIVEN, LEILA L.
70-11 35 Ave., Jackson Heights, N. Y.
GIZIEWSKI, ETHEL M.
735 N. 17 St., Milwaukee 7
GOODWIN, MARGARET C.
2024 N. 33 St., Milwaukee
GRACE, MARYANN L.
3106 N. 56 St., Milwaukee
GRANT, DOROTHY L.
1024 Main St., Racine
GRANT, MRS. ELEANOR F.
Excelsior Springs, Missouri
GRANZOW, ELIZABETH R.
1565 N. Franklin Place, Milwaukee 2
GREZINSKI, VICTORIA L.
2150-A S. 19 St., Milwaukee 7
GUNDERSON, MRS. ARLEEN S.
434 N. RANDALL, Madison
GUARDANT, LOIS B.
Luther Hospital, Eau Claire
HALL, PRISCILLA K.
Methodist Hospital, Madison 3
HARDER, FLORENCE L.
4217 W. Fond du Lac Ave., Milwaukee
HARPER, VIVIENNE M.
324 W. Washington Ave., Madison 3
HASSELS, ANNA
1638 N. Case St., Milwaukee 2
HAUBRICK, SYLVIA E.
1614 54 St., Kenosha
HENSCHEL, CARMEN
753 N. 29 St., Milwaukee
HERIN, BERNICE
908 N. 19 St., Milwaukee
HOFFMAN, CLARA
3035 W. Wisconsin Ave., Milwaukee 8
HOGAN, MARY C.
3035 W. Wisconsin Ave., Milwaukee 8
HOPPER, RUTH J.
Winnebago State Hospital, Winnebago
HUBBARD, MRS. MAGDALENE T.
528 N. 60 St., Wauwatosa
JENNY, MARTHA R.
1492 University Ave., Madison 6
JOHNSON, ROSEMARY
1020-A W. State St., Milwaukee
JORDHEIM, OLGA M.
St. Luke's Hospital, Racine
KAHN, FLORENCE
2310 W. Kilbourn Ave., Milwaukee 3
KAMINSKI, MRS. YVONNE K.
1301 College Ave., Racine
KERN, ALVIN B.
7215 W. Hadley St., Milwaukee 13
KERRWIN, DORIS
1018 N. Jefferson St., Milwaukee 2
KOMAR, DORA
615 N. 14 St., Milwaukee 3
KOWALKE, ERNA M.
1038 N. Case St., Milwaukee
KRAABEL, R. ELINE*
309 Central Ave., Apt. 3, Eau Claire
KREICK, OLINDA
5367 N. 34 St., Milwaukee 9
KREUGER, LEONA
949 N. 23 St., Milwaukee 3
KREUGER, VIRGINIA R.
Veterans Administration Hospital, Wood
KULZICK, MRS. MAXINE H.
812 Butternut Road, Madison 4
LANGE, EMMA P.
841 N. 26 St., Milwaukee 3
LARSON, BERNICE E.
University of Wisconsin School of Nursing, Madison 6
LAWTON, ELIZABETH A.
801 S. 57 St., West Allis 14
LAWTON, MRS. WEALTHY
916 N. 24 St., Milwaukee 3
LEE, MRS. MARIAN K.
14825 Newton St., Eau Claire
LOCKE, MRS. ERDA O.
317 N. Murray, Madison
LUNDMARK, MRS. MARGARETA H.
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LUTOVSKY, DOROTHY
3068 N. 27 St., Apt. 202, Milwaukee 10
MABARD, BERNICE M.
3220 W. Meinecke Ave., Milwaukee 10
MEBRIDE, ELIZABETH
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MERGER, M. EVELYN
8900 W. Wisconsin Ave., Milwaukee
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MILLER, GENEVA E.
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MULANEY, GERTRUDE S.
Milwaukee Dept. of Health, Room 805, City Hall, Milwaukee 1
MURPHY, ELLIE M.
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425 Lorch St., Madison 5
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509 St. Joseph St., Marshfield
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REDDEMAN, LOLA A.
1309 Linden Drive, Madison 5
REGENFUSS, LORRAINE A.
6107 Seventh Ave., Kenosha
REITAN, MRS. EDITH
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THOMPSON, BIRGITE
216 Bellinger St., Eau Claire

THOMPSON, RUTH E.
312 St. Lawrence Ave., Beloit

TOPZANT, MARTHA A.
2161 N. 73 St., Wauwatosa 13

TOUTENHOOFD, KOREN E.
Veterans Administration Hospital, Woods

TURCK, A. SYLVIA
1206 S. 69 St., Milwaukee 14

VERNON, MRS. RUTH
741 S. 23 St., Apt. 5, Milwaukee 4

WATSON, SHIRLEY
118 S. Mills St., Madison 5

WEISS, ROSE M.
St. Mary's Hospital, Milwaukee 2

WHTA, VIOLETTE V.
Mendota State Hospital, Mendota

WILHELM, MARGARET A.
4544 W. Leon Terrace, Milwaukee 10

WINTER, MARGARET
2215 E. Newton Ave., Milwaukee 11

WOLFENDEN, MARJORIE M.
433 Lorch St., Madison 5

ZABLOCKI, MABEL D.
1010 Mound St., Madison 5

ZELLMER, CAROL
5333 N. 64 St., Milwaukee 9

ZIEGEL, ERNA E.
1226 W. Dayton St., Madison 5

ZINZOW, MRS. ROSELLA
1377 N. 54 St., Apt. 204, Milwaukee 8

BORDEAUX, MRS. ESTHER P.
123 E. College Ave., Sheridan

HUNNELL, IRENE C.
245 E. Burkitt, Sheridan

McLEAN, GRAZIELLA
Memorial Hospital, Rock Springs

WESTON, MRS. DAPHINE
Memorial Hospital of Laramie County, Cheyenne

CURTIS, MRS. CLARA W.*
Caixa Postal 1264, Rio de Janeiro, D. F.

KAIN, CATHERINE M.*
Av. Rio Branco 251-12, Caixa Postal 1830,
Rio de Janeiro, D. F.

ELLIS, KATHLEEN W.
Bessborough Hotel, Saskatoon, Saskatchewan

McDONEL, HELEN M.
Winnipeg General Hospital, Winnipeg, Manitoba

PENHALE, HELEN E.
11069 82 Ave., Edmonton, Alberta

WRIGHT, ALICE L.
1106 W. 13, Vancouver, B. C.

Myers, Mrs. Lydia M.
Box 221, Caranqui

CRAWFORD, MARTHA H.
109 Regent St., Colombo

CULLEY, FRANCES E.
Wuhu General Hospital, Wuhu, Anhui

WEIR, MILLIE E.
c/o American Embassy, Guatemala City

CATTELAIN, MARTHA P.
P.O. Box B.S1, Port au Prince

572
INDIA—2

JOHNSON, IDA M.
Memorial Hospital, Fatehpur, United Provinces

MARTYN, FLORENCE H.*
Board of Missions of the Methodist Church.
150 Fifth Ave., New York 11, N.Y.

IRAN—1

FULTON, JANET
American Hospital, Teheran

JAPAN—1

WHITE, SARA G.
Tokyo Foreign Missionaries, APO 500, c/o Post-
master, San Francisco, Calif.

MEXICO—1

MONTEITH, MRS. MARY C.
Apartado 16, Montemorelos, N. L.

NETHERLANDS WEST INDIES—1

STAMBAUGH, RUTH E.
Lago Oil & Transport Co., Ltd., Medical Dept.,
Aruba, Curacao
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*No state league
**TOTAL MEMBERSHIP SEPTEMBER 15, 1949**

(Continued)

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*No state league

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**Deceased Members**

Names from 1893 to December 31, 1948, are given in previous annual reports. The names of members whose deaths have been reported since December 31, 1948, follow:

AUSTIN, IDA F. ........................................ December 16, 1948
BURGESS, ELIZABETH C. ................................ July 22, 1949
CLERKIN, PATRICK ..................................... August 16, 1948
COX, LUCY M. .......................................... June 16, 1949

MURRAY, CHRISTINA CAMERON ...... December 4, 1948
MASSE, SOPHIA TEFTA ............................... March 10, 1949
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