Forty-First Annual Report

of the

National League

of

Nursing Education

1935
PROCEEDINGS

of the

Forty-First Annual Convention

of the

National League of Nursing Education

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NATIONAL HEADQUARTERS
50 West 50th Street
New York, New York
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50 W. 50th St., New York, N. Y.

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197 Clarendon St., Boston, Mass.

†Mrs. George Carpenter, Jr.
5 Hortense Place, St. Louis, Mo.

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138 S. Oxford St., Brooklyn, N. Y.

†Mrs. Gammell Cross (ex officio)
112 Benevolent St., Providence, R. I.

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Alma C. Haupt (ex officio)
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Katharine Tucker (ex officio)
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Representing the National League of Nursing Education

†Mrs. Linzee Blagden
129 E. 36th St., New York, N. Y.

†Mrs. Robert McClellan
Cambridge, N. Y.

* Members of Executive Committee.
† Lay associates.
COMMITTEES

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2065 Adelbert Rd., Cleveland, Ohio

Effie J. Taylor (ex officio)
Yale University School of Nursing,
New Haven, Conn.

Claribel A. Wheeler (ex officio)
50 W. 50th St., New York, N. Y.

Anna D. Wolf (ex officio)
525 E. 68th St., New York, N. Y.

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*Laura M. Grant
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*Marion G. Howell
2065 Adelbert Rd., Cleveland, Ohio

* Members of Executive Committee.
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This committee, with Clara D. Noyes, Chairman, includes ten representatives from each national nursing association, the presidents of which are ex officio members.

Following are the representatives of the National League of Nursing Education:

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Teachers College, New York, N. Y.

ADDA ELDREDGE
8 S. Michigan Ave., Chicago, Ill.

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735 E. 15th St., New York, N. Y.

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114 Clifton Place, Jersey City, N. J.

SALLY JOHNSON
Massachusetts General Hospital, Boston, Mass.

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Johns Hopkins Hospital, Baltimore, Md.

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43 Rupert St., Amherst, Nova Scotia, Canada

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CLARIBEL A. WHEELER (ex officio as Executive Secretary)
50 W. 50th St., New York, N. Y.

EFFIE J. TAYLOR (ex officio as President)
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COMMITTEE COMPOSED OF REPRESENTATIVES OF THE NATIONAL LEAGUE OF NURSING EDUCATION, NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, AND AMERICAN ASSOCIATION OF HOSPITAL SOCIAL WORKERS

JOINT COMMITTEE ON COMMON EDUCATIONAL PROBLEMS

Representing the National League of Nursing Education

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ISABEL M. STEWART
Teachers College, New York, N. Y.

CLARIBEL A. WHEELER
50 W. 50th St., New York, N. Y.

ANNA D. WOLF
525 E. 68th St., New York, N. Y.

Representing the National Organization for Public Health Nursing

DOROTHY J. CARTER
50 W. 50th St., New York, N. Y.

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Representing the American Association of Hospital Social Workers

ANTOINETTE CANNON
122 E. 22d St., New York, N. Y.

RUTH LEWIS
Social Service Dept., Washington University, St. Louis, Mo.

KATE McMAHON
Simmons College, Boston, Mass.

MARY TAYLOR
Presbyterian Hospital, New York, N. Y.
PAST OFFICERS OF THE
NATIONAL LEAGUE OF NURSING EDUCATION

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

Anna L. Alston, President
Louise Darche, Secretary
Lucy L. Drown, Treasurer

Officers elected in the years following have been:

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

1895 Boston, Mass., February 13, 14.
    President, Linda Richards; Secretary, Louise Darche; Treasurer, Lucy L.
    Drown.

1896 Philadelphia, Pa., February 11, 12, 13, 14.
    President, M. E. P. Davis; Secretary, Mary S. Littlefield; Treasurer, Lucy L.
    Drown.

1897 Baltimore, Md., February 10, 11, 12.
    President, M. Adelaide Nutting; Secretary, Lavinia L. Dock; Treasurer,
    Lucy L. Drown.

1898 Toronto, February 10, 11, 12.
    President, Mary Agnes Snively; Secretary, Lavinia L. Dock; Treasurer,
    Lucy L. Drown.

1899 New York, N. Y., May 5, 6.
    President, Isabel McIsaac; Secretary, Lavinia L. Dock; Treasurer, Lucy L.
    Drown.

1900 New York, N. Y., April 30, May 1, 2.
    President, Isabel Merritt; Secretary, Lavinia L. Dock; Treasurer, Anna L.
    Alline.

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

1902 Detroit, Mich., September 9, 10, 11.
    President, Lystra E. Gretter; Secretary, Lavinia L. Dock; Treasurer, Anna L.
    Alline.

1903 Pittsburgh, Pa., October 7, 8, 9.
    President, Ida F. Giles; Secretary, M. Adelaide Nutting; Treasurer, Anna L.
    Alline.

1905 Washington, D. C., May 1, 2, 3.
    President, Georgia M. Nevins; Secretary, M. Adelaide Nutting; Treasurer,
    Anna L. Alline.

1906 New York, N. Y., April 25, 26, 27.
    President, Annie W. Goodrich; Secretary, M. Adelaide Nutting; Treasurer,
    Anna L. Alline.
1907 Philadelphia, Pa., May 8, 9, 10.
   President, Maude Banfield; Secretary, Georgia M. Nevins; Treasurer, Anna L. Alline.

1908 Cincinnati, Ohio, April 22, 23, 24.
   President, Mary Hamer Greenwood; Secretary, Georgia M. Nevins; Treasurer, Anna L. Alline.

1909 St. Paul, Minn., June 7, 8.
   President, Isabel Hampton Robb; Secretary, Georgia M. Nevins; Treasurer, Anna L. Alline.

1910 New York, N. Y., May 16, 17.
   President, M. Adelaide Nutting; Secretary, M. Helena McMillan; Treasurer, Anna L. Alline.

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

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

In June, 1912, the name of the Society was changed to the National League of Nursing Education.

1913 Atlantic City, N. J., June 23, 24, 25.
   President, Mary C. Wheeler; Secretary, Jessie E. Catton; Treasurer, Mary W. McKechnie.

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

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

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

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

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

1919 Chicago, Ill., June 24 to June 28.
   President, S. Lillian Clayton; Secretary, Laura R. Logan; Treasurer, M. Helena McMillan.

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

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

1922 Seattle, Wash., June 25 to July 1.
   President, Anna C. Janné; Secretary, Martha M. Russell; Treasurer, Bena M. Henderson.
1923 Swampscott, Mass., June 18 to June 25.
   President, Laura R. Logan; Secretary, Martha M. Russell; Treasurer, Bena
   M. Henderson; Executive Secretary, Effie J. Taylor.

1924 Detroit, Mich., June 16 to June 21.
   President, Laura R. Logan; Secretary, Ada Belle McCeley; Treasurer, Bena
   M. Henderson; Executive Secretary, Blanche Pflefferkorn.

   President, Laura R. Logan; Secretary, Ada Belle McCeley; Treasurer,
   Marian Rottman; Executive Secretary, Blanche Pflefferkorn.

1926 Atlantic City, N. J., May 17 to May 23.
   President, Carrie M. Hall; Secretary, Ada Belle McCeley; Treasurer,
   Marian Rottman; Executive Secretary, Blanche Pflefferkorn.

1927 San Francisco, Calif., June 6 to June 11.
   President, Carrie M. Hall; Secretary, Ada Belle McCeley; Treasurer,
   Marian Rottman; Executive Secretary, Blanche Pflefferkorn.

1928 Louisville, Ky., June 4 to June 9.
   President, Carrie M. Hall; Secretary, Ada Belle McCeley; Treasurer,
   Marian Rottman; Executive Secretary, Blanche Pflefferkorn.

1929 Atlantic City, N. J., June 17 to June 21.
   President, Elizabeth C. Burgess; Secretary, Stella Goostray; Treasurer,
   Marian Rottman; Executive Secretary, Nina D. Gage.

1930 Milwaukee, Wis., June 9 to June 14.
   President, Elizabeth C. Burgess; Secretary, Stella Goostray; Treasurer,
   Marian Rottman; Executive Secretary, Nina D. Gage.

1931 Atlanta, Ga., May 4 to May 9.
   President, Elizabeth C. Burgess; Secretary, Stella Goostray; Treasurer,
   Marian Rottman; Executive Secretary, Nina D. Gage.

1932 San Antonio, Tex., April 11 to April 15.
   President, Elizabeth C. Burgess; Secretary, Stella Goostray; Treasurer,
   Marian Rottman; Executive Secretary, Claribel A. Wheeler.

1933 Chicago, Ill., June 12 to June 16.
   President, Effie J. Taylor; Secretary, Stella Goostray; Treasurer, Marian
   Rottman; Executive Secretary, Claribel A. Wheeler.

1934 Washington, D. C., April 23 to April 27.
   President, Effie J. Taylor; Secretary, Stella Goostray; Treasurer, Marian
   Rottman; Executive Secretary, Claribel A. Wheeler.

1935 New York, N. Y., June 3 to June 8.
   President, Effie J. Taylor; Secretary, Stella Goostray; Treasurer, Marian
   Rottman Fleming; Executive Secretary, Claribel A. Wheeler.

The Organization has affiliations with
American Association of Hospital Social Workers, 18 East Division Street, Chicago, Ill.
The American Child Health Association, 50 West 50th Street, New York, N. Y.
American Dietetic Association, 185 North Wabash Avenue, Chicago, Ill.
American Hospital Association, 18 East Division Street, Chicago, Ill.
American Nurses' Association, 50 West 50th Street, New York, N. Y.
American Psychiatric Association, New York State Psychiatric Institute and Hospital,
   722 West 168th Street, New York, N. Y.
American Red Cross Nursing Service, Washington, D. C.
American Social Hygiene Association, 50 West 50th Street, New York, N. Y.
American Society for the Control of Cancer, 1250 Sixth Avenue, New York, N. Y.
Association of Collegiate Schools of Nursing, Teachers College, New York, N. Y.
Association for Promotion and Standardization of Midwifery, New York, N. Y.
Maternity Center Association, 1 East 57th Street, New York, N. Y.
National Education Association of the United States, Washington, D. C.
National Organization for Public Health Nursing, 50 West 50th Street, New York, N. Y.
National Tuberculosis Association, 50 West 50th Street, New York, N. Y.
National Committee for Mental Hygiene, 50 West 50th Street, New York, N. Y.
PROCEEDINGS
OF THE
FORTY-FIRST ANNUAL CONVENTION
OF THE
NATIONAL LEAGUE OF NURSING EDUCATION
New York, N. Y., June 3-8, 1935
Opening General Session
Monday, June 3, 8:00 p.m.

Presiding: Effie J. Taylor, R.N., President.
The invocation was given by the Reverend L. Ernest Sunderland, D.D.,
Superintendent of the New York Protestant Episcopal City Mission Society.

ADDRESS OF WELCOME
MRS. LINZEE BLAGDEN, Executive Vice President,
Board of Managers, Bellevue School of Nursing

Your Committee on Arrangements has done me a great honor in asking
me to be the one to say a word of welcome to you at this the forty-first con-
vention of the National League of Nursing Education. I look upon it as a
tribute to the Board of which I am privileged to be a member. This self-
perpetuating body has marched beside your profession for 63 years, some-
times leading, at others, following and supporting you in measures essen-
tial to your progress.

In starting a school for nursing in a general hospital in this country, the
first Board of Managers of the Bellevue Training School for Nurses of
course turned to St. Thomas’ Hospital and Florence Nightingale for direc-
tion. Having shown this wisdom, their own vision and ideals established a
firm base for growth and development. I think we all are glad to unite in
doing homage to their memory. They would indeed be proud and happy
could they realize that from the beginning they made in 1872, this great
assembly has resulted,—and so to you who represent the best expression of
the nursing schools from the vast regions of this country I extend the most
heartfelt welcome and greeting.

In looking over this interesting record I have one regret, and feel it
strongly, that is that more people outside of the field of nursing have not
been as conversant as they should be, and as I think would have been mu-
tually advantageous, with the problems of education and training with which
you have had to grapple. My experience has been most fortunate. When
I was very young, in my early twenties, I was asked to join the Board of
Managers of the Bellevue Training School for Nurses. I had never been to a hospital before and one of the managers took me all over Bellevue. It was an exhausting and harrowing experience, but more than that it was bewildering. I attended meetings and visited wards, I didn’t think much about the nurses, except to wonder how they did it. I got a distinct impression of a remarkable atmosphere of kindness. Something of the spirit seemed to pervade that great space of suffering, misery, and loneliness, and I realized that the hospital and its inmates had a lesson for life of infinite value. Miss Goodrich was the superintendent, as that position was then called, and she seemed to me a person of rare distinction, but I hadn’t the least conception of the complicated and intricate duties that she had to face. Little by little light dawned, but there wasn’t much opportunity to consider educational problems per se, they were so interwoven with practical difficulties of administration, salaries, housing, overcrowded wards, recreational facilities and the lack of them, questions to be taken up with the city authorities to further benefit the patients or the nurses, or even to protect our own existence.

The managers who had gone before had established and carried on the school on so independent and strong a basis that the tradition for forging ahead has been a very potent influence in the consideration and action of successive boards. The history of it all is too familiar to you to go into. Since that first school, started and financed for a long time by private funds, has grown to the place it now holds, we all appreciate the important part the Board of Managers has taken in reaching the present goal. For all these reasons I would urge in the most emphatic terms that every training school in the country should have a group of citizens, representative of their community, closely allied with all that goes on in a school of nursing and its laboratory, the hospital, public health, and allied fields. It does not seem to me possible to lay down definite rules for the organization of such boards that shall be common to all hospitals. They exist in many hospitals now but not in all, by any means. At once I know your minds jump to kinds of hospitals. There are some of which the nursing school is one unit of a teaching institution, others where the nursing school is the only teaching unit. But these are matters of detail. That a nursing school should be represented on the central board of the institution to which it is attached through its own board of trustees, or managers, is the point I want to make.

The board is the interpreter to the public, and should be informed on all that the principal of the school is working to hold and to bring about, and should also know what the public is thinking and wanting and expecting from the pupil and graduate nurse. Besides that, some knowledge of educational standards and school curriculum on the part of the managers, or board, or whatever one likes to call the body, is necessary. At the same time an equally important consideration for a vigilant board is the appreciation of the responsibility for the sick, so increasingly dependent on nursing care, which in turn is dependent on the health and the general bearing of the
individual student. She must, to be a good nurse, have all the attributes that one ideally associates with nursing. She must be strong, fearless, accurate, kind, courageous, knowledgeable, tactful, and a good companion in many instances. How can she be unless her health is safeguarded as far as possible and provision is somehow made and opportunity given for recreation, cultural activity, a measure of study or expression in something away and apart from her work, in something that belongs to herself? An interested nursing committee in close touch with the directress of the school and her staff can do a great deal in providing these things and in keeping the balance between them and nursing requirements.

Close cooperation between the directress and supervisors and instructors and a lay body informed and with interests and contacts outside the hospital, develops a combination of viewpoints with mutual benefit to all departments of the institution and affords great benefit to the layman. Some definite contract or arrangement must, of course, be made with the hospital authorities and the affairs of the schools delegated by them to the board, and close contact between the groups arranged for through joint conference and representation on the board of trustees. It might be that the appointment of major positions, the inclusion of budget requests for new departures or departments, or permission to try out some new things with money specially raised—later to take their place in the school organization, could be left to the board and director of the school, subject to the approval of the hospital authorities. Changes, improvements, or developments, could come about only after the most carefully checked arguments are presented and all questions involved are considered. Such an organization helps the school to keep moving forward, to meet the changing demands and requirements, and to graduate a happier, more helpful, better adjusted nurse citizen. After all, we are all together in the effort to improve conditions about us and, more than ever before, can we think and work at a common problem with respect for the contribution to thought each group from its experience, knowledge, and good will has to make.

The more I say, the more intricate the pattern I try to weave becomes. For what your profession has done in planning for the changes to meet changing demands is seen all about us, and the gathering here tonight bears testimony to that. The Study of the Grading Committee and the Time Study, the former made at a cost of $250,000—$98,000 of which was contributed by the profession itself—the latter financed by the Bellevue Board, are also evidence of the interest and ability of those dedicated to the care of the sick and prevention of disease—evidence, too, that their own advancement is not the incentive of such labor but rather the best and most efficient service and care that can be given to those in need of it.

Goethe said that wherever the contact with Life is made, Life itself holds interest, so we take from it what we are willing, able, and prepared to find. The greater our capacity, the more we are whole people, true, rounded, and
rich in thought, the richer is the recompense. Our spirits grow in strength and we can give accordingly.

I am very happy to welcome the members of the National League of Nursing Education to New York City. We appreciate your coming and the opportunity you give us to widen our knowledge. We hope that you will feel repaid for your effort and that your stay may be a happy one.

ADDRESS OF WELCOME

AGNES GELINAS, R.N., President, New York State League of Nursing Education

Henry David Thoreau said that he had three chairs in his house: one, for solitude; two, for friendship; three, for society. We who are members of the New York State League feel, like Thoreau, that in our home state we have special chairs for our guests—chairs for friendship and chairs for society.

To those who represent the community and who are not League members I wish to extend the first welcome and a very particular sort of greeting. We like to think that there are a great many of these society chairs filled with those who represent the community at large—the friends who help to support nursing education projects, inspire the nurse leaders, and help to interpret the aims and objectives of nursing education to society. To you we extend a very cordial welcome and our appreciation in anticipation of your contributions to come this week.

The friendship chairs, I know are well occupied. The National League of Nursing Education seems to strengthen old relationships. These yearly meetings are eagerly anticipated by its members because we have learned that we can not get very far by arguing over long distances. Group discussions help us to clarify our thinking and we benefit greatly by our annual meetings. It is a great privilege to extend a warm welcome to the old and new members of the National League of Nursing Education. We hope that you exchange chairs frequently so that you will make many new friends this year. We also hope that you will take some time to enjoy the city.

The advance publicity about this 1935 National League of Nursing Convention has brought the announcement that the deliberations will revolve around the changes that are needed in the curriculum. This challenging topic has attracted over one thousand members and friends of the organized educational profession to New York City.

What, after all, do we come to these meetings for? What can we hope to accomplish this week? Of all things we might try to do on our return home, what is most worth while?

We come to the League meetings for inspiration and guidance so that in educating our students they will be able to utilize their education in shaping the society of tomorrow. This year, particularly, we come in order to learn how some of our schools can win the material means and public support
necessary to develop collegiate schools of nursing. We want guidance in the matter of combating forces, which, under the guise of economical necessity, would exploit and deprive our students of the broad cultural and professional education they need in order to learn to serve the community more adequately. We come to study the content of the new curriculum which aims to prepare students for greater social activity. We are eager to hear about newer trends in the profession.

We hope to accomplish a great deal during this week. A new philosophy of nursing education will surely evolve from the ideas and ideals of our speakers and from our various group discussions. This philosophy should help us to declare ourselves significantly, should give new courage and fresh incentive to those who are building the new curriculum, and should guide us when we try to put the aims and objectives of the revised curriculum into practice. The ever-increasing realization that nursing education is a matter of national concern rather than state interest should also influence us to initiate the plans to develop a national accrediting agency, a national board of examiners and a nation-wide integration of particular educational projects sponsored by the National League of Nursing Education.

My hope is that this meeting will not result in a lot of wishful thinking but rather that we will see how to reach out toward a greater participation in professional, social, and economic activities, so that on our return to our own communities we will better prepare our students to eventually supply community leadership in the matters of health education and disease prevention.

The members of the New York League of Nursing Education join me in extending to our guests from New England, the South, the Middle West, Southwest, Northwest and the Pacific Coast their cordial welcome to the metropolitan East. This is a particularly happy time for us and we appreciate your coming so that we may renew old friendships and make new friends, so that we can sit down together, put our problems on the table, and reach agreements on at least a few outstanding nursing problems. I trust that you will all have a very happy experience out of the 1935 National League of Nursing Education meetings.

**PRESIDENT’S RESPONSE AND ADDRESS**

**TWENTY-FIVE YEARS IN NURSING EDUCATION**

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

It is twenty-five years since the League had the honor of meeting in New York City. In the year 1910 the convention of the two national nursing organizations was held, and the golden anniversary of the founding of the first modern training school for nurses established by Florence Nightingale in St. Thomas’ Hospital, London, England, was celebrated. It is strangely
suitable, and, indeed, significant that the invitation from the New York State League should come to the National League in 1935 to convene again in this city, at which time we celebrate the seventy-fifth anniversary of the establishment of that historic school.

It is a particularly happy occasion, for on the anniversary evening, June 4th, we anticipate that many of those who were present in Carnegie Hall and participated in the memorable celebration in 1910 will be with us again. We rejoice in the kindly dealing of time which has privileged a new generation of nurses to know personally one whose contribution stands out most eloquently in our nursing history, and who throughout the last forty-five years has been to American nurses their Florence Nightingale. On this occasion we pay tribute to the work and influence of Mary Adelaide Nutting and to her dearly beloved whilem colleague, Isabel Hampton Robb, the pioneers in nursing education in America. It is to their insight, clear, far-reaching vision, and courage that nursing has now a respected place with other professional schools in the many universities in this and other countries of the world.

The idea of establishing an organization for the study of uniform standards, through which the training of nurses could be maintained on an educational plane, was conceived by Isabel Hampton, and it was in New York City in January, 1894, that the first convention was held in the Academy of Medicine. I esteem it therefore a great honor and a great privilege to address you on this occasion at the opening session of the forty-first anniversary of the founding of the first national association of nurses in the United States.

As we look back over the years and attempt to recall the events which have passed in rapid succession, we are filled with awe and with deep inspiration as the picture unfolds and again recedes upon the canvas of our consciousness. Schools of nursing have multiplied many times since that inaugural year, and from out these schools has passed an army of nurses into a field for which, in the main, they were inadequately armed. Some, by their prowess, have brought prestige to themselves and to nursing. Some inevitably have passed unnoticed and unknown. The greatest number by far are faithfully working day by day, seeking to give back to the cause for which nursing stands what they themselves have received through their inheritance and through their training; and under the inspiration of our glorious leaders who have pointed the way, they are seeking also to provide for the American people the kind and the quality of nursing care to which every human being should be heir.

In 1910 trained nursing was somewhat of a luxury, and to people of moderate means was available in only a limited way. Today, through the rapid development of visiting nursing and other interested agencies the nursing care of patients may be obtained on whatever basis their needs may require, and to a large extent nursing care can be purchased at a price which the patient can afford to pay.
The National League of Nursing Education has many functions, but perchance its greatest usefulness may be fulfilled in discovering the ways by which nurses may be prepared to serve the community, and, in accord with this great objective, in further studying the content of education which should be included in the preparation of nurses adequately to meet their responsibilities. Another primary function which this organization must accept is to indicate where and under what conditions students can best be instructed in the art and the science of nursing, that they may be equipped with knowledge and skill to bring to the people both within and without the hospital what they urgently require.

While nursing education must always be specifically concerned with the mastery and perfection of skills and techniques essential to the practice of therapeutic procedures in the hospital itself, a broader and more comprehensive vision for the education of nurses must supersede the limited outlook which relates almost entirely to the acquiring of manual dexterity. The advancements in the fields of medicine and in the newer field of public health have greatly changed the emphasis which was formerly placed on the content of knowledge required by nurses to function cooperatively with physicians in the cure of disease.

During the last twenty-five years the dominant note in medicine has been shifting gradually from cure to prevention, and we are, by this inevitable force of change in thought and practice, constrained to enlarge our thinking of a quarter of a century ago and to reconstruct our ideas for the education of nurses so that they may be in accord with the newer knowledge of the causes and cure of disease available today, and also with our changing social and economic conditions.

The League is vitally concerned with the fundamental structure of nursing education, and its worthiness as a guide will be tested by the extent to which it is able to wield an influence in preparing students for the practice of nursing to meet abundantly the needs of those who are dependent upon it.

When last we met in New York on a similar occasion to that which is now being celebrated, the new consciousness was first beginning to dawn within the medical and psychological fields of education that the mental and the physical lives of human beings are inseparable. It was between 1909 and 1912 that we began to realize that nursing involved not only the care of the body but an understanding also of the more intangible conditions interpreted through reactions, responses, and behavior in their many and varied forms. It was approximately at this time, perhaps even a little later, that we became familiar with such terms as mental hygiene, mental therapy, child development, and child guidance, and began to talk of mental disease rather than of insanity.

A new era was born to medical science as the relation of psychiatry and psychology to general medicine was established. With great rapidity this understanding in the medical world shed its influence upon the practice of nursing for which practice a new type of education was made evident. When
nurses began to realize that patients with emotional disturbances and behavior difficulties were not just queer, troublesome, and disagreeable, but were ill and suffered as much as or more acutely than they suffered when in physical pain, a new conception was given to nursing. A new field of research and study was opened then as nurse educators sought to interpret the relations existing between the mind and the body, the reactions which each had upon the other, and the body of knowledge which nurses required in order to minister to patients who depended upon them so vitally for their support and comfort.

At once the more progressive schools incorporated into their curricula courses in general, applied, and abnormal psychology. At the present time, psychology and psychiatry are required courses in the curricula in some states, and in the majority of good schools these subjects in one form or another are included in the course of study, whether or not they are required by state laws. As we have become more understanding of the influence which the mind exerts upon the bodily functions and reactions, and bodily reactions upon the activity of the mind, and environment upon each, our deepening and increasing knowledge of these intimate relationships with their cumulative effect upon personality, has convinced us that nurses should be as thoroughly acquainted with these interactions as they are with the procedures, techniques, and skills which were formerly thought to encompass the whole of nursing.

During the past quarter of a century, the knowledge gained through mental hygiene has had a great influence on the trend which nursing education has taken, and the gradually shifting emphasis from the practice of purely routine technical procedures to a study of the total individual in his natural environment, through the use of the case study method of teaching nursing, has changed from the concept described in 1873, when the first American training schools were established. In a history of one of the early schools, the function of nurses is thus described:

Nurses are not medical men—on the contrary nurses are there and solely there to carry out the orders of the medical and surgical staff, including, of course, the whole practice of cleanliness, fresh air, diet, et cetera. The whole organization of discipline to which the nurses must be subjected is for the sole purpose of enabling them to carry out intelligently and faithfully such orders and such duties as constitute the whole practice of nursing.1

Our ideas relating to the function of the nurse have changed since this was written in 1873. This change has been influenced greatly by research as to the cause and prevention of mental and emotional disturbances. The fact that much of mental illness and maladjustment in adult life can be traced directly back to problems unknown and unrecognized in early childhood make the nurse a strategic person in discovering these early signs and symptoms, and in emphasizing to the parents the need for close observation and skillful handling of children in all of their daily activities and contacts.

1 1873-1923. Fiftieth Anniversary, Bellevue Training School for Nurses.
This concept of the function of nurses is very clearly set forth by a well-known social worker in her book entitled *Mental Hygiene in the Community*. Miss Bassett sees the nurse with broad, unbiased vision, as probably the most important person in the field of health teaching, and she expresses her opinion thus:

When the nurse leaves the hospital and engages in private duty nursing, she is confronted not, as formerly, with one patient under controlled hospital conditions but with a whole family group displaying a most perplexing network of relationships which directly affect the patient. In the home the nurse may discover in full operation, all the resentments, the hatreds, fears, dominations, feelings of guilt, and jealousies which often complicate family relationships, and the expression of these reactions are often intensified in periods of family stress. . . . The psychologically trained nurse who is scientifically trained should be able in the future to throw much light on these problems, thus making her own contribution to the field of mental hygiene. . . . Probably no other professional group has such a unique opportunity to promote mental as well as physical health, as public health nurses.¹

The point of view described by this most progressive psychiatric social worker differs greatly from that described almost three-quarters of a century ago. In 1873 the concept we received was that of a follower always faithful in service, disciplined to obedience, and subservient to authority. Today we conceive the nurse to be a scientific worker, questioning in her interest, trained to lead and to teach intelligently. She is also prepared by education to assist the physicians and research workers, who are striving through investigation, observation, and study to find new knowledge through which to protect and preserve the health of our people.

While the contrast between these two concepts is vivid and startling, there are elements of similarity which are fundamental and essential, without which the art of nursing would lose its beauty and its deepest value.

May we endeavor always to keep the spirit of service in our work, to keep all that was noble and beautiful in the old traditions, but to keep them alive by keen thinking, deep knowledge, and understanding of ourselves as well as of those whom we are called upon to serve.

We find the world today in its present chaotic state largely because we were not able to interpret the thinking of each other; we were not able to understand the effect which mental attitudes have upon our bodily reactions. It has been frequently said that the people of the world are sick today, and sick because they do not understand, not only the world at large, but themselves in their reactions to each other, as they go in and out fulfilling the duties and tasks of everyday life. Conflict and strife seem uppermost in educational fields, in business, in politics, and in world relations, and it may be because our people are fearful of themselves and of each other.

The League of Nursing Education has a challenge of great magnitude to meet, if it be true that nurses make more intimate contacts with a larger number of people in homes and in institutions than any other group of

health or community workers. We, the nurse educators, are faced with the responsibility of preparing young women to go out from our schools of nursing armed with the right kind of knowledge to attack the problems they will meet in their contacts with people. Our nurses must not only learn to follow orders obediently but how to interpret needs. They must learn not only how to work under authority and rule, but how to work alone and to provide for their own emergencies. They must learn not only how to deal with a single patient, but how to deal also with the family and the community. They must learn not only how to assist in getting the patient well, but how to help him keep well and prevent a recurrence of his present illness. And finally, good nurses must know not only how to care for the sick body, but how to help relieve the strain and anxiety of mental worry and unrest. It is not enough to give the patient good physical care and wish him good night and a refreshing sleep, if his mental anguish, fear, and worry have been overlooked. Nurses have other functions more binding, more urgent, and more real than those which can be absolved by a series of physical manipulations, though these are not to be minimized. The mental therapies are more intangible and more difficult to practice. They can not be hurried and often require some sacrifice of individual time, as one endeavors to get near the sick one and share with him his personal problems and understand his difficulties.

The whole patient in all of his relationships becomes a fascinating study which can be made only by persons scientifically trained, those who have a sound background of knowledge in the biological and social sciences, and who have also acquired a profound grasp of these sciences in their application to the art of nursing. The art of nursing has a deeper connotation than the practice of nursing procedures. It means more than the application of therapeutic measures in the cure of disease and an intellectual knowledge of many subjects. It embodies all of these—but more—for in addition it is the art of living with people, of knowing them intimately, of understanding their strengths and their weaknesses, of sharing their lives and having that deep though illusive knowledge of how and when to help them.

Dr. Stephen Rushmore, in a recent article, described "the care of the patient as religion of the physician," and I know of nothing which also so beautifully describes the art of nursing, or which raises nursing upon so high a pedestal, as to think of it in its broadest and most ideal sense, in the care of patients, also as "the religion of the nurse."

**WHAT SOCIETY NEEDS FROM NURSING**

**WILLIAM J. ELLIS, LL.D., PH.D., Commissioner, Department of Institutions and Agencies, State of New Jersey**

It is a fitting thing on this occasion, which marks the 75th anniversary of the founding of the first hospital training school for nurses by Florence Nightingale in London, in 1860, for us to consider together for a little
while the subject which has been assigned to me, "What Society Needs from Nursing."

Like the medical profession, the profession of nursing has shown extraordinary development during the last half century. This development and extension is due in large part to the strides made in our scientific knowledge. The discoveries of Pasteur and Lister, Dr. Morton, and Dr. Koch were crowded into the last half of the nineteenth century. Medicine and the nursing profession have been stimulated by these scientific advances. The influence of leaders among the nurses themselves, from the days of Miss Nightingale, down to the present, has been synonymous with the spread of the influence and prestige of this essential profession.

In our own country, the training schools for nurses were first sponsored (about 1870 to 1873) by Bellevue Hospital, New York, the New England Hospital for Women at Boston, and the Massachusetts General Hospital. It is interesting to know that when Bellevue was getting ready to begin nurse training, Miss Nightingale was asked to recommend procedures, and that she responded with an outline of instructions which requires but little change to make it completely applicable today.

An important factor in developing your profession has been the cooperation and affiliation of hospitals and the nurses themselves. In 1893 was founded the American League of Nursing Education, and in 1896 the American Nurses' Association, followed by the rapid development of State Associations and the State Boards of Examiners, who have done so much to accelerate the development of this profession.

The multiplication of hospitals of many types and the increasing complexity of the tasks have made demands upon the nurses' knowledge and ability progressively more exacting and difficult. The public health movement is responsible for drawing nurses into new and wider ranges of duty and responsibility. The nurse is accorded a strategically important share in the hard task of securing the continuous and intelligent cooperation of man in his own deliverance from disease.

You have, no doubt, learned that the functions of the nurse are constantly changing and expanding. It is a challenge to the leaders among nurses to find that the broad general field of nursing is so comprehensive.

They tell us that in this country in 1926 there were 2,155 hospital training schools, with an enrollment of 76,527 students. The number of schools and the number enrolled has been reduced, according to a recently compiled report of the League of Nursing Education, to 1,472 schools of nursing and an enrollment of 67,533 students. You who have completed the course know full well that all who enroll do not graduate from the courses of training, which, no doubt, you have found reasonably rigorous.

While in 1900 there were only 90 nurses for each 1,000 physicians, in 1920 there were 1,028 to each 1,000 doctors, and at the 1928 rate of production, there would be in 1965, 4,371 nurses for each 1,000 doctors or four and one-third nurses for every doctor.
There is a demand for properly trained nurses in public institutions. For example, more and more the old type attendant or practical nurse is giving way to the demands for skill and education as the only safe means for protecting health and combating disease. Of course, the nurses’ lot is not easy. But some people would emphasize the necessity for self-sacrifice as though self-sacrifice was the only demand upon the nurse.

Florence Nightingale long ago denied that nursing demanded complete sacrifice of self. She said, “Nursing is not a sacrifice, it is a life, the happiest of any.” Fortunately, nursing does offer satisfactions in abundance. It is an interesting life, with its wide range of contacts, with problems which constantly challenge one’s thought, with evidence of achievement, and with the thrill of adventure. There are a few modest material satisfactions, but above all, there is the gratitude and confidence of the patients themselves.

Nurses need satisfactions even more than these. They need play and recreation, friendships, social life, intellectual stimulation, and spiritual refreshment, just as other people do.

It is one of your greatest opportunities that your profession brings you into contact with people who learn to depend upon you and have confidence in you. Nothing develops or educates one so much as these human contacts.

Trained nurses in increasing numbers are going out from our hospitals, not merely to take care of the sick but to carry on an organized work of prevention and eradication of disease through departments of public health, tuberculosis clinics, mental hygiene clinics, and other forms of social-service work.

On the occasion of his appearance as President of the American Public Health Association, last September, Dr. Haven Emerson issued a challenge to public health authorities to bestir themselves about the business of putting into practical service the knowledge of biologic science which has become available through the course of the years.

“‘If we are to make full use of biological knowledge,” said Dr. Emerson, “we must command, first, some increase in effective intelligence; second, something of the spirit of religious devotion even to the point of self-denial in the material possessions and accessories of today’s life; and third, courage to apply what biology has taught us to believe.”

That challenge by Dr. Emerson applied not only to members of the medical profession but also to the allied professions of education and public welfare administration. All three of these will find their hands strengthened and upheld by the members of this profession of yours, the great nursing organizations of this and other countries.

Quoting the historian Kirsopp Lake, Dr. Emerson observed, “If the general intelligence rate rises even a fraction of one per cent, that rise constitutes a revolution in social conditions,” adding that it would be evidence of a major gain if tradition and superstition were to be replaced by reasoning based on objective observation and by habits of thought which lead to controlled experiments for information,
The multitude is much victimized with false claims of healthfulness for foods, drugs, soaps, cigarettes, candies, cough drops, illuminated milk, ice, bread, and other items.

Nurses engaged in their ministrations to the people, whether it be in the hospitals, in private service, or in the prevention of illness and the promotion of social welfare, will be able to offset much of the vicious propaganda which preys upon ignorant human fears of illness or on futile hopes for health. No new knowledge is required. The training through which every qualified nurse must pass gives her a fund of facts and sound ideas with which to offset published falsehoods and thus help to lift intelligence levels.

Recent changes in the basic economic factors at work in our nation will probably bring about an increasing discrepancy between the production of wealth and the need for its expenditure for lengthening the period of education and in making provision for the decent care of aged persons in our population. Perhaps this tendency will require a choice between sacrificing some of our costly luxury expenditures and meeting the necessities of adequate investments in health and culture. So long as we spend, as a people, nine billion dollars a year for tea, coffee, tobacco, alcohol, cosmetics and beauty treatments, we may not logically plead an inability to support necessary services devoted to the promotion of health and public education.

Members of the nursing profession can do much in the quiet promotion of services leading to enduring satisfactions and the deeper securities of life as they move about in their daily contacts among the people. They can teach that practice of self-denial in small things which would be an augury of decent restraint in the affairs of community life.

Members of the nursing profession are in a particularly fortunate position to stimulate courageous application of the practical biological knowledge at our command. Yours is the knowledge and the opportunity to teach those lessons of personal hygiene and of careful sanitation which your training has taught you so well to understand.

The conditions of sanitation which have turned our towns and cities from pest holes, which they frequently were at the time of Florence Nightingale, into areas where death rates are low, have not spread universally. We still have sordid slums, both urban and rural, where the ravages of disease rage almost unchecked. Unsanitary home conditions and personal habits still make hundreds of thousands of our less fortunate, from the rural south to the industrial north, walking museums of potential disease. Environmental sanitation has been well begun in this country but it is far from finished. More than half of the people in some of our southern states, and far too many in the northern states, are living today at a sanitary level no higher than that of domestic animals. The cattle in many a certified dairy farm live under a technique of cleanliness superior to that in vogue among a large fraction of our population which actually wallows in filth.

The most fertile field today for the practical application of our biologic knowledge is in that of social disease. By controlled experiment we know
that so small an incidence as two-tenths of one per cent of syphilitic infection is to be found in selected groups of young men and women of university caliber. On the other hand it is known that syphilis in recognizable form exists in as high as 37 per cent of rural white and Negro populations of some of our southern states.

Credit is due the medical and nursing professions for their untiring efforts to awaken public interest in this menacing social disease. Leaders in the field of social welfare—and especially Homer Folks of the New York State Charities Aid Association—are to be commended for the vigor with which they have launched their program of public education. Such support is essential to a successful state and nation-wide organized warfare in this next great public health crusade.

What has been accomplished in controlling other communicable diseases of men can and must be done with syphilis. But we shall not accomplish this end by using euphemisms concerning the origin, means of transmission, and the course of this disease. Syphilis is the most prevalent communicable disease. It is, moreover, the one for the prevention of which we are doing the least, although we have a reservoir of knowledge for instant practical use greater than that for combating any other disease, unless it be diphtheria, malaria, or hookworm.

Syphilis affords us our greatest public health challenge today. We must make a frontal attack on it. We must destroy those attitudes of squeamishness which have frustrated the efforts of the last twenty years, during which, in spite of increasing attention to this disease as a social and health problem, we have failed to make any material reduction in its general incidence.

Nurses engaged in public health work or in private practice are in advantageous positions to help solve this problem. As the years go on there will undoubtedly be an increasing amount of attention devoted to the prevention, diagnosis, and treatment of syphilis. There will be more clinics established and more need for trained nurse personnel in connection with them. The social service work emanating from such clinics will largely be in the hands of a trained nurse personnel.

There are other fields of public health and public welfare work in which the nursing profession will undoubtedly play an increasingly important rôle as the service arm providing administrative and technical skill for the solution of our many social problems.

For example, the necessities of making provision for the more adequate prevention and care of mental disease is pressing hard on the heels of all public welfare administrators. The extent of the problem is indicated by recent reports which indicate that the number of hospital beds devoted to mental patients was 44 per cent of all the million institutional beds in this country while the number of beds in general hospitals was only 40 per cent of all institutional beds. Moreover, while the mental hospital beds were in use about 94 per cent of the time, the general hospital beds were in use only 66 per cent of the time. From 1927 to 1928 the number of mental
patients increased nearly 19,500 while the number of general hospital patients was increasing about 12,000.

We are confronted in all urban centers with an increase of mental instability much greater than the increase in population. The result has been that every state has been obliged to carry on what amounts practically to a continuous construction program in order to provide sufficient beds in mental hospitals to care for the number of patients coming to them. This has been taking place in the face of a constantly increasing rate of discharge from these hospitals, the development of social services connected with mental hospitals designed to make earlier release possible and practicable, and an increasing development of mental hygiene clinics.

As a result, public health administrators are using their powers of persuasion to organize community adjustment clinics analogous to the tuberculosis clinics which have made remarkable progress in recent years toward the conquest of tuberculosis. In New Jersey, for example, the tuberculosis clinics and sanatoria have succeeded, during the period 1919 to 1933, in reducing the annual tuberculosis death rate per 100,000 of the population from 111 to 54. This was brought about through a persistent and well coordinated campaign of scientific research, institutional services, and organized community cooperation under leadership afforded by the state. The success of the tuberculosis clinics led to application of a similar technique to the prevention and treatment, in the communities, of mental disease. Experience with mental hygiene clinics has now proceeded sufficiently to determine that their widespread use, with appropriate organizations set up in each community along lines similar to the organizations dealing with tuberculosis, would no doubt succeed in greatly reducing commitments to mental hospitals.

Nursing organizations may look forward to participating actively in this widespread movement. The general hospital training schools, especially where they have developed affiliation with modern, well-staffed mental hospital training centers, are in a position to give a most valuable background to workers in the field of psychiatric nursing. This training properly guided and extended affords one of the most promising means for progressive measures looking toward prevention and treatment in the field of mental hygiene. This is particularly true since the general hospitals have been devoting more attention to developing psychiatric services in connection with their own clinics. The day is coming when a psychiatric pavilion will be a usual part of every large general hospital center.

In other words, we are looking forward to a much greater emphasis on the preventive aspects of the mental disease problem. Clinics will become available, not only through the general hospitals, but also in connection with public school systems, juvenile courts, and social agencies. These will all work together under the general leadership which has already been established in connection with the state mental hospitals, where scientific research in this field has been developed to a high point of effectiveness.

Another allied field in which nurses may well take an expanding interest
is that of public welfare organizations. There was a time when each new social problem which arose to the point of general recognition brought about the creation of a new agency to deal with it. As a result, most communities have today a multiplicity of social agencies, both public and private, each devoting its energies to some phase of a general problem. The need for integrating these services into some form of coördinated whole has long been recognized. Various steps have been taken to bring about effective coöperation among the agencies serving respective communities. The time has passed when these various agencies can decide to work in isolation.

Development of the county welfare board as a means of providing a generalized type of welfare service, limited in its scope only by the nature of the problems it meets, and utilizing not only the services of its own personnel but the specialized services of private agencies, has been effected in certain states. Other states are moving in this direction; so much so, that it requires little foresight to determine that the future will see a great development of the county welfare unit.

For purposes of administration the county provides, in most instances, a unit large enough to permit of the maintenance of an adequate staff of social workers and technicians. At the same time the county is ordinarily sufficiently compact so that the members of the welfare board, made up of public spirited citizens serving on a voluntary basis, are in intimate contact with the local conditions which affect their decisions and policies.

Where the county welfare board has had an opportunity to demonstrate its advantages under conditions of adequate state coöperation and supervision it has proven to be a highly satisfactory arrangement.

As the county welfare board form of organization spreads there will undoubtedly be many opportunities developed for trained nurse personnel to participate in the varied services centering in each such board.

Those of you who are familiar with the spectacular careers of the three great nineteenth century heroines of the nursing profession, Miss Nightingale, Clara Barton, and Dorothea L. Dix, will recognize that a high standard of achievement has been fixed for the profession by these pioneers.

Florence Nightingale succeeded in reorganizing the medical service of the British Army as the result of her labors at Scutari during the Crimean War. She then founded the first hospital training school for nurses at St. Thomas Hospital, London, in 1860, and established the broad principles upon which the profession has advanced to its present high standards of personnel and skill.

Clara Barton carried nursing service directly to the battlefields during our Civil War, and thereby laid the foundations for the Red Cross which later became her enduring monument.

Dorothea L. Dix found the insane, the feebleminded, and the epileptic confined with utmost barbarity in outhouses connected with our jails and almshouses and made such a competent campaign in behalf of these forgotten unfortunates that she is credited personally with establishment of
no less than twenty state hospitals for the insane and the foundation for the modern methods of individual treatment, not only of the insane but other types of dependents and delinquents.

These women went far because, first, they seized upon ideals and fought valiantly for them with an unyielding determination; second, because they realized that nursing service is something more than merely caring for the sick— a soap and water job in many instances, a dietary job in others, a social service job in still others; third, because they trained themselves, or had the gift, to be good administrators. They were able to view the problems before them with a perspective which enabled them to discover the primary elements they must organize for success.

Nursing is a great calling. Whether because of the traditions established by Nightingale, Barton, and Dix, or whether ministering to the ill and the unfortunate creates such qualities, members of the Guild of Nurses have succeeded in establishing a tradition of coolness and calm competence in the face of danger and panic, whether it be the danger of the silent microbe, the bursting bombs of battle, or the demoralization of fire, flood, or earthquake.

An expanding civilization has need for such qualities in many key positions of society. Keep the torch which has been handed to you burning brightly. Measure your achievements in terms of understanding and sympathetic human service and your members will receive the homage due for work well done.

**Opening Business Session**

**Tuesday, June 4, 9:45 a.m.**

The meeting was called to order by the President, Effie J. Taylor. Since the roll call indicated that representatives from more than fifteen states were present, the Chair declared the Forty-first Annual Convention of the National League of Nursing Education in session.

**Report of the Secretary**

Immediately following the close of the convention in Washington, the newly elected Board of Directors met to appoint the standing and special committees for the year. A special Committee on the Child in Nursing Education was appointed. This committee has been exceedingly active this year and has held a successful institute in New York City. Action was taken at that meeting authorizing the preparation of standardized records for schools of nursing to be sold by the League. As the Section on Mental Hygiene of the American Nurses’ Association has been dissolved, there will be a Committee on Mental Hygiene for the League. The Board also took action on the death of Mrs. Helen Hartley Jenkins, an honorary member of this association.

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1 By-laws—Article XI, Section 3. "Members from fifteen states shall constitute a quorum for the transaction of business at any annual convention."
There was a full attendance of officers and directors at the series of meetings in January. On recommendation of the Committee on Education the Board recommended to the Revision Committee that the name of the Education Committee be changed to Committee on Curriculum, because a great many other committees of the League are dealing with problems of education and the name of the organization itself makes the name of this committee inconsistent. Action will be taken on this recommendation at this convention.

The Report of the Committee to Consider Lay Participation recommended that the work be done through a national committee and that the Committee plan for a program meeting at the time of the annual convention.

In connection with a proposed study of tuberculosis, the Committee on Studies felt that the greatest source of danger to nurses was the undiagnosed case in a general hospital. The Committee recommended that a recommendation go from the Board of Directors to the American College of Surgeons requesting that the latter organization include in its Manual of Standardization for Hospitals a clause relating to the importance of diagnostic measures for the purpose of detecting patients with tuberculosis. Such a recommendation was sent to the American College of Surgeons.

In connection with the Report of the Committee on Subsidiary Workers, there was a good deal of discussion as to the wisdom of compulsory legislation which would include the subsidiary group. A motion was carried, although not unanimously, that we approve the principle that all persons who give nursing service for hire should be licensed. The Board disapproved the setting up of schools for the training of subsidiary workers unless there is control of their practice in the state, and approved the use of the term "nursing aide" for the present in lieu of some better term.

On recommendation of the Committee on Standards, the Board approved the recommendation that the maximum of 48 hours including organized classes and practice for student nurses be changed to 44, and that all schools should look forward to building the professional education on two years of general education beyond high school.

The Board also arranged for a survey of a number of mental hospitals where there are schools of nursing, and Miss Harriet Bailey was selected to carry on the work. The Board approved the recommendation from the Joint Board that the Committee on Nursing Service of the National Organization for Public Health Nursing be made a joint committee.

A communication was received from the Honorable Frances Perkins, Secretary of Labor, asking Miss Taylor as President of the League to become a member of the Nurses' Advisory Committee of the Economic Security Committee.

On recommendation of the Committee to Work with the Committee on Nursing of the A. H. A., it was voted that a letter be sent to the American College of Surgeons requesting that they urge hospitals without schools to see that graduate nurses are employed in sufficient number to secure good nursing care.
Through the generosity of a friend of nursing education the Research Foundation of Children’s Hospital of Cincinnati has made a gift to the League for carrying on and publishing the Curriculum for Schools of Nursing. The Board expressed its appreciation of the facilities which Teachers College has made available for the work of the Curriculum Committee and voted that a letter be sent to Dean Russell expressing our appreciation of his cooperation.

Miss Carrie M. Hall was appointed to fill the unexpired term of Miss Louis as chairman of the Finance Committee.

There are now 33 state leagues. The total membership of the League in 1934 was 3,957. We have received notice of the death of the following members, many of whom have made outstanding contributions to nursing education:

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<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Sister Margaret Laverty</td>
<td>June, 1934</td>
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<tr>
<td>Ida R. Falconer</td>
<td>June 14, 1934</td>
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<tr>
<td>Jean M. Cocheur</td>
<td>September 26, 1934</td>
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<td>Margaret E. Dorne</td>
<td>October 11, 1934</td>
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<td>Sarah C. Barry</td>
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<td>May S. Loomis</td>
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<td>Maude A. Wood</td>
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<td>Kathryn K. Schulken</td>
<td>November 12, 1934</td>
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<td>Evelyn Wood</td>
<td>November 27, 1934</td>
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<td>Bertha Hamer</td>
<td>December 14, 1934</td>
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<td>Leslie Wentzel</td>
<td>January 1, 1935</td>
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<td>Ida Venner Rogers</td>
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<td>Sister Caroline Braun</td>
<td>March 22, 1935</td>
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<td>Lucy Minningerode</td>
<td>March 24, 1935</td>
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<td>Marie Louis</td>
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<td>Nellie F. W. Crossland</td>
<td>April 10, 1935</td>
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<td>Elsie Helmers</td>
<td>April 29, 1935</td>
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<td>Ursula Heileman</td>
<td>May 21, 1935</td>
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<td>Fantrein Pemberton</td>
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Charter Member

Mary Sands Littlefield         | March 14, 1934

Charter Member and Life Member

Anna Aline Brown              | December 16, 1934

Respectfully submitted,

Stella Goosraty, Secretary

FINANCIAL REPORT OF THE TREASURER

Miss Marian Rottman, Treasurer,

National League of Nursing Education,
50 West 50th Street,
New York, N. Y.

Dear Madam:

Pursuant to engagement, I have made an examination of the books and accounts of the National League of Nursing Education for the purpose of
verifying by audit procedure the correctness of the transactions for the year ended December 31, 1934, and present herewith the following two Exhibits and four Schedules:

Exhibit "A"—Schedule "1"—Statement of Income and Expenses of Special American Nurses' Association Fund for the year ended December 31, 1934.
Exhibit "A"—Schedule "2"—Statement of Cash Receipts and Disbursements of the Fund for Carrying on grading activities for the year ended December 31, 1934.
Exhibit "B"—Statement of Income and Expenses of the General Fund for the year ended December 31, 1934.
Exhibit "B"—Schedule "1"—Statement of Headquarters Expenses for the year ended December 31, 1934.

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

In my opinion based upon such examination, the accompanying two Exhibits and four Schedules fairly present, in accordance with the principles of accounting maintained by the Association during the year under review, its position at December 31, 1934, and the results of the operations for the year.

Very truly yours,

(Sgd.) FREDERICK FISCHER, JR.,
Certified Public Accountant


EXHIBIT A—GENERAL FUND

STATEMENT OF FINANCIAL CONDITION, DECEMBER 31, 1934

Assets

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash in bank</td>
<td>$16,491.46</td>
</tr>
<tr>
<td>Headquarters petty cash fund</td>
<td>20.00</td>
</tr>
<tr>
<td>Receivable account on $8,000.00 contribution</td>
<td>4,000.00</td>
</tr>
<tr>
<td>from American Nurses' Association</td>
<td></td>
</tr>
<tr>
<td>Investments (at book value)</td>
<td></td>
</tr>
<tr>
<td>$5,000 Plainfield Title and Mortgage Guaranty Co.</td>
<td></td>
</tr>
<tr>
<td>1st Mortgage certificate 3% due Dec. 15, 1941</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>$5,000 Plainfield Title and Mortgage Guaranty Co.</td>
<td></td>
</tr>
<tr>
<td>1st Mortgage certificate 3% due June 15, 1942</td>
<td>5,000.00</td>
</tr>
<tr>
<td>$5,000 Chicago, Rock Island and Pacific R. R. Co.</td>
<td></td>
</tr>
<tr>
<td>4% due April 1, 1934, Certificate of Deposit</td>
<td>4,951.00</td>
</tr>
</tbody>
</table>

| Total Assets                                          | $35,462.46   |
Liabilities

Unexpended balances, December 31, 1934, of the following funds:

- Special American Nurses' Association Fund, per Schedule "1" ........................................ $7,402.57
- Fund for Carrying on Grading Activities, per Schedule "2" ........................................ 7,084.49

Total Liabilities ........................................ $14,487.06

Net Asset Value ........................................ $20,975.40

The above Net Asset Value represents the Balance of the General Fund December 31, 1934, per Schedule "3."

EXHIBIT A—SCHEDULE 1

STATEMENT OF INCOME AND EXPENSES OF SPECIAL AMERICAN NURSES' ASSOCIATION FUND FOR THE YEAR ENDED DECEMBER 31, 1934

Income

- Contribution from American Nurses' Association ........................................ $8,000.00

Total Income ........................................ $8,000.00

Expenses

- Salaries—General ........................................ $350.00
- Office equipment ........................................ 147.80
- Committee on State Problems ........................................ 3.26
- Committee on Mental Hygiene ........................................ 96.37

Total Expense ........................................ 597.43

Unexpended Balance, December 31, 1934, per Exhibit "A" ........................................ $7,402.57

EXHIBIT A—SCHEDULE 2

STATEMENT OF RECEIPTS AND DISBURSEMENTS OF THE FUND FOR CARRYING ON GRADING ACTIVITIES FOR THE YEAR ENDED DECEMBER 31, 1934

Receipts

- Transferred from Nurses Committee for Financing Grading Plan ........................................ $5,480.08
- Transferred from Committee on the Grading of Nursing Schools ........................................ 73.51

Sales of publications:
- Standing Type of Nursing Schools, Today and Tomorrow ........................................ $1,732.76
- An Activity Analysis of Nursing ........................................ 1,138.00
- Nurses, Patients, and Pocketbooks ........................................ 23.00

Total Income ........................................ $8,447.35
### Disbursements

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of holding type for &quot;Nursing Schools,</td>
<td>$52.60</td>
</tr>
<tr>
<td>Today and Tomorrow&quot;</td>
<td></td>
</tr>
<tr>
<td>Salaries—Special Curriculum</td>
<td>$679.00</td>
</tr>
<tr>
<td>Salaries—General</td>
<td>$350.00</td>
</tr>
<tr>
<td>Equipment</td>
<td>$116.10</td>
</tr>
<tr>
<td>Shipping</td>
<td>$41.00</td>
</tr>
<tr>
<td>Postage</td>
<td>$122.16</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>$6.00</td>
</tr>
</tbody>
</table>

**Total Disbursements** ........................................ $1,362.86

Unexpended Balance December 31, 1934, per Exhibit "A" ........ $7,084.49

### EXHIBIT A—SCHEDULE 3

**STATEMENT OF CHANGES IN THE GENERAL FUND FOR YEAR ENDED DECEMBER 31, 1934**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance, December 31, 1933</td>
<td>$17,024.77</td>
</tr>
<tr>
<td>Add—Received on account of returned check on 1932 dues</td>
<td>2.40</td>
</tr>
<tr>
<td>Adjusted Balance, December 31, 1933</td>
<td>$17,027.17</td>
</tr>
<tr>
<td>Add—Excess of Income over Expenses for year ended December 31, 1934, per Exhibit &quot;B&quot;</td>
<td>3,948.23</td>
</tr>
<tr>
<td>Balance, December 31, 1934, per Exhibit &quot;A&quot;</td>
<td>$20,975.40</td>
</tr>
</tbody>
</table>

### EXHIBIT B

**STATEMENT OF INCOME AND EXPENSES OF THE GENERAL FUND FOR THE YEAR ENDED DECEMBER 31, 1934**

**Income**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions in lieu of calendar sales</td>
<td>$7,850.69</td>
</tr>
<tr>
<td>Fees for services—Department of Studies</td>
<td>2,840.08</td>
</tr>
<tr>
<td>Registration fees—Biennial Convention 1934</td>
<td>1,526.77</td>
</tr>
<tr>
<td>Share of net income of the 1934 Biennial Convention Exhibit</td>
<td>2,476.92</td>
</tr>
</tbody>
</table>

**Membership Dues:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>$10,184.75</td>
</tr>
<tr>
<td>Individual</td>
<td>1,058.00</td>
</tr>
<tr>
<td>Individual with application</td>
<td>347.00</td>
</tr>
</tbody>
</table>

**Sales of:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christmas cards</td>
<td>$237.63</td>
</tr>
<tr>
<td>Photographs</td>
<td>168.75</td>
</tr>
<tr>
<td>Slides</td>
<td>267.55</td>
</tr>
<tr>
<td>State League supplies</td>
<td>52.50</td>
</tr>
<tr>
<td>Publication—&quot;Curriculum&quot;</td>
<td>$782.05</td>
</tr>
<tr>
<td>Sundry National League of Nursing publications</td>
<td>1,825.96</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest from Investments</td>
<td>271.95</td>
</tr>
</tbody>
</table>

**Total Income** ........................................ $29,890.60
Expenses

Board of Directors' expenses .................................. $350.00
President's expenses .............................................. 94.81
Officers' expenses .................................................. 767.76
Executive Secretary's travel expenses ....................... 65.39
Director of Studies Convention expenses ................... 63.66
Director of Studies, travel expenses, refunded in fee ........ 86.89
Salaries—Special .................................................... 800.00
Education Committee ............................................... 63.83
Program Committee ............................................... 155.05
Committee on Studies ............................................. 15.05
Reporting Convention 1934 ....................................... 88.00
Convention 1934 ..................................................... 183.86
Dues paid to other organizations .................................. 30.00
Stationery ............................................................. 193.67
Premiums on Treasurer's Bond ................................. 12.50
Acoustical work at Headquarters office ..................... 250.00
Printing 1934 annual report ..................................... 1,992.91
Printing 1933 annual report ..................................... 2,246.63
Miscellaneous .......................................................... 125.68
Printing and other expenses of publications, etc., for sale:
  Sundry National League of Nursing publications ................ $741.81
  Photographs ....................................................... 193.30
  Slides .............................................................. 96.29
  State League Supplies ........................................... 37.43
Headquarters expenses, per Schedule "1" ...................... 17,285.85

Total Expenses .................................................... $25,942.37

Excess of Income over Expenses, per Exhibit "A" ............... $3,948.23

EXHIBIT B—SCHEDULE 1

STATEMENT OF HEADQUARTERS' EXPENSES FOR THE YEAR
ENDED DECEMBER 31, 1934

Headquarters' Expenses

General

Salaries .......................................................... $7,176.24
Share of Receptionist salary ................................... 120.00
Extra stenographic service .................................... 740.22
Rent ................................................................. 1,585.32
Special office care .............................................. 18.00
Telephone .......................................................... 234.19
Telegrams .......................................................... 53.54
Supplies ............................................................ 216.52
Shipping service ................................................ 287.74
Postage and express ............................................. 953.20
Letter service ..................................................... 387.06
Library service .................................................... 132.00
FORTY-FIRST ANNUAL CONVENTION

Entertainment ................................................. $37.10
Insurance ................................................... 25.32
Federal tax on checks ...................................... 8.46
Miscellaneous ............................................... 239.98

Department of Studies
Salaries ................................................................ $5,044.26
Supplies ......................................................... 26.70

Total Headquarters Expenses, per Exhibit "B" ............... $17,285.85

NATIONAL LEAGUE OF NURSING EDUCATION
GENERAL FUND
FINANCIAL REPORT
January 1 to May 31, 1935

Balance, December 1, 1934 ................................. $20,491.46

Income
Curriculum ....................................................... $121.75
Publications .................................................... 511.69
Nursing Schools, Today and Tomorrow .............. 758.20
An Activity Analysis of Nursing ....................... 430.50
List of Schools of Nursing ................................ 490.00
Photographs .................................................... 132.10
Slides .................................................................. 295.40
Dues—State ....................................................... 9,317.50
Dues—Individual ............................................... 1,265.00
Dues—with application ....................................... 148.00
State League Supplies ....................................... 34.12
Contributions in lieu of Calendar Sale ............ 919.15
Nurses, Patients, and Pocketbooks ................. 53.50
Royalties ........................................................ 72.90
Fees—Department of Studies ......................... 300.00
Director of Studies Expenses Refunded .......... 24.30
Two Oil Paintings ............................................. 135.00
Interest on Mortgage Certificates ................. 212.50
American Conference on Hospital Service ........ 100.00

Funds for Carrying on Grading Activities
Nurses Committee for Financing Grading Plan ...... $3,537.95
Joint Committee on Educational Policies .......... 1,304.90

Special Research Fund ...................................... 7,527.99

Sundry Accounts
Other Publications ........................................... $6.55
Refund on Dues .............................................. 92.05
Refund—Advance for traveling expenses ........... 100.00
Refund on Publications ................................... 1.00

Total Income .................................................. $48,363.51
<table>
<thead>
<tr>
<th>Expenses</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headquarters Budget</td>
<td>$11,462.66</td>
</tr>
<tr>
<td>Publications</td>
<td>546.55</td>
</tr>
<tr>
<td>Slides</td>
<td>87.69</td>
</tr>
<tr>
<td>Officers’ Expenses</td>
<td>356.09</td>
</tr>
<tr>
<td>Directors’ Expenses</td>
<td>511.36</td>
</tr>
<tr>
<td>American Hospital Association Booth</td>
<td>43.33</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>28.53</td>
</tr>
<tr>
<td>Auditing Books</td>
<td>100.00</td>
</tr>
<tr>
<td>State League Supplies</td>
<td>59.50</td>
</tr>
<tr>
<td>Committee on Records</td>
<td>63.29</td>
</tr>
<tr>
<td>Committee on Studies</td>
<td>11.85</td>
</tr>
<tr>
<td>Committee on Finance</td>
<td>20.50</td>
</tr>
<tr>
<td>Committee on Lay Participation</td>
<td>36.51</td>
</tr>
<tr>
<td>Committee on Program</td>
<td>12.72</td>
</tr>
<tr>
<td>Traveling Expenses—Executive Secretary</td>
<td>48.19</td>
</tr>
<tr>
<td>Traveling Expenses—President</td>
<td>55.46</td>
</tr>
<tr>
<td>Photographs</td>
<td>91.00</td>
</tr>
<tr>
<td>Convention Expenses</td>
<td>154.92</td>
</tr>
<tr>
<td>Treasurer’s Bond</td>
<td>12.50</td>
</tr>
<tr>
<td>Stationery</td>
<td>19.18</td>
</tr>
<tr>
<td>Nursing Information Bureau</td>
<td>300.00</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$14,021.83</strong></td>
</tr>
</tbody>
</table>

| Special A. N. A. Fund                   |            |
| Accredited List                         | $340.28    |
| General Salaries                        | 958.32     |
| Committee to Work with A. H. A.—       |            |
| Traveling Expenses                      | 7.30       |
| Postage                                 | 15.00      |
| Letter Service                          | 10.49      |
| Printing                                | 35.19      |
| Committee on Mental Hygiene—Traveling Expenses | 49.38 |
| Committee on State Board Problems—Letter Service | 15.60 |
| Special Survey on Mental Hygiene—Salaries | 275.00 |
| **Total Special A. N. A. Fund**         | **1,706.56** |

| Funds for Carrying on Grading Activities |            |
| Salaries                                 | $958.33    |
| Standards Committee—Mimeographing       | 1.50       |
| Committee on the Child in Nursing —     |            |
| Mimeographing                           | 37.57      |
| **Total Funds for Carrying on Grading Activities** | **997.40** |

| Special Research Fund                   |            |
| Salaries                                 | $1,625.00  |
| Mimeographing                            | 23.10      |
| Publications                             | 120.78     |
| Postage                                  | 53.00      |
| Traveling Expenses                       | 194.87     |
| Stationery                               | 22.54      |
| Extra Stenographic Service               | 7.25       |
| Supplies                                 | 8.58       |
| Equipment—Typewriter                     | 105.30     |
| Miscellaneous                            | 8.35       |
| **Total Special Research Fund**          | **2,168.77** |
Sundry Accounts
Check returned ........................................ $3.00
Other publications .................................... 6.55
Refund on Dues ........................................ 92.05
Advance for traveling expenses ..................... 100.00
For 1936 Biennial Expenses ......................... 11.40
Advance for rental—Carnegie Hall .................. 200.00

Total Expenses .......................................... $19,307.56
Deposited in Savings Account ......................... 10,000.00

Balance in Bank, May 31, 1935 ....................... $19,055.95

Respectfully submitted,
MARIAN ROTTMAN FLEMING, Treasurer

REPORT OF THE EXECUTIVE SECRETARY

As Executive Secretary of the National League of Nursing Education, I have the honor and privilege of presenting to the membership a report of the activities carried on at Headquarters since our last convention in Washington.

When one reviews the events which have transpired during the past year, and considers the projects in which we are now engaged, one is impressed with the fact that we are moving in new directions.

After several lean years during which there were many anxious moments, fortune has waved her magic wand, and lo! our prayers are answered. In January, 1934, we were not quite certain where funds were to be secured to carry forward certain much-needed projects. Today we are not only out of the red, but we are actually engaged in a constructive program. Funds from the Committee for Financing the Grading Plan, the sale of the final reports of the Grading Committee, the special appropriation from the A. N. A. made in January, 1934, for its Educational Department, and the many unsolicited contributions from state groups, have greatly helped, to say nothing of the gift of $30,000 from a friend of nursing, which has come to us through the Research Foundation of the Cincinnati Children’s Hospital for the purpose of revising the curriculum and other League projects.

You will hear the details of the projects now being carried forward through the various committee reports. Consequently, I shall not discuss these activities in my report. I wish, however, to mention in this connection that the pieces of work which our committees are doing entail an enormous amount of work and correspondence on the part of our Headquarters staff.

OUR MEMBERSHIP

It is encouraging to note that in two of the worst years of the depression during which our membership drive took place, we were able to increase
our membership to nearly 4,000. The paid-up members in 1934 totaled 3,937. At the present time 1,074 of the 1934 members have not paid their dues. Last year a personal letter was written to every member who had not paid her dues. The same procedure will be followed this year. It would be extremely helpful, however, if the state leagues could assume more responsibility in checking up on lapsed members. Up to date we have received dues for 89 sustaining members.

STATE AND LOCAL LEAGUES

Although no new state leagues have been organized within the past year, several of the states have followed the suggestions of the National regarding the formation of local leagues, and there are now 26 local leagues. In 21 states the state leagues are functioning as educational departments of the state nurses’ association.

New committees have also been formed in several states in accordance with suggestions received from the National. Four states, to our knowledge, have their own bulletins through which they acquaint their members with information received from the National and with their own state activities. This is a commendable practice and should be encouraged because it is the most effective way of passing on information.

Several states have revised their Constitution and By-laws to include the changes made in the National League By-laws.

CHANGES IN PERSONNEL

In October, Miss Mabel Smith was added to the League staff to assist with the curriculum revision at the college. In November, Miss Ella Taylor, former assistant to Dr. May Burgess, came over to the League. On April first, Miss Elizabeth Pierce of Cincinnati was engaged to assist with the curriculum and other projects. In the same month, Miss Harriet Bailey was temporarily engaged for the purpose of making a survey in state mental hospitals.

Miss Mary Vedder, who for eight years so faithfully served the League as secretary, resigned in December and Miss Elizabeth Thomson was appointed to succeed her. A permanent stenographer was employed last fall, but it has been necessary, because of the pressure of work, to employ two additional clerical workers the greater part of the year. This does not include the clerical staff employed at the College on the curriculum work. The size of our present staff as compared with that of a few years ago, is an index of the increase in the League’s activities.

CORRESPONDENCE AND INTERVIEWS

Since the convention last April, our office at Headquarters has looked like a beehive, except that there were no drones in it. The annual report was mailed to members the first of September. Since April we have mailed approximately 26,394 letters of which 12,084 were form letters. We have
received 13,355 letters. The Executive Secretary has held approximately 1,340 interviews with persons coming to the office.

CLOSING OF THE OFFICE OF THE GRADING COMMITTEE

The office of the Committee on the Grading of Nursing Schools was closed October first, and the committee's publications and office equipment were turned over to the League. We received the final reports of the committee—Nursing Schools—Today and Tomorrow, and An Activity Analysis of Nursing—for sale and distribution.

LIST OF SCHOOLS MEETING MINIMUM REQUIREMENTS SET BY LAW

One of the major activities of the Headquarters office since October has been the revision of the list of schools accredited by the various states. This piece of work has required almost the entire time of Miss Ella Taylor and one secretary. The work has been expertly done and carefully checked and rechecked in order to obtain the most accurate information possible. A card file of the information by schools has been prepared for office use. The League is appreciative of the assistance given us by the individual schools and also by the state boards of nurse examiners.

The study has revealed some rather significant information. Since the last list of schools was published in 1931, there are 330 fewer accredited schools and 17,000 fewer students registered in schools. The total number of schools in 1931 was 1,802. Today, there are 1,472 schools. In 1934, 3,000 fewer students were graduated from schools of nursing than in 1931.

OTHER SPECIAL WORK

In addition to receiving information for and tabulating the accredited list, Miss Taylor has collected data for the Committee on State Board Problems. This has included information on state laws, state board rulings, and methods of inspection. She prepared and tabulated the results of a questionnaire on salaries, health of staff, vacations, sick leave, etc., sent to 500 hospitals under the joint auspices of the Nursing Division of the Council of the American Hospital Association and the League Committee.

It is our purpose, during the summer, to revise our list of courses for graduate nurses, and to publish a small pamphlet on the League to take the place of The National League of Nursing Education, what it is and why you should be a member, the supply of which has been exhausted.


Activities of the N. L. N. E. functioning as the Department of Education of the A. N. A. which are now being carried forward are:

1. Work with state boards of nurse examiners
2. Work on problems of mental hygiene and psychiatric nursing
3. Work in setting up the essentials of a good hospital nursing service
4. Publication of the accredited list of schools
You will hear of these activities from the various committees making reports.

It is needless to state that there exists between our two organizations a fine working relationship and a spirit of give and take which makes working together a pleasure. In fact, this spirit is characteristic of all our groups at Headquarters. With such mutual understanding and cooperation on the part of our national groups, the future of nursing looks brighter and more hopeful.

Contributions from State Organizations

Although we have made no appeal for funds during the past year we have received contributions from state groups amounting to $2,087.04. This includes funds from the following organizations:

- State Leagues ............................................. $351.75
- Local Leagues ............................................. 512.50
- State Nurses Associations ...................... 802.80
- District Associations ................................. 218.50
- Alumnae Associations ............................... 188.09
- Community Health Associations ................. 5.00
- Individuals ................................................. 7.00

Nursing Information Bureau

The Nursing Information Bureau of the A. N. A. is also serving the League, both through the Bulletin and through its releases to the public. Much publicity has been given to the final report of the Grading Committee. The three vocational pamphlets—*So You Want to be a Nurse, How to Choose a Nursing School,* and *When You are a Nurse,*—have met a long-felt need and have been received with great favor throughout the country. The League office has distributed 2,250, and the Bureau has distributed altogether over 76,534 copies. The Bureau is making use of the opportunity afforded by this convention for special releases. We are fortunate to have such admirable facilities through which to publicize nursing education.

Field Work

The League is greatly handicapped because of no allocation of funds for field work. It is possible for us to respond only to those requests where expenses are paid. This greatly limits our opportunities to secure a larger membership, and to promote our program in the states, particularly those states having no state leagues.

The Executive Secretary attended the convention of the American Hospital Association in Philadelphia in September where she was on the program of the nursing section. The League shared a booth with the *American Journal of Nursing* at this convention where the final reports of the Grading Committee were sold.

She attended the meeting of the New York State Nurses’ Association as a representative of the New York City League of Nursing Education, of which she served as president for two years. She also participated in the
program of the conventions of the Maine State Nurses’ Association and the New England Division.

In April she spoke at a public meeting in Detroit upon the invitation of the Detroit League of Nursing Education. At the request of Miss Olive Sewell, Executive Secretary of the Michigan State Nurses Association, she addressed four District Associations in Ann Arbor, Lansing, Grand Rapids, and Travers City.

In May, at the invitation of the Buffalo local league, she spoke at a large district meeting, at which the Buffalo League had charge of the program.

PLANNING ITINERARIES FOR FOREIGN NURSES

The League office seems to have taken on a new function—the planning of itineraries for foreign nurses. We planned visits in the United States for two English nurses from Guy’s Hospital, London, last winter, and have planned a series of visits for a nurse from Southern Rhodesia for this summer. This necessitates voluminous correspondence. The hospitals visited have all generously entertained these guests.

THE BIENNIAL CONVENTION IN LOS ANGELES

The Executive Secretary is the chairman of the Headquarters Biennial Convention Committee, for the 1936 Biennial Convention to be held in Los Angeles the week of June 21st. A new Manual of Procedure for the Biennial Convention, based on the experience of the executives of the three national organizations has been prepared. Mrs. Alma Scott visited Los Angeles on her return from Hawaii to see just what facilities were available. Tentative arrangements have been made for the number of sessions to be held and tentative meeting places listed. Mrs. Sally Hanshue has been engaged as Exhibit Manager. With two conventions under way at the same time, your Executive Secretary has been living and dreaming conventions.

THE FUTURE

When one considers the major activities in which the League is engaged at the present time—the reconstruction of the curriculum to meet present-day needs, the attempt, by work with state boards of nurse examiners, to secure more uniform standards of state requirements governing schools of nursing in the various states, the study of facilities for the preparation of nurses in psychiatric nursing, the setting up of the essentials of a good hospital nursing service, and the various and valuable projects of the Department of Studies—it would seem that we are making progress in the right direction. However, all the time, effort, and money which are being put into these pieces of work will be wasted unless the results of the studies and recommendations can be used, and actually put into practice by local groups. A curriculum may be published but its value lies in its use as a guide in the revision of curricula of schools of nursing. In like manner, standards are helpful only as they can be applied to actual situations. A national pro-
gram is of value only as it meets the needs of the local groups and is made effective in local communities.

The findings and recommendations of the Committee on the Grading of Nursing Schools are now available to all. Are these findings and recommendations being used by hospital boards and school committees to eliminate certain schools and to improve others? Or, are they being ignored or discredited in some instances, or taken too literally in others? Is there not a real danger that some good schools will be discontinued while poor ones go merrily on their way? Is it not a serious situation when schools are closed in certain isolated districts where graduates from larger centers can not be secured, and where, in place of the schools of nursing, courses for attendants are being established? Will not the whole standard of nursing service be lowered by replacing schools of nursing with courses on a lower level, especially in communities where there are no other schools of nursing. Undoubtedly, some schools should be closed because they are not needed in the community, but every attempt should be made to improve others instead of closing them.

The Joint Committee on Community Nursing Service of our three national nursing organizations which has as its objective the coordination of community nursing services, is one of the most encouraging developments yet conceived by our national groups, because it is only by the stimulation of local groups to an awareness of their nursing needs that real progress will be made.

Is it not the function and duty of our state leagues to assume more active leadership in the solution of some of the vital problems of nursing education and nursing service?

I wish to express to the officers and members of the Board of Directors, and especially to Miss Effie J. Taylor, our President, my appreciation of the support and cooperation which I have received during the past year, and to assure them that the work under their direction has been a pleasure and an inspiration.

Respectfully submitted,

CLARIBEL A. WHEELER, Executive Secretary.

REPORT OF THE DIRECTOR OF STUDIES

There is in the minds of all of us the desire to do something new, and, if possible, something no one has ever done before. Call this desire what we will, it is the urge behind the driving power that better the old and sometimes creates the new.

You must know that we who are at Headquarters have a very great desire to better the old and, if possible, create the new, and report whatever we have succeeded in accomplishing to our membership at the annual meeting. I think in our case this desire is motivated by something more than an urge to better and to create. For this is the time when we give account
of our stewardship and of the trust and the responsibility you have reposed in us. It is also the time when we review our work searchingly and critically as to the manner in which we have met that trust.

Looking back over the year, I find myself somewhat in a dilemma when attempting to list new undertakings. Most of our activities have been concerned with probing and exploring old problems and situations—trying to find out the possibilities of these situations and whether or not they invite further exploration. Because we discovered, while making a survey in a state where more than 100 nursing schools were located, that there was not one communicable disease hospital, or communicable disease department in a general hospital in that state that offered affiliation to student nurses, we sent a questionnaire to every state. Through this questionnaire we sought to find out the names, the location, and the daily census of those institutions or hospital departments in which acute communicable disease patients are cared for—both those which accept students for experience and those which do not. From some of the states we received excellent clear-cut replies, giving us precisely the information we had requested, from others we received replies giving little or no information.

I am recording this very general summary of these questionnaire returns chiefly because of their relationship to the new curriculum in which we are all so much interested. It raises a direct curriculum question. Do we believe that classroom instruction and discussion satisfy the practical needs of communicable disease nursing, or do we believe that, in so far as it is possible, this instruction should be given opportunity to become a vital functioning part of nursing preparation through experience? If we believe the latter, we need to find out where and how this experience can be given.

Closely related to the problem of securing acute communicable disease nursing experience is that of tuberculosis nursing. So ancient is this subject that one almost feels like shaking the dust from and apologizing for its time-worn appearance when bringing it up for public discussion. Yet the League had the temerity to give considerable time during the past year to a consideration of a study that would explore the clinical possibilities for tuberculosis nursing experience. For various reasons the study did not materialize. That does not mean, however, that we have entirely abandoned the idea. Considering the social menace and yearly devastation of the disease, we do not believe that we can.

A second limited questionnaire study undertaken was concerned with the number of bedside nursing hours provided per patient in each 24 hours. The questionnaire was sent to a representative group of general and children's hospitals maintaining an acute service. An analysis of the returns on these questionnaires, findings from surveys made by the League, and other studies on the subject show a wide variation in practice. Thus, on the medical and surgical services (ward and semi-private patients only) the nursing-hour provisions range from 1.3 hours per patient to 3.7 hours per patient in 24 hours. One hospital provided 6.3 hours per medical patient.
but this is disregarded here because it so obviously represents a typical situation. Similar discrepancies exist on the obstetrical and pediatric services. While variations in hospital practices and construction will undoubtedly affect nursing-hour needs, these differences can hardly explain the discrepancies that appear to exist. We submit here the hours provided for ward and semi-private patients as indicated by the larger number of institutions studied.

<table>
<thead>
<tr>
<th>Type of Patient</th>
<th>Hours of Bedside Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Medical</td>
<td>3 -3 1/2 hours</td>
</tr>
<tr>
<td>Adult Surgical</td>
<td>&quot; 3 -3 1/2</td>
</tr>
<tr>
<td>Obstetrical</td>
<td>&quot; 2 1/2-3</td>
</tr>
<tr>
<td>Mothers</td>
<td>&quot; 2 1/2-3</td>
</tr>
<tr>
<td>Infants</td>
<td>&quot; 6</td>
</tr>
<tr>
<td>Pediatric</td>
<td>&quot; 4 1/2</td>
</tr>
<tr>
<td>Infants</td>
<td>&quot; 4</td>
</tr>
</tbody>
</table>

Another well-known and much discussed problem that confronted us was concerned with the cost of nursing service with a school versus the cost of nursing service without a school. The specific purpose of a confidential survey that we were requested to make was to ascertain whether it would cost the hospital more or less if the school were given up. But so many factors as yet undetermined enter into a cost study that an attempt to render a satisfactory analysis presents a perplexing problem. For one thing, it is difficult to abstract nursing service and nursing school expenditures from hospital bookkeeping. Then the question of the number of the nursing service personnel and the hours they are on duty is intimately associated with that of costs. Obviously the cost of the nursing service to a hospital providing two hours of bedside nursing per patient will be less than the cost to a hospital where three hours are provided, other things being equal. Obviously too, in a hospital where the nurses are on duty 56 hours weekly the cost of the nursing service will be less than in a hospital where the nurses are on duty 48 hours weekly. Nursing service figures in different hospitals are not comparable because of the differences in practice from which these figures are derived. We need definitions of specific costs, that is, what goes into these costs, we need a logical accounting system, and then we need the adoption of tentative standards for a reasonably adequate nursing service. I know of no article that presents more clearly the difficulties encountered in making cost analyses than that written by Mr. Albert W. Buck, Superintendent of New Haven Hospital, and published in the 1928 Modern Hospital Year Book under the title, "A Study of Hospital Services and Costs in the United States."

At the time of the convention last year the League Board delegated to the Department of Studies the task of preparing a set of nursing school records. A committee was appointed to work with the Director of Studies in carrying out the project. The committee members appointed were Henrietta Adams, Marian Rottman Fleming, May Kennedy, Elizabeth Melby,
Edna Newman, and Claribel Wheeler, with our president acting in an advisory capacity. Recently Sister Domitilla consented to serve on the committee.

The records that have been completed and are now available are a set of admission forms and a cumulative health record. We plan to consider next those forms which are concerned with the student's record while she is in the school. In preparing the records the Committee has consistently kept in mind the importance of (1) the relevancy of the information requested, (2) the probability of securing it, (3) clearness in the phrasing of questions, (4) economy in number and bulk of records to avoid excessive filing space requirements, and finally (5) workability of the records for schools of nursing. We hope that schools of nursing adopting the League records will write to us after a reasonable trial period and state frankly whether or not the records appear to be meeting the five criteria that are listed above.

Since February of this year we have given considerable time to the curriculum project. The Central Curriculum Committee requested of the Committee on Studies that a study be made to find out, if possible, the traits that characterize the successful nurse and those that characterize the unsuccessful nurse. An announcement of the proposed study with a brief explanation of its purpose and a request for descriptions of the two types of nurses functioning in specific situations appeared in the American Journal of Nursing and Public Health Nursing magazines early in the year. As a result 114 such descriptions of the hospital, the public health, and, to a more limited extent, the private duty nurse have been assembled. These word portraits are extremely interesting since they represent the thinking of nurses who are in the field as to how the good nurse and the nurse who is not so good act in a specific situation. Thus, for example, the successful nurse is portrayed as one who "enters the house quietly and greets the patient with a smile," whereas the unsuccessful nurse, "enters the house like the landing of the Marines"; the successful nurse, "explains to the patient in simple language and in a reassuring way how to swallow the tube," whereas the unsuccessful nurse "does not explain to the patient the test to be given or how to swallow the tube with the least discomfort"; the successful nurse "forces fluid at frequent intervals on the sick pneumonia patient," while the unsuccessful nurse "does not force fluids at frequent intervals on the sick pneumonia patient"; and so on through a list of almost a thousand specific behavior expressions which characterize the nurse who is doing good nursing and the nurse who is not. Since the study was undertaken for curriculum purposes, we have endeavored to work out a technique that will convert these raw materials into a form that will be helpful to the production committees by pointing up the traits and the behavior exhibiting these traits that should be developed or perhaps reinvigorated in a well-thought-out curriculum plan.

In connection with the curriculum we have also given assistance in as-
sembling and listing certain source materials in order that they may be conveniently available for the use of the production committees.

In this report I have endeavored to avoid details and to indicate some of the broader implications of the work as I see them. I have omitted mention of incidental activities, such as the preparation of articles for magazine publication, several papers for meetings, reports of confidential surveys that were made, and certain mechanical assistance we are giving to the Committee on Mental Hygiene and Psychiatric Nursing in carrying on the psychiatric nursing study. Neither have I referred to inquiries we have received concerning possible studies. Some of these inquiries call for only brief replies, others may require considerable time, either in clarifying the purpose of the study and the form it may take, or in submitting a detailed plan. Perhaps one of the most significant of the inquiries that we received was one from a nurses’ examining board asking whether the Department of Studies would be available for advice on survey techniques and for directing the annual survey.

This then, in the main, is the report for the year for the Department of Studies. To our President, to the Committee on Studies, to the Committee on Records, to a capable, faithful assistant, I welcome this opportunity to express thanks for and appreciation of their counsel and help.

Respectfully submitted,

Blanche Pfefferkorn, Director of Studies

REPORT OF THE COMMITTEE ON ARRANGEMENTS

During the early fall two meetings of the Arrangements Committee were held during which visits were made to the various hotels having the necessary accommodations for the convention. The Committee arranged for the accommodations on the basis of an attendance of 1,000, including visitors.

After due consideration and after consulting the President of the League it was decided to hold the convention at the Hotel Roosevelt in New York City. This hotel will have ample accommodation for registration, meetings, etc.

In consultation with the hotel the date of the convention was fixed for the week of June 3, 1935.

The details of the arrangements have been attended to by subcommittees, the chairmen of which have met frequently during the spring making the arrangements for the meeting. The details of these arrangements are included in the program.

If our coming convention is a success much of the credit will be due to the assistance received from Miss Wheeler and her staff.

We wish to remind you that the State Leagues of New Jersey and New York are joint hostesses.

Respectfully submitted,

Helen Young, Chairman
REPORT OF THE COMMITTEE ON EDUCATION

Since this is probably the last official report of the Education Committee (as such), it might be considered an appropriate time for an historical review and obituary, but the fact is that the Education Committee is not going out of commission. It is simply changing its name. The reasons for the change will be presented by the Board but a few words of explanation may be given here.

The Education Committee which sponsored the Curriculum project in the first place and was responsible for the last revision, decided last summer to proceed with a new revision. The first plan was to enlarge the Education Committee and to set up a subcommittee on Curriculum Revision. When we began to organize, we found that we wanted to include representatives from so many other League committees and so many national and state organizations, that the status of a subcommittee for such an important project was out of the question. Moreover, the name "Education Committee" was not sufficiently specific to describe the distinctive functions of this body, so it was decided to set up a special committee called the "Curriculum Committee" to coordinate the various groups coming into the scheme. The Education Committee not only sponsored the project and turned over all its accumulated materials and plans to the Curriculum Committee, but continued to serve as the senior member of the new firm whose report appears under its own name. A few other projects which were not completely liquidated at the time were retained by the Education Committee and this report will deal especially with them.

It will be recalled that the Education Committee has been working for some years on the education of the graduate nurse. Following the publication of its report on the faculty of the nursing school, the Committee undertook the study of advanced courses in clinical subjects and set up a number of committees for this purpose. The reports so far issued in the American Journal of Nursing are as follows:

Postgraduate Education—Old and New—April, 1933.
Advanced Courses in Clinical Subjects—June, 1933.
(By I. M. Stewart, Chairman.)
Advanced Courses in Surgical Nursing—November and December, 1933.
(Report of Subcommittee on Surgical Nursing,
Blanche Pfefferkorn, Chairman.)
Advanced Courses in Medical Nursing, 1934.
(Report of Subcommittee on Medical Nursing,
Mrs. Mary Marvin Wayland, Chairman.)

The other subcommittees have been working hard on their reports and it is expected that these will soon be ready for publication. The committees are as follows:

Subcommittee on Advanced Courses in Pediatric Nursing,
Elizabeth Pierce and Maud Kelly, Joint Chairman.
Subcommittee on Advanced Courses in Obstetric Nursing and Midwifery,  
Hazel Corbin, Chairman.

Subcommittee on Advanced Courses in Psychiatric Nursing,  
Anna K. McGibbon, Chairman; and  
Neurological Nursing, May Kennedy, Chairman.

Subcommittee on Technical Specialties,  
Jane Van de Vrede, Chairman.

There is also a Reviewing Committee with Miss Claribel Wheeler as  
chairman to coordinate the reports and arrange for their publication.

The chairmen of the Subcommittees on Clinical Specialties met with the  
Reviewing Committee July 8, 1934, to consider a number of points in  
connection with the preparation and publication of these reports. The  
problem has been especially difficult because of the fact that this type of advanced  
clinical course is new and we have had to explore the field and experiment  
as we went along. Moreover, the chairmen and the members of these  
committees are exceedingly busy women and it has been impossible to get  
consecutive time to devote to the study of conference work demanded by  
such a project. Thanks are due not only to the chairmen and members of  
the Clinical Subcommittees but to members of the Reviewing Committee  
and to Virginia Henderson of the Department of Nursing Education, Teachers  
College, who gave valuable assistance to the chairman in connection  
with this piece of work.

The members of the Education Committee are convinced that there is a  
great need for the development of advanced clinical courses. Much of this  
work must necessarily be located in hospitals though it is desirable to have  
access to good college courses as well. A few centers for such advanced  
clinical preparation are developing but more are needed and it is hoped that  
the League may be able to set up some machinery for evaluating the courses  
and giving information to those who need guidance in securing postgraduate  
clinical training on different levels.

The Subcommittee on Motion Pictures and other illustrative teaching  
materials, of which Miss Ella Best is chairman, has been transferred to the  
Curriculum Committee. In winding up the work of the old Committee,  
the chairman wishes to thank Miss Best who has served for some time as  
secretary, the chairmen of subcommittees and all the other members for  
the fine service given to the Committee, the League, and the profession.  
As previously stated, many of the members are now serving on the Curricu-

Respectfully submitted,  
ISABEL M. STEWART, Chairman

REPORT OF THE COMMITTEE ON ELIGIBILITY

During the year 92 applications for individual membership in the Na-
tional League of Nursing Education were received. Of these applications
84 have been approved by the Eligibility Committee, 2 have been referred to the Board of Directors for action, and 5 are still in the hands of the Eligibility Committee.

In states where there are no state leagues and admission is through individual membership, two states have doubled their membership: Arizona, Vermont; and three states have increased their membership by 50%: Alabama, Montana, Mississippi.

Since our Junior Active membership remains very small, it is recommended by this Committee that there be a more concerted effort to bring our younger nurses who are eligible, to participate in the work of this organization.

Endorsed applications, as listed, have been approved and recommended for membership by the Committee on Eligibility:

**Junior Active Members**

Burnham, Margaret Rafter, Bridgeport Hospital, Bridgeport, Connecticut
Campbell, Cornelia, Greenville General Hospital, Greenville, South Carolina
Carlson, Rubie M., Mount Sinai Hospital, Cleveland, Ohio
Doggett, Sarah Frances, Greenville General Hospital, Greenville, South Carolina
Dominick, Miriam E., Mount Sinai Hospital, Cleveland, Ohio
Eaton, Hazel A., Middlesex Hospital, Middletown, Connecticut
Frazier, Amelia May, Middlesex Hospital, Middletown, Connecticut
Gabriel, Ruth Margaret, Hartford Municipal Hospital, Hartford, Connecticut
Geffken, Viola Elizabeth, Middlesex Hospital, Middletown, Connecticut
Hatch, Bessie M., Bridgeport Hospital, Bridgeport, Connecticut
Jeary, Pauline F., Middlesex Hospital, Middletown, Connecticut
Martinkat, Alma A., Waterbury Hospital, Waterbury, Connecticut
Mason, Lida M., 1803 Valentine Avenue, Cleveland, Ohio
Matthews, Edna M., Waterbury Hospital, Waterbury, Connecticut
McClelland, Mildred J., Mount Sinai Hospital, Cleveland, Ohio
Pardue, Josephine Grace, 3200 Main Street, Stratford, Connecticut
Poscavage, Frances Louise, 281 North Main Street, Ansonia, Connecticut
Steiner, Mary Jane, Western Reserve University Hospital, Cleveland, Ohio
Stempel, Elinor Frances, Bridgeport Hospital, Bridgeport, Connecticut
Welborn, Mary Milwee, Greenville General Hospital, Greenville, South Carolina

**Active Members**

Andrews, Fern, Grant Hospital, Columbus, Ohio
Argus, Florence, Stamford Hospital, Stamford, Connecticut
Baham, Kathryn Helena, Hartford Municipal Hospital, Hartford, Connecticut
Barres, Olivia L., Huron Road Hospital, Cleveland, Ohio
Barrett, Arlyth J., Mount Sinai Hospital, Cleveland, Ohio
Bowen, Frances W., Stamford Hospital, Stamford, Connecticut
Bower, Irene, Western Reserve University, Cleveland, Ohio
Bowler, Ruth Norma, 64 Robbins Street, Waterbury, Connecticut
Braddock, Esther, Yavapai County School Nurse, Prescott, Arizona
Childs, Mary Ruth, Winona Infirmary, Winona, Mississippi
Churchill, Helen C., Brandon State School, Brandon, Vermont
Diefenthaler, Alice Carol, Grant Hospital, Columbus, Ohio
Dudley, Etta N., Grenada General Hospital, Grenada, Mississippi
Edmondson, Pauline, Stamford Hospital, Stamford, Connecticut
Fagan, Helen L., Hartford Municipal Hospital, Hartford, Connecticut
Fagan, Lucille, Holy Rosary Hospital, Miles City, Montana
Fisher, Hilda H., Jewish Hospital, Cincinnati, Ohio
Folckemer, Elizabeth M., Visiting Nurse Association, Cleveland, Ohio
Grawn, Charlotte R., Stamford Hospital, Stamford, Connecticut
Guthrie, Ayleene R., District Hospital, Manassas, Virginia
Haviland, Alice L., 2573 East 55 Street, Cleveland, Ohio
Hicks, Florence L., Arizona State Nurses' Association, District 1, 1637 North 10 Street, Phoenix, Arizona
Hood, Eloise, St. Margaret's Hospital, Montgomery, Alabama
Howard, Viola, St. Joseph's Hospital, Phoenix, Arizona
Huff, Kathleen, Greenville General Hospital, Greenville, South Carolina
Johnson, Viola Sara, Robbins Street, Waterbury, Connecticut
Kerr, Elizabeth, Ohio Valley General Hospital, Wheeling, West Virginia
Lenz, Mary B., St. Ann's Hospital, Cleveland, Ohio
Linfield, H. Grace, Kennedy Deaconess Hospital, Havre, Montana
Loud, Beatrice Adelaide, Central Maine General Hospital, Lewiston, Maine
Mag, Lillian P., Woman's Hospital, New York, New York.
Martin, Mary E., St. James Hospital, Butte, Montana
May, Frances C., Mississippi State Tuberculosis Sanatorium, Sanatorium, Mississippi
McKnight, Helen, Stamford Hospital, Stamford, Connecticut
Minson, Margaret, 151 South 2d Street, Globe, Arizona
Offenbacher, Hazel, Mount Sinai Hospital, Cleveland, Ohio
Ostlie, Sophie L., Akron City Hospital, Akron, Ohio
Parker, Magiwhite, St. Margaret's Hospital, Montgomery, Alabama
Patteson, Harriette A., Petersburg Hospital, Petersburg, Virginia
Prendergast, Mary Josephine, Hartford Municipal Hospital, Hartford, Connecticut
Read, Ruth Anna, White Cross Hospital, Columbus, Ohio
Ryan, Janet Ovedia, Middlesex Hospital, Middletown, Connecticut
Schuster, Dorothea, Waterbury Hospital, Waterbury, Connecticut
Senna, Helen Norinna, Stamford Hospital, Stamford, Connecticut
Sister Florence Maria Kreheler, Good Samaritan Hospital, Dayton, Ohio
Sister Francis Xavier, St. Vincent's Hospital, Billings, Montana
Sister Helen Neuhoff, Providence Infirmary, Mobile, Alabama
Sister Laura Nicaise, City Hospital, Mobile, Alabama
Sister Mary Alexine, St. James Hospital, Butte, Montana
Sister Mary Mechtilda Catty, St. Frances Hospital, Hartford, Connecticut
Sister M. Alice, St. Ann's Hospital, Cleveland, Ohio
Sister Rosita Maria Cullum, Dr. Pila's Surgical Clinic, Ponce, P. R.
Smith, Clara Ione, Stuart Circle Hospital, Richmond, Virginia
Sullivan, Mary Ellen, Hartford Municipal Hospital, Hartford, Connecticut
Sweeney, Frances, St. Mary's Hospital, Tucson, Arizona
Tatum, Tama Boyce, Jackson Infirmary, Jackson, Mississippi
Thompson, Agnes B., Luther Hospital, Watertown, South Dakota
Troupe, Katherine, St. Luke's Hospital, Cleveland, Ohio
Varnado, Maude, 2d Avenue, Laurel, Mississippi
Vinson, Mary Elizabeth, St. Margaret's Hospital, Montgomery, Alabama
Watts, Wilhelmina, 1190 Monroe Street, Globe, Arizona
Wooster, Zella, Cabaniss Hall, Richmond, Virginia
Wyant, Annie Laurie, Protestant Hospital, Norfolk, Virginia

Associate
Fulton, Janet, American Mission, Kermanshah, Persia
Respectfully submitted,

M. Cordelia Cowan, Chairman
REPORT OF THE COMMITTEE ON FINANCE

The Committee on Finance begs to submit the budget for 1935.

A tentative budget for six months was submitted to the Board of Directors at its meeting in January, 1935. This budget is for the fiscal year. The attached estimated income and expenses are based in part upon actual income and expenditures during the first four months of this year.

The budget is prepared on the General Account of the organization and on three special funds. In the general account, the appropriation for Headquarters’ expenses will be found to be supported by an itemized estimate of its expenditures.

Provision is made for the use of a special fund allocated by the American Nurses’ Association to the League, functioning as the educational department of the A. N. A.

In connection with the fund which was received from the Grading Committee to be used for continuation of Grading Committee activities, it has seemed wise to your Committee to allocate the sum of $1,000 to the Joint Committee on Nursing Service.

A special research fund has been set up by the gift of $15,000 from an interested friend. The major portion of this fund is appropriated for the Central Curriculum Committee. $2,500 is allocated to an Advisory Council for Continuation of Grading Activities. The Committee recommends that another name be found for this council or committee. As the League already has an Advisory Council, this name is misleading.

NATIONAL LEAGUE OF NURSING EDUCATION

1935 Budget

GENERAL ACCOUNT

Estimated Income

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash in Bank, December 31, 1934</td>
<td>$6,004.40</td>
</tr>
<tr>
<td>Curriculum (old)</td>
<td>200.00</td>
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<tr>
<td>Publications—reprints and studies</td>
<td>1,200.00</td>
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<tr>
<td>Nursing Schools—Today and Tomorrow</td>
<td>1,500.00</td>
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<tr>
<td>An Activity Analysis of Nursing</td>
<td>750.00</td>
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<tr>
<td>Accredited List</td>
<td>750.00</td>
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<tr>
<td>Photographs</td>
<td>225.00</td>
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<tr>
<td>Slides</td>
<td>500.00</td>
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<tr>
<td>State League Supplies</td>
<td>75.00</td>
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<tr>
<td>Dues—State</td>
<td>10,000.00</td>
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<tr>
<td>Dues—Individual</td>
<td>1,500.00</td>
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<tr>
<td>Department of Studies</td>
<td>1,000.00</td>
</tr>
<tr>
<td>Interest on Mortgage</td>
<td>400.00</td>
</tr>
<tr>
<td>Registration Fee—Convention</td>
<td>800.00</td>
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<tr>
<td>Contribution in lieu of Calendar sale</td>
<td>1,000.00</td>
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<tr>
<td>Sale—Oil Paintings</td>
<td>135.00</td>
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<tr>
<td>American Conference on Hospital Service</td>
<td>100.00</td>
</tr>
<tr>
<td>Records</td>
<td>600.00</td>
</tr>
</tbody>
</table>

$26,539.40
### Estimated Expenses

1935 Annual Report—printing and mailing .................................................. $2,200.00 
Auditor’s fees ............................................................................................... 100.00 
Board of Directors Meeting—officers and directors, January ....................... 900.00 
Booth—American Hospital Association Convention .................................. 100.00 
Commitees:
(a) Eligibility ................................................................................................. 5.00 
(b) Finance ................................................................................................... 50.00 
(c) Functions ............................................................................................... 5.00 
(d) Lay Participation ................................................................................... 75.00 
(e) Library facilities ..................................................................................... 5.00 
(f) Nominating ............................................................................................. 20.00 
(g) Records .................................................................................................. 75.00 
(h) Revisions ............................................................................................... 5.00 
(i) Studies ..................................................................................................... 50.00 
Convention:
(a) Miscellaneous ....................................................................................... 50.00 
(b) Officers’ expenses ............................................................................... 500.00 
(c) Program and Speakers ......................................................................... 250.00 
(d) Publicity—through Nursing Information Bureau ................................. 100.00 
(e) Reporting ............................................................................................... 100.00 
Dues—American Child Health Association ...................................................... 5.00 
Headquarters Budget ................................................................................... 18,478.61 
Miscellaneous .............................................................................................. 100.00 
Nursing Information Bureau ......................................................................... 500.00 
Photographs .................................................................................................. 150.00 
Publications ................................................................................................. 650.00 
Records—printing ....................................................................................... 650.00 
Slides ........................................................................................................... 950.00 
State League Supplies .................................................................................. 250.00 
Stationery ...................................................................................................... 75.00 
Traveling Expenses and Field Trips (Executive Secretary) ......................... 200.00 
Traveling Expenses (President) .................................................................... 200.00 
Balance ........................................................................................................ 90.79 

**Total** ....................................................................................................... $26,539.40

### Special A. N. A. Fund

**Estimated Income**

Balance in Bank, December 31, 1934 .......................................................... $3,402.57 
A. N. A. ....................................................................................................... 4,000.00 

**Total** ....................................................................................................... $7,402.57

**Estimated Expenses**

Accredited List ............................................................................................... $2,000.00 
Committee to Work with A. H. A.:
Postage, Stationery, Letter Service, etc. ...................................................... $200.00 
Traveling Expenses .................................................................................... 200.00 

Committee on State Board Problems:
Postage, Stationery, Letter Service, etc. ...................................................... $200.00 
Traveling Expenses .................................................................................... 200.00 

**Total** ....................................................................................................... 400.00
Committee on Mental Hygiene:
- Postage, Stationery, Letter Service, etc. $200.00
- Traveling Expenses 200.00
- Total $400.00

Special Survey on Mental Hygiene and Psychiatric Nursing 1,075.00
General Salaries 2,300.00
To be allocated for Studies and other purposes at Board Meetings 827.57

**Total Funds for Carrying on Grading Activities** $7,402.57

### Funds for Carrying on Grading Activities

**Estimated Income**
- Balance in Bank, December 31, 1934 $7,084.49
- Nurses' Committee for Financing Grading Plan 3,557.95
- Joint Nursing Committee on Educational Policies 1,304.90

**Total Estimated Income** $11,927.34

### Estimated Expenses
- General Salaries 2,335.00
- Committee on the Child in Nursing Education 100.00
- Joint Committee on Community Nursing Service 1,000.00
- Standards Committee 300.00
- Balance 8,192.34

**Total Estimated Expenses** $11,927.34

### Special Research Fund

**Income**
- 1935 $15,000.00

**Total Income** $15,000.00

### Expenses
- For Central Curriculum Committee 12,500.00
- Advisory Council for Continuation of Grading Activities 2,500.00

**Total Expenses** $15,000.00

### Headquarters Budget for 1935

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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<tr>
<td>Salaries</td>
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<td>Special office care (increase in rate)</td>
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<tr>
<td>Supplies</td>
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<tr>
<td>Shipping Service (additional for sending Accredited List and Records)</td>
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<tr>
<td>Postage and Express Charges (additional for mailing Accredited List and Records)</td>
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<td>Telegrams</td>
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<tr>
<td>Letter Service</td>
<td>450.00</td>
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<tr>
<td>Extra Stenographic Service</td>
<td>500.00</td>
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<tr>
<td>Library Service</td>
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<tr>
<td>Entertainment Fund</td>
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**Total Headquarters Budget for 1935** $15,000.00
PROCEEDINGS

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<tr>
<th>Description</th>
<th>Amount</th>
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</thead>
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<tr>
<td>Miscellaneous Expenses</td>
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<td>Insurance—Workmen’s Compensation and Employer’s Liability and Fire Insurance</td>
<td>$84.33</td>
</tr>
<tr>
<td>Reference Books and Reports (needed for office information)</td>
<td>$25.00</td>
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<td><strong>Department of Studies:</strong></td>
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<tr>
<td>Salaries</td>
<td>$5,540.00</td>
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<tr>
<td>Special Field Traveling Expenses</td>
<td>$75.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$18,478.61</strong></td>
</tr>
</tbody>
</table>

Respectfully submitted,

CARRIE M. HALL, Chairman

REPORT OF THE COMMITTEE ON HEADQUARTERS

At the meeting of the Board of Directors held in April, the President of the League was made the chairman of the Headquarters Committee. The personnel of the committee, however, remains the same.

Five meetings have been held during the year to handle any matters which needed attention during the interval between Board meetings. One meeting was held soon after the convention to appoint additional members of committees as authorized by the Board of Directors.

This Committee acts on the applications of new individual members of the League. Other matters which have received attention have been arrangements for taking over the publications of the Grading Committee, the appointment of Miss Ella Taylor to the League staff, and the consideration of the programs and projects of the special committees.

The minutes of these meetings are sent to all Board members.

Respectfully submitted,

EFFIE J. TAYLOR, Chairman

REPORT OF THE COMMITTEE ON NOMINATIONS

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

In September nominating blanks were sent to the presidents of 33 state leagues.

Twenty ballots were returned.

The following nominees have allowed their names to appear on the ballot:

Vice President: Nellie X. Hawkinson, Chicago Illinois
              Harriott L. P. Friend, Philadelphia, Pennsylvania

Secretary: Stella Goostay, Boston, Massachusetts
          Gladys Sellew, Chicago, Illinois
REPORT OF THE PROGRAM COMMITTEE

The Committee was organized in October and November, 1934. The first meeting was held at Teachers College, New York City, on November 16 at 3:30 p.m. Various topics for the central theme of the program were presented. After discussion, the suggestions were summarized by showing how all of the topics might be included under the general heading Philosophy of Nursing Education which must presuppose the newer concept of nursing. From a broad point of view, it would include the system under which nursing education would be placed, whether apprenticeship or some new method, the effect of the economic situation on nursing, the different phases of the curriculum, such as the natural sciences, the social sciences, public health, medical sciences, the nursing arts, and leisure time activities, the latter including health and recreation.

It was pointed out that other professions are undergoing a stage of experimentation and a change in their philosophy of education. Plans for the most beneficial type of program were discussed.

Because of the size of the committee it was felt that a smaller committee should be organized and asked to formulate detailed plans to be discussed at the following meeting. It was decided that a tentative plan for the program should be sent to various outstanding nurses throughout the country, asking for suggestions and names of speakers. Replies were received from seventeen states.

A report of the Committee's work was submitted at the January meeting of the Board of Directors of the League. It was decided to have two days devoted to a consideration of the various phases of the nursing school curriculum. The responsibility for this part of the program to be assumed by the Central Curriculum Committee under the direction of Miss Stewart.

Considerable difficulty was encountered in securing those who were chosen to take part in the program. Several of the speakers selected had previous engagements. It was necessary for others to withdraw, thus necessitating several changes in the selection of speakers.

Four meetings of the large committee were held in addition to the subcommittee conferences. At the last meeting held on February 22 there was a discussion concerning the most suitable time for the presentation of
the Saunier’s medal. A motion was made and carried that the medal be presented at the banquet meeting on Wednesday evening, June 5.

The complete report of the Committee is embodied in the program of the convention.

Respectfully submitted,
GRACE WATSON, Chairman

REPORT OF THE COMMITTEE ON PUBLICATIONS

Immediately after the convention the Annual Report was edited and published. A lighter and cheaper weight of paper was used to reduce the expense of publication. Although the Committee hesitated to see the volume cheapened in any way, the change in paper has not greatly detracted from the appearance of the book, and no adverse criticisms have been received from our members.

The final reports of the Grading Committee were turned over to the League in September. We received 3,500 copies of Nursing Schools—Today and Tomorrow, 1,500 copies of An Activity Analysis of Nursing, and 683 copies of Nurses, Patients, and Pocketbooks. Complimentary copies of the first two publications were sent to the Grading Committee, to foundations, and to other groups and interested individuals. A number of copies were used by the Nursing Information Bureau of the American Nurses’ Association. The first copies were sold at the Convention of the American Hospital Association in Philadelphia. When notices went out that they were available, the office was so swamped with orders that it was necessary to employ a special clerk.

The List of Schools Meeting Minimum Requirements Set by Law has been revised and is on sale at this convention. The work on this list has taken much time and effort, and we trust that it will be found useful. Up to date over 500 orders have been received, which is some evidence of its value.

Another real accomplishment of the League this year is a partial set of nursing school records which will meet a long-felt need. Prepared by a special committee under the Department of Studies after much study and consultation, the following records are available and others will be published later:

Directions Concerning the Use of Records
Instructions Concerning Application for Admission
Application for Admission
Pre-entrance Medical Record
Pre-entrance Dental Record
Personality Report
Secondary School Record
Interview with Applicant
Cumulative Health Record

A Suggested Vocational Guidance Program for Schools of Nursing by Eugenia K. Spalding, and A Study of the Place of Chemistry in the Basic
Preparation of the Professional Nurse by Edna Morse, have been added to our publications this year. These curriculum studies have proven most popular and have apparently met a need on the part of the schools. Many copies of the Curriculum Study in Social Hygiene for Nurses, and of the Study of the Social Content in the Basic Nursing Curriculum have been sold also.

Reprints of all the articles on the revision of the curriculum which have appeared in the last numbers of the American Journal of Nursing have been secured and are now available.

Although 1,500 copies of the Nursing School Faculty were printed, it has been necessary to order a second supply.

We are using the three vocational pamphlets, So You Want to be a Nurse, How to Choose a Nursing School, and When You are a Nurse published by the Nursing Information Bureau of the American Nurses’ Association which also serves the National League of Nursing Education. These are purchased from the Journal in quantities but are distributed free of charge in answer to the many requests received daily from students.

New literature appearing on our Publications List since our last convention includes the following:

**Books**
- Nursing Schools—Today and Tomorrow
- An Activity Analysis of Nursing
- Nurses, Patients, and Pocketbook
- A List of Schools of Nursing Meeting Minimum Requirements Set by Law

**Reprints**
- State Board Examinations—Objective Type
- The Subsidiary Worker in Nursing Services from the Point of View of the Committee on Subsidiary Workers in Nursing Services
- Tuberculosis Among Nurses
- Annie W. Goodrich—Crusader
- Eight Years of the Grading Committee—a historical sketch of the work of the Committee on the Grading of Nursing Schools
- The Next Step Forward and Curriculum Revision
- A Tentative Program for Curriculum Reconstruction
- What Educational Philosophy Shall We Accept for the Curriculum?
- What Standards Shall We Accept for the New Curriculum?
- What Sources and Techniques Shall We Use in Revising the Curriculum?
- How Shall We Plan the Program of Study?
- Orienting the Preliminary Student (Four Programs with a Reading List)
- The Right of the School of Nursing to the Resources of the University
- Who is Concerned with the Reform of Nursing Education?
- A Program for Staff Education

**Mimeographed Studies**
- A Study of the Place of Chemistry in the Basic Preparation of the Professional Nurse
- A Suggested Vocational Guidance Program for Schools of Nursing
- Suggested Readings and Materials Pertaining to Child Development and Parent Education
- Suggestions from the Inventory of a Hospital Nursery School or Playroom
The following is a summary of the sale, since the last convention, of some of our most popular publications:

<table>
<thead>
<tr>
<th>Publication</th>
<th>Copies Sold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Schools—Today and Tomorrow</td>
<td>1,659</td>
</tr>
<tr>
<td>An Activity Analysis of Nursing</td>
<td>859</td>
</tr>
<tr>
<td>The Nursing School Faculty</td>
<td>724</td>
</tr>
<tr>
<td>A Curriculum Study in Social Hygiene for Nurses</td>
<td>207</td>
</tr>
<tr>
<td>Study on the Use of the Graduate Nurse for Bedside Care in the Hospital</td>
<td>97</td>
</tr>
<tr>
<td>A Study of the Social Content of the Curriculum</td>
<td>133</td>
</tr>
<tr>
<td>Illustrative Material</td>
<td>93</td>
</tr>
<tr>
<td>Tests and Measurements Suitable for Use in Schools of Nursing</td>
<td>119</td>
</tr>
<tr>
<td>Curriculum for Schools of Nursing</td>
<td>355</td>
</tr>
<tr>
<td>The Story of the National League of Nursing Education (also sold by the publisher)</td>
<td>114</td>
</tr>
<tr>
<td>A Study of the Place of Chemistry in the Basic Preparation of the Professional Nurse</td>
<td>39</td>
</tr>
</tbody>
</table>

Profits made on most of our publications, not including the Grading Committee Reports, are negligible, as it is our purpose to give the profession the greatest possible amount of service. Reprints are often sent out in response to inquiries for information on specific subjects, thus saving an enormous amount of correspondence, and at the same time giving material on the subject which has been carefully prepared. For this reason, the chairman of the Publications Committee deliberately seeks to secure articles for the Educational Department of the American Journal of Nursing which will meet the needs of the profession for information on important questions of the day. It is the desire of the Publications Committee to make this service more and more valuable.

Respectfully submitted,

CLARIBEL A. WHEELER, Chairman

REPORT OF THE COMMITTEE ON REVISIONS

The work of this Committee has been considerably lessened this year because much of the routine work, such as checking on the By-laws of the state leagues, has been taken care of at the National office.

The form used as a guide for state leagues was rewritten to conform to the 1934 revisions of the National.

The Committee approved the changes in the By-laws as submitted by the states of New York, Tennessee, Kansas, Nebraska, California, and Pennsylvania.

The following changes in the By-laws are recommended:

1. Amend Article VII, Section 1-b, by striking out the word "Education" and substituting the word "Curriculum."

2. Amend Section 3 by striking out "The Committee on Education" and inserting the words "The Committee on Curriculum."

Respectfully submitted,

M. ANNA GILLIS, Chairman
REPORT OF THE COMMITTEE ON THE CHILD IN NURSING EDUCATION

Since the appointment of this Committee in June, 1934, it has held six meetings to plan its activities which have been directed toward stimulating an interest on the part of the nurse in obtaining a better understanding of children which has such far-reaching social significance. The work of the Committee may be briefly summarized as follows:

Four articles dealing with the relation of child development to nursing education have been published in the *American Journal of Nursing*; two pamphlets, one on Suggested Readings and Materials for Schools of Nursing Relating to Child Development and Parent Education and the other on Toys and Equipment for a Nursery School or Playroom in a Hospital have been put out in mimeograph form by the National League of Nursing Education; and talks have been given by members at nursing education meetings and to student and staff nurses in a few New York City hospitals.

On April 27 the Committee sponsored a one-day institute on the Child in Nursing Education held at Lincoln School, Teachers College, Columbia University. The program gave functional aspects of child care by means of demonstrations and exhibits in addition to theoretical aspects. A mental test of a six-year-old girl by a psychologist proved to be a particularly valuable demonstration of a child specialist's approach to children. She was able so to work with this child that the child had a sense of security in spite of being before a large audience. Another interesting demonstration was the baby's bath that brought out the opportunities afforded by the bath for the infant's physical and social development.

An exhibit of old-fashioned children's clothing, some of the garments a hundred years old, was a source of interest and was educational in showing the strides we have made in the hygiene of children's clothing. Dr. Arnold Gesell's moving pictures of the child in home situations given as a closing feature of the program, were particularly enjoyed and also made an excellent summary of the points in child development and parent education made by the speakers of the institute.

This institute was also of value because it helped to foster a better understanding among other professional groups interested in children and nurses.

The institute was well attended. That there were nurses from Chicago, Cleveland, and Philadelphia is somewhat indicative of the great interest of nurses in the child.

The Committee is considering work on the construction of that part of the new curriculum dealing with the well and sick child as its major interest for the coming year.

Respectfully submitted,

ALFHELD J. AXELSON, Chairman
REPORT OF THE COMMITTEE ON CURRICULUM

ORGANIZATION OF THE COMMITTEE

The Curriculum has always been recognized as the child of the Education Committee and it seems strange to have it appear now under its own name. But the fact is that the child has outgrown its old home and needs a little more space for its enlarging activities.

The project of Curriculum revision has been on the mind and conscience of the Education Committee for some time. The matter was taken up actively last fall because the need was obvious and urgent. In spite of the fact that the resources in sight were then quite inadequate for such a large undertaking, the League Board approved the action of the Education Committee and we began to see what could be done to provide ways and means. As we proceeded with plans, it became evident that we needed a special kind of organization to bring together the various groups whose work touches closely on the Curriculum of the nursing school, and who might be in a position to make a contribution to the project. These groups are found not only in the League organization but in the sister organizations of A.N.A., N.O.P.H.N., and A.C.S.N., and several other agencies. The creation of a Curriculum Committee was authorized last December by the N.L.N.E. Board through a referendum vote and plans proceeded without interruption under the new Committee.

The general plan of organization was described in the January number of the American Journal of Nursing (1935) with an accompanying chart. The Central Committee at present is made up of thirty-six members who represent twenty-one committees, organizations, or other groups.

The following committees of the Curriculum Committee are drawn from its own members. They are named according to their primary functions, Steering Committee, Aims and Program of Study Committee, and Standards Committee.

There are also eighteen Production Committees, the chairmen and members of which may or may not belong to the Curriculum Committee. In addition to these committees, there is a staff which helps to carry responsibility for planning and production. This staff is composed of a full-time Secretary, Elizabeth Pierce, a Curriculum Specialist (on half time), C. Mabel Smith, and five office and research assistants assigned to this project from one of the city agencies without expense to the Committee. Much assistance has been given also by Blanche Pfefferkorn of the Department of Studies of the N.L.N.E. and by Lenore Bradley and other members of the New York State Department of Education staff at Albany.

The work of the Curriculum Committee is centered in Teachers College which has turned over one room to serve as an office for the Committee and another for a curriculum laboratory. In addition, library and other college facilities have been generously placed at our disposal. This forms the hub of the organization but radiating out into the states, connecting
lines have been established with twenty-nine state committees. These committees have no direct responsibility for curriculum planning and production but they are exceedingly helpful as advisors on all sorts of questions including the selection of personnel for committees and scholarships. They have assisted greatly by sending us source materials, organizing discussion groups, giving their reactions on the proposals of the Committee and serving as interpreters of these proposals to others. The District of Columbia, Massachusetts, Pennsylvania, Virginia, and Connecticut have contributed financially by raising funds for scholarships or by sending special contributions. The state committees have been active also in working on local curriculum problems. One of the most encouraging results of the Curriculum program to date has been the letters from our colleagues in the field, telling us of their interest and assuring us of the value of the national program in stimulating curriculum discussions in local and state associations.

We must mention also the consultants who have collaborated in the Committee’s work. These have been selected as representatives of allied professional and lay groups and also as experts in special subject-matter fields. The list of consultants, which now numbers ten, will be considerably extended when the Production Committees get under way.

In addition we have had a large group of individual collaborators in the field who have been in touch with the Committee through correspondence. To the list of collaborators must be added many faculty members and students of Teachers College who have supported the Committee actively throughout the year and have contributed helpful suggestions and criticisms as well as a number of special studies.

The New York State Department of Education has worked very closely with the Curriculum Committee during this year and has assigned several of its staff to assist with studies. The Curriculum Committee has promised in return to make its results available to the Department. The same arrangement was open to other states wishing to collaborate in this way.

One major contributor must be specially mentioned because her generous gift to the N.L.N.E. last winter has made it possible to do many things which would have been impossible otherwise. She prefers to remain anonymous but she is a member of a board of hospital trustees and her gift was made through the Children’s Hospital Research Foundation of Cincinnati.

MEETINGS OF THE CURRICULUM COMMITTEE

There have been five regular meetings, including that of the Education Committee, at which the first plans for Curriculum revision were submitted and recommendations made for the organization of the present Curriculum Committee. These meetings which were held in New York, November 6 and December 12, 1934, and January 19, 25, and April 5 and 6, 1935, have dealt chiefly with matters of organization and policies. Since most of the recommendations have been embodied in the series of articles published monthly in the American Journal of Nursing (January to June,
inclusive), it is not necessary to attempt any summarization of the minutes in this report. One of the main objects of the Committee in publishing these articles was to prepare the way for active discussion and criticism of the proposed plans at this annual meeting of the N.L.N.E. It was decided by the Board that the program at this meeting should center about the Curriculum and that every possible opportunity should be given for League members to say what they think about the proposed plans before they become further crystallized. A meeting of the Central Curriculum Committee is to be held at the end of the convention week in order to bring together the results of these discussions and to consider possible changes in the tentative plans submitted.

The Committee has already secured opinions from representative nurses in the field through a series of Question Lists based on the Journal articles. Many accepted the suggestion of the Committee that they form discussion groups and send in replies from the group instead of individually. These replies have been summarized and the results seem to show that the nurses who have registered their opinions in this way are about 95% in accord with the proposals of the Committee. We realize that this vote of confidence may be misleading and we are anxious to have the members of this organization consider all the proposals critically, to discuss them frankly, and to let us know how they are thinking.

**Plans for the Next Steps**

The work of the Committee up to date has been largely devoted to the first step in a Curriculum program, that of initiating and organizing, setting up principles and policies, and clearing the ground for the next step of production. We are just entering this second stage at the present time. Whereas the first step is administrative in nature and is best handled by a small number of workers, the second requires a wide range of subject-matter specialists who also need to have teaching experience and who are able to work closely together in Production Committees. To start these groups off together along the same lines, we have arranged a week of special conferences for chairmen following the N.L.N.E. meetings. A three-week course on Curriculum Construction will be given at Teachers College to help in orienting those who are working on Production Committees. A number of scholarships have been given to Committee members for this period. Some scholarships may be given also for the summer and fall sessions.

After the conference week, the Production Committees will get to work on their various courses of study and will have the first draft ready to submit early in August. When these outlines have been approved, they will be mimeographed and we shall ask a number of schools in different parts of the country to help us to try them out during the coming year. Meanwhile, the committees will be working out the courses in more detail and it is hoped that the final report will be ready for publication by the summer or fall of 1936.
The staff and their associates have been busy for months collecting files of raw materials, bibliographies, studies, etc., for the use of Production Committees. In addition, we have recently secured from our colleagues in the field, criticisms of the present curriculum courses and suggestions for needed changes. All of these materials will be available for the use of Production Committees.

**SOME OF THE OUTCOMES HOPED FOR**

We can be fairly sure that the new Curriculum will not fully meet all our expectations, but we believe that some progress has been made in this latest revision in the use of newer principles and methods of curriculum construction. We are certainly making a definite effort to locate new materials and to apply critical and objective methods in evaluating them. We are also trying to use construction techniques that are reliable and at the same time not too complicated for relatively untrained curriculum makers to use. We believe that the educational by-products of a curriculum construction project are almost, if not quite, as important as the actual courses of study which emerge. For this reason, we are anxious to reach as many of our members as we can and to have them follow the program and send us their criticisms and suggestions. We hope that this experience will lead to the training of more nurses in the principles and techniques of curriculum making so that the next time the N.L.N.E. revises its curriculum, plenty of well-qualified people will be available to pick up the work and carry it through in expert fashion. The present chairman would like to notify the younger generation that they must get ready to engineer the next revision and if they are to keep up with the present rapid advances in curriculum making, they will need to get into training at once.

This reference to the future brings up the question of whether schools of nursing will not soon be far enough advanced and independent enough to do away with the need for a national curriculum. The answer depends a good deal on what we conceive to be the function of the League Curriculum. If we think of it as a model to be copied, there can be only one answer. The sooner our schools emerge from this stage of dependence, the better. If we think of the League Curriculum as a means of crystallizing the best current standards and practices in nursing education (so far as they can be determined and supported by our professional group) we can see a continuing function for the League Curriculum. But it must be clearly understood that we do not believe in a uniform or stereotyped curriculum for all schools of nursing. Reasonable experimentation and differentiation in programs should be stimulated and not discouraged by such an instrument. The Curriculum Committee hopes to make this point clear, not only through its introductory statement but through the set-up of the program itself. It is probable that the aims and objectives will be much the same for all schools although there may be variations here also. Many different ways may be found for reaching these objectives and all schools do not need to follow the same route in reaching the goal.
This is a very general summary of the work of the Curriculum Committee. The Committee’s proposals in regard to Aims, Standards, Program, etc., are to be discussed at several sessions of this convention. Reprints of the *Journal* articles may be secured at the N.L.N.E. booth. In addition, the chairman and members of the Committee will be glad to answer inquiries so far as they can. It will be remembered that we are still in the early stages of the undertaking and all the blue prints have not yet been drawn up. The Committee has open ears and an open mind for all kinds of constructive suggestions and invites League members to register their opinions during the coming sessions or in writing to the chairman or secretary of the Committee.

Respectfully submitted,

**Isabel M. Stewart, Chairman**

**REPORT OF THE COMMITTEE TO CONSIDER LAY PARTICIPATION IN NURSING EDUCATION**

The Committee was organized in December, 1934, and two meetings have been held. The concept of lay participation in activities related to professional work is so new in the National League of Nursing Education that the chairman has not availed herself of the privilege of adding to the Committee, preferring to work through the experimental year with a small group.

**PURPOSE OF THE COMMITTEE**

The following statement of purpose was accepted by the Board of Directors at the January, 1935, meeting:

"The chairman stated that the purpose of the Committee was to consider ways in which the National League of Nursing Education could work with lay groups, particularly members of school committees and members of hospital boards, who are especially interested in nursing education. Although the League is a professional organization and makes no provision for lay members, it has felt for a long time that it needed the advice and stimulation of a group of lay persons who are directly concerned with schools of nursing. It has realized that there has been no means provided by which persons who are members of school committees and hospital boards could come in direct contact with the educational group and learn first hand of the many problems involved in the present system of nursing education. The League believes that both the lay group and the profession would profit by an affiliation which would lead to joint thinking."

**PLAN OF PROCEDURE**

"The question before the Committee was stated to be, shall we go forward with a plan for building up school committees, or do we think it would be better to set up a new plan of organization for lay participation? The Committee was unanimous in the opinion that lay participation in the affairs of nursing education is necessary and that nursing school committees had received relatively little guidance from the National League of Nursing Education."
PROGRAM

It was agreed that, for the present, work should be done through the national committee, i.e., it was thought unwise to encourage the organization of similar committees in state leagues until the national committee had paved the way, so to speak.

With the approval of the Board of Directors, the Committee has planned for a luncheon meeting, to be held in the Roosevelt Hotel, June 5, 1935. The program is a forum on Nursing School Committees. Dr. C.-E. A. Winslow will preside and those who will open discussion on the major aspects of the question are:

Miss Evelyn Davis, National Organization for Public Health Nursing
Dr. C. W. Munger, Chairman of the Committee to Work with the Nursing Committee of the Council on Community Relations and Administrative Practice of the American Hospital Association
Miss Margaret Ashmun, Principal, School of Nursing, Orange Memorial Hospital

Plans for the luncheon have been announced through the *American Journal of Nursing* and the Bulletin. In addition, letters were sent to the principals of all accredited schools in the New England and North Atlantic Divisions, inviting them to send names of members of nursing school committees or hospital boards, who might be interested in attending.

When this report was written (May 27) 360 invitations had been sent out. Replies have indicated considerable interest on the part of lay people. This plan has involved considerable detail, all of which has been cared for in the League office. The chairman is most grateful for the assistance given. We shall know on Wednesday how successful our planning has been. On the basis of interest already shown, it is believed that larger plans for lay participation can be formulated and the state leagues can be encouraged to organize committees.

Respectfully submitted,

MARY M. ROBERTS, Chairman

REPORT OF THE COMMITTEE ON THE USE OF LIBRARY FACILITIES

The Committee has made little progress during the year. It has recommended to the Board of Directors of the League that a request be made to the proper Bellevue authorities for permission to print and sell Miss Doyle’s and Miss Casamajor’s material which was prepared in connection with their study of the Bellevue School of Nursing Library.

It is also recommended that the Board ask Miss Doyle and Miss Casamajor for permission to use this material.

The Committee also recommended that the Board secure the services of Miss Casamajor, if funds can be obtained, for the purpose of preparing a basic list for a school of nursing library.

It was learned from Headquarters by letter of February 18, 1935, that Miss Goosray was writing Mrs. Osborn regarding the Bellevue library material.
In 1930 the Committee prepared a list of reference books for a library of a school of nursing which would cost approximately $212. This list was prepared as a suggestion in response to a number of inquiries. It was revised in 1933 at the request of the Executive Secretary of the League and submitted to her in August of that year.

During my chairmanship efforts have been made to secure grants from the Carnegie Corporation and also scholarships from various sources such as the American Library Association in order that a study might be made of the general library situation in schools of nursing. These efforts which entailed a number of conferences and considerable correspondence have been without result.

It has seemed to the chairman that the abilities of the very able members of this Committee have been used to little avail and that the time asked of them, while not great, has not been effective and that there is very little to show for the many hours that the chairman, herself, has devoted to the Committee work since she was appointed in 1929.

Perhaps we haven’t failed if what we have done may be like the accomplishments of a man who had worked for a lifetime only to put up at the end a signboard, "Do not take this road—I have gone over it and found it profitless." Maybe our wanderings astray will help our successors more nearly to reach a goal.

On April 9 the chairman submitted to the League her resignation as she believes the time is ripe for active participation of the Committee in the work of the Central Curriculum Committee and that the chairman should be some one in close touch with League Headquarters and Teachers College, and who lives in New York.

Respectfully submitted,

JULIA C. STIMSON, Chairman

REPORT OF THE COMMITTEE ON MENTAL HYGIENE AND PSYCHIATRIC NURSING

The geographic distribution of the members of the Committee on Mental Hygiene and Psychiatric Nursing has prohibited a meeting of the entire committee at one time. The chairman has had many meetings with individual members and there have been two group meetings. There was a meeting in Chicago in October, 1934, of the members living in the vicinity of that city, and the members living in the East met in November. As a result of these two meetings a definite program was outlined. The functions of the Committee seemed to the members to be as follows:

1. Aiding in improving the care of the mentally ill. This could best be accomplished by:
   a. Interesting nursing educators in the care of the mentally ill patient, so that the subjects of mental hygiene and psychiatric nursing would be included as required subjects in the curriculum of the school of nursing
b. Emphasizing the importance of including the mental aspect as a significant factor in the study and care of every sick person

c. Getting nurses interested in and prepared for state hospital positions and for psychiatric nursing and mental hygiene work in the community

2. Informative—distribution of data on matters pertaining to psychiatric nursing and mental hygiene, such as:
   a. Information regarding graduate courses in psychiatry and mental hygiene
   b. Information regarding various therapeutics: recreational and occupational therapies, hydrotherapy, etc.
   c. Information on the subject of a general nature which is constantly being sought by nurses in the field

3. Relationships—seeking best means of becoming associated with:
   a. Psychiatrists and mental hygienists so that we may learn what they expect of the graduate nurse and how she might cooperate and work with them
   b. Departments of Public Welfare or those groups which control state institutions in order that nurses may be informed regarding positions and the qualifications for same
   c. Mental hygiene societies in the various states so that nurses might cooperate with them in their activities
   d. State Board Examiners. It is important that this Committee and the state boards get in closer relationship with each other so that the board will have information on mental hygiene and psychiatric nursing, for the nurses of their respective states
   e. Superintendents of Schools of Nursing and Governing Boards of Hospitals. It is important that superintendents and governing boards become interested in the subjects of mental hygiene and psychiatry in order that these subjects may be included in the curriculum

4. Publicity
   a. The public should be better informed regarding mental hygiene and psychiatric nursing. The Committee is making an effort to assist organizations in procuring programs and speakers on these subjects
   b. It should also assist in procuring articles for magazines and journals

5. The Committee should study facilities for courses in mental hygiene and psychiatric nursing

6. The Committee will assist, wherever possible, those nurses who are interested and who are working in state hospitals to improve the nursing care of the patients and to promote the education of the nurse

Miss Harriet Bailey was secured to make a survey of mental hospitals and she is now at work on this very important project. We have been in close touch with the Nursing Committee of the American Psychiatric Association and have its approval in this work. It is hoped that the study will be broad, comprehensive, and valuable to all interested in the care of the mentally ill and the education of the nurse. It will probably be a year before the report will be complete and we will have recommendations to offer for your consideration.

I wish to take this opportunity to express my personal gratitude and the gratitude of the Committee to Dr. Ross McC. Chapman, Chairman of the Committee on Nursing of the American Psychiatric Association, for his interest and coöperation. He has been of great assistance to us in every
way possible. Without this, it would have been most difficult for the Committee to have proceeded with its program.

The Committee is working on a reading list for psychology, psychiatry, mental hygiene, and related subjects. When the list is completed, it will be available to those who are interested, through the League Headquarters.

There is a subcommittee securing the information regarding the training of male nurses. Many requests come to Headquarters for information on this subject and we are endeavoring to procure data for distribution.

A subcommittee, with Miss Anna McGibbon, is preparing a course in psychiatric nursing for affiliate and graduate nurses. This will be published in the Journal as a part of the program for graduate study.

The chairman has helped many organizations in planning programs for psychiatric nursing and mental hygiene. She has also assisted schools of nursing of general hospitals and special hospitals in planning courses of study in these two subjects.

The correspondence has been extensive. Many nurses throughout the country are seeking advice regarding the possibilities in the field of psychiatric nursing and mental hygiene; and others are wanting information regarding schools of nursing where they can get graduate courses in psychiatry and mental hygiene.

The work of the Committee has been interesting and we trust that what has been accomplished during the past year has been and will continue to be of value to the nurse. We feel that we are just beginning a task that is bound to be far reaching and of great importance to the nursing profession, and will undoubtedly do much in bringing nurses into the field of mental hygiene and psychiatric nursing.

Respectfully submitted,  

MAY KENNEDY, Chairman

REPORT OF THE COMMITTEE ON SISTERS’ PROBLEMS

A meeting of the Committee on Sisters' Problems was held last April 22, in Washington, D. C. Sister Olivia, chairman, presided.

After a general discussion of the previous year’s work, the suggestion was made that this Committee be allowed to continue its work indefinitely.

It was suggested that a study be conducted by this Committee to consider the professional problems of Sisters conducting schools of nursing. This study was begun in February, 1935, under the title of "A Critical Survey of the Professional Relationship of the Catholic Sisters Conducting Schools of Nursing."

It was decided that the membership of the Committee would need to be enlarged in order to accomplish this study and accordingly the following members were appointed and accepted:

Sister Andrea, S.C., St. Vincent's Hospital, Indianapolis, Indiana
Sister Berenice, O.S.F., St. Joseph's Hospital, Milwaukee, Wisconsin
Sister Celestine, Hotel-Dieu, New Orleans, Louisiana
Sister Mechtilde, S.S.J., St. Francis Hospital, Hartford, Connecticut
Sister M. Maurice, R.S.M., Catholic University, Washington, D. C.
Sister M. Robert, S.S.J., St. Joseph Hospital, Elmira, New York
Sister M. Rita, Mercy Hospital, San Francisco, California
Sister M. Valeria, St. Margaret's Hospital, Montgomery, Alabama

The chairman sent out a tentative program to each of the members of the Sisters' Committee assigning to each a geographical area as follows:

Sister John Gabriel, Washington, Oregon, Montana, and Idaho
Sister Rita, California, Utah, and Nevada
Sister Victory, Arizona, New Mexico, Texas, Oklahoma, Arkansas
Sister Celestine, Louisiana, Mississippi, Georgia, South Carolina, Alabama
Sister Giles, Colorado, Kansas, Missouri
Sister Carmelita, Iowa, Michigan, Tennessee, Kentucky
Sister Euphrasia, Virginia, West Virginia, Delaware, Maryland, District of Columbia
Sister Laurentine, Pennsylvania
Sister Carmella, Ohio
Sister Ephrem, Minnesota
Sister Olive, South Dakota, North Dakota, Nebraska
Sister Berenice, Wisconsin
Sister Vincent, Illinois
Sister Andrea, Indiana
Sister Robert, State of New York, Massachusetts, Rhode Island
Sister Mechtilde, Connecticut, New Hampshire, Vermont, and Maine
Sister Ursula, City of New York

Each chairman has been requested to form a subcommittee in the area above, through which the study of selected problems might be made.

The main topics considered were: membership; participation in organizations and activities; costs.

The problems as reported from the Sisters' Committee revolve around the low percentage of membership in the professional organizations, the question of dues for membership, the evening meetings, the time involved in participation in the organization activities, the reticence of Sisters in assuming leadership, the small representation of Sisters on the most important committees.

Similar problems are recognized by the presidents of state leagues, state nurses' associations, and by the state boards of nurse examiners. There is every indication from the sources of information, whether through formal inquiries, correspondence, or personal interviews, that the state organizations appreciate the willingness with which the Sisters cooperate whenever their aid is solicited.

A meeting of the Committee on Sisters' Problems was held on Monday a.m., June 3, 1935, at the Roosevelt Hotel. At this meeting Sister Victory read the final report of her study.

Respectfully submitted,

SISTER M. OLIVIA, Chairman
REPORT OF THE COMMITTEE ON STANDARDS

Since the last meeting of the League in Washington, April, 1934, the Committee on Standards has held two meetings. Both of these were in New York City, one on January 22 and the other on June 2.

At the January meeting the revised material on Standards which had been sent to committee members following the Washington meeting was again reviewed by the Committee as a whole and then referred to a small subcommittee charged with the responsibility of coordinating and editing the material and putting it into satisfactory form for immediate publication.

This plan for publication was not carried forward, however, for several reasons, the primary one being that with the development of the work of the Central Curriculum Committee it became evident that there was need for further discussion of the interrelationship of nursing school standards and curriculum standards and of how the work of these two committees can best be coordinated.

The meeting held June 2 was called for this purpose. At this meeting the plan of the Standards Committee was again reviewed in relation to the work of the Central Curriculum Committee and also in relation to the establishment of some kind of a program for the evaluation of schools of nursing for accreditation—the need of which is becoming increasingly evident.

As a result of the discussion at this meeting it was decided not to delay the publication of a Manual on Standards for a Good School of Nursing until the Central Curriculum Committee is ready to bring out the revised curriculum but to proceed with its publication at once.

It is planned to have this manual ready for distribution within a few months and the Committee hopes that it will prove to be a helpful guide and a stimulus to schools of nursing, and also that it may serve as a step toward the establishment of some kind of a national program for the accreditation of schools of nursing.

Respectfully submitted,

NELLIE X. HAWKINSON, Chairman

REPORT OF THE COMMITTEE ON STATE BOARD PROBLEMS

(See page 263)

REPORT OF COMMITTEE ON STUDIES

Two meetings of the Executive Committee of the Committee on Studies were held during the year—one in July and one in December. The minutes of both meetings were sent to the members of the Committee as a whole.

At the December meeting it was voted that the chairman of the Committee and the Director of Studies represent the Committee on Studies on the Central Curriculum Committee.
During the year the Department of Studies has received inquiries concerning the possibilities of twelve special studies, in some instances from individual institutions, in others from organizations or groups.

In the main, the function of the Committee has been to advise with the Director of Studies on program of work and special questions which may occur and to review reports of confidential studies. The details of the year's program are given in the report of the Director of Studies.

Respectfully submitted,

MARIAN ROTTMAN FLEMING, Chairman

REPORT OF THE COMMITTEE ON SUBSIDIARY WORKERS IN NURSING SERVICES

(See page 264)

REPORT OF THE COMMITTEE TO WORK WITH THE NURSING COMMITTEE OF THE AMERICAN HOSPITAL ASSOCIATION

The Special Committee appointed to work with the Nursing Committee of the Council of Community Relations and Administrative Practice of the American Hospital Association has held two meetings during the year, one at the time of the January Board meetings and one, of the Executive Committee only, on May 11.

In January Miss Elsie Lawler found it necessary to resign as chairman of the Committee, and Miss Laura Grant was appointed to succeed her. Miss Grace Allison has resigned from the Committee, and Miss Josephine Goldsmith and Miss Elizabeth Pierce are new members.

Under the direction and in the name of the two committees a questionnaire on salaries, health of staff, vacations, sick leave, etc., was prepared by Miss Ella Taylor and sent out through the League office to 500 hospitals. Of the 500 questionnaires sent only 231 were returned, but the results have been tabulated and do show interesting trends.

The work on the Manual of the Essentials of Good Hospital Nursing Service has nearly been completed. Part of the material has been prepared by our Committee and part by the A.H.A. Committee. Much of the work has been done at the Headquarters office. The units have been passed back and forth between the two committees, and recently a conference between representatives of the two committees was held.

The Committee recommended to the Board of Directors that a letter be written to the American College of Surgeons requesting that they urge hospitals without schools to see that graduate nurses are employed in sufficient numbers to secure good nursing care. This recommendation was accepted and the letter written. A cordial reply assuring the League of cooperation in this respect was received.
It is the purpose of the committees to have the manual published in the early autumn if possible, so that other important projects may be undertaken by these committees.

Respectfully submitted,

LAURA GRANT, Chairman

REPORT OF THE JOINT COMMITTEE ON COMMUNITY NURSING SERVICE

The depression has exposed a great paradox in the nursing situation in most communities in the United States. On the one hand, there are thousands of citizens needing nursing care who are going unnursed. On the other hand, there are thousands of nurses unemployed. This situation led the American Nurses' Association to suggest to the National Organization for Public Health Nursing that a committee representing lay groups as well as nurses be formed to study the problem of adequate community nursing service. It was felt that the National Organization for Public Health Nursing, because it has lay members, was the logical national organization to sponsor such a committee.

Two meetings of this Committee have been held—one in December, 1934, and one in March, 1935. Miss Sophie Nelson is chairman and the membership consists of nurses and laymen nominated by the three national nursing organizations, together with the directors at Headquarters and the editors of the two magazines. Because of the exceedingly broad scope of such a committee, it was felt by the N.O.P.H.N. Board that this Committee properly should be a joint committee of the three national nursing organizations. At the Joint Board meeting in January, 1935, this was made a joint committee with the same personnel.

The functions of the Committee have been outlined as follows:

To assist communities, upon their request, through consultation and advice in meeting the need for a planned, related, and more complete nursing service

To stimulate like interest and action in other communities

One of the first considerations of the Committee was the outlining of the principles which might be used by local communities as a guide to the study of their own nursing needs. These principles are as follows:

1. That a responsible group representing the nursing profession, the medical profession and such lay groups concerned with nursing as hospital boards, schools of nursing committees, boards of public health nursing agencies, etc., work out plans in each community for a community nursing program

2. Analyzing community nursing problems include
   a. How much nursing care is needed for different types of situations
   b. What are the present facilities
   c. What are the gaps and duplications as shown by a. and b.
3. Meeting community nursing needs involves
   a. Reducing the number of agencies which distribute nursing services to as few agencies as possible and providing one coördinating agency through which all types of needed nursing service may be obtained
   b. An understood relationship and division of responsibility between the various nursing facilities
   c. A concerted effort to fill in gaps and eliminate duplication
   d. The establishment in every community of some type of machinery for supplying nursing service

The Committee feels that the goals for community nursing service are the same for city and rural situations although plans for reaching them may vary in accordance with the type and size of the community.

One of the biggest problems before nursing is the education of laymen to a better understanding of the problems involved in nursing and the Committee feels that this is best accomplished by giving laymen an opportunity for actual participation in nursing affairs.

Another phase of the Committee's program may be to assemble in usable form all the facts at present available from existing studies and developing methods for the conduct of any further studies which may be indicated. A selected number of communities may be assisted in working out a plan for a more complete and more related nursing service.

If this Committee is to assist communities in (1) analyzing their nursing problems and their existing nursing agencies, and (2) in working out a more satisfactory and more coördinated nursing program, it is obvious that the Committee will need the services of a full-time staff member. The Committee has, therefore, voted that an executive secretary be appointed, that a budget be set up, and that the budget be shared by each of the three national nursing organizations.

The Committee is now in the stage of getting from each of the three national nursing associations the necessary budget allowance and as soon as that is obtained the plans of the Committee will go forward.

In general, the Committee feels that the problem of community nursing service in any local situation is one of coördinating and possibly combining existing agencies and in developing whatever new set-up is necessary. From correspondence, from contacts in the field, and from interest shown by many state and local groups, it is obvious that this tremendous question of community nursing service is being given broad consideration and that we need the guidance of this joint Committee of the three national nursing associations to help the public understand better the meaning of good nursing and to help nursing improve its organization to provide the service which the public needs.

Respectfully submitted,

ALMA C. HAUP, Secretary
REPORT OF ISABEL HAMPTON ROBB MEMORIAL FUND COMMITTEE

This Committee begs to report that the usual business has been transacted since our last report.

The annual meeting held in January was well attended, ten members being present. The resignation of Miss Helena McMillan was accepted and Miss Helen Denne of Wisconsin appointed to fill the vacancy. It was decided to offer five scholarships this year and they have been awarded as follows:

Milenka Herce, Detroit, Michigan, Graduate of the Mt. Sinai, New York
Anna K. McGibbon, Providence, Rhode Island, Graduate of Butler Hospital School of Nursing
Mary E. Shepard, Boston, Massachusetts, Graduate of Massachusetts General
Florence R. Parisa, Minneapolis, Minnesota, Graduate of School of Nursing, University of Kansas
Lucy F. Hoblitzele, St. Louis, Missouri, Graduate of School of Nursing, University of Rochester

Forty-five applications representing 42 schools were received from the following states:

Alabama           Maine           Missouri           Pennsylvania
California        Maryland        New Jersey        Rhode Island
Florida           Massachusetts    New York          Virginia
Illinois          Michigan        Ohio              Wisconsin
Iowa              Minnesota       Oregon           Territory of Hawaii

The applicants were desirous of further preparation for work in the following fields:

Administration and Supervision in Schools of Nursing .......................... 11
Administration in Social Service ............................................... 1
Nursing Education ................................................................. 18
Teaching in Pediatrics ............................................................ 2
Public Health ................................................................. 12
Frontier Nursing Service ...................................................... 1

Sixteen are working toward a bachelor's degree and six toward a master's. The places of study selected:

Teachers College, Columbia University, New York ............................ 26
University of California ......................................................... 4
Simmons College, Boston ......................................................... 3
University of Michigan ......................................................... 2
Western Reserve University ................................................... 2

and one each at University of Chicago, Syracuse University, Marquette University, Lohenstine Clinic, Washington University, St. Louis, University of Minnesota, University of Oregon, and Florida State College.

Of the candidates, 11 already had degrees, 10 had had some college work, 17 had had either normal school or summer college work in addition to high school, and 7 had high school only. Of the 43 candidates, 29 were
members of the League, and 32 were subscribers to the *American Journal of Nursing*.

It was decided at the meeting in January that the A.N.A. Committee on the Florence Nightingale International Foundation should be notified that the Robb Committee would be interested in making a contribution of $500 toward an international scholarship if a properly qualified person applies.

During the year, $837 was received in contributions and $1,277.46 interest on investments.

**REPORT OF THE MCISSAC LOAN FUND**

During the year ending December 31, 1934, there were 58 inquiries and 26 applications. Fourteen loans were granted, seven loans repaid in full and eleven in part. The contributions during the year were $852 and payment in loans $1,280.85, and disbursements $2,545.18.

Respectfully submitted,

Elsie Lawler, Chairman

The President appointed the following committees: Committee on Resolutions: Frances Ziegler, Virginia, chairman; Pearl Castile, California; Eleanor Lee, New York; June A. Ramsey, Michigan; Tellers: Charlotte Pfeffer, Virginia, chairman; Ella Hasenjaeger, New Jersey; Nellie S. Parks, Ohio; Inspectors of Election: Maud Kelly, New York, chairman; Alma Gault, Illinois; Laura Robinson, New York.

**Open Session Conducted by Advisory Council**

**Tuesday, June 4, 2:30 p.m.**

Presiding: Effie J. Taylor, R.N., President.

The roll call showed that representatives of twenty-four state leagues and four educational sections of state nurses’ associations were present.

Miss Taylor announced that the reports of state leagues and sections had been summarized and copies distributed in order that the time might be spent in discussing problems.

**REPORTS OF STATE LEAGUES OF NURSING EDUCATION**

In summarizing the reports from state leagues sent to Headquarters in May the following facts were revealed: that there are 33 state leagues and 26 local leagues; that 21 of the state leagues function as the department of education of their state nurses’ association and that two others are considering the matter at the present time; that the membership in the leagues is 3,580, approximately 760 of these members being new.

Arkansas

*Members: 8*

*Activities:* The League sponsored an educational program at a joint meeting with the State Nurses’ Association which was well attended by an enthusiastic audience.

*Problems:* Inability to secure new members, and interest members of schools of nursing; lack of cooperation of state board of nurse examiners.

*All membership figures taken from Headquarters’ files of 1935 paid-up members, August, 1935.*
CALIFORNIA

Members: 223
Local Leagues: Two, the Northern Branch and the Southern Branch.
Activities: Continuation of work for survey of schools in state; sponsoring of a bill in State Legislature to provide a transfer of funds which would make survey possible assisting districts with programs and institutes.

COLORADO

Members: 63
Local Leagues: One, Denver.
Activities: Three well-attended meetings, one in Denver, and two in Colorado Springs. Annual meeting: Topic—How the Quality of the Nursing at Night Might Be Improved. Spring meeting: Reports of the Biennial. Fall meeting: All-day meeting. Beautiful pageant on nursing history. President of Colorado College gave inspiring address on Trends in Education.
Problems: Inability to organize local leagues; inability to obtain cooperation of State Association in using State League in its proper function as educational group.

DELWARE

Members: 23
Activities: Demonstration of new procedures, techniques, etc., all nurses invited; monthly meetings.

DISTRICT OF COLUMBIA

Members: 88
Activities: Monthly meetings with good attendance; joint meeting with the Graduate Nurses’ Association held in January. Guest speaker, Miss Lenore Bradley, whose subject was “the results of the survey of the nursing situation in New York State.”
Curriculum revision has been given an outstanding place on the programs. Sister Olivia, Director of Nursing Education at Catholic University, gave several talks on curriculum revision in general and on the plan of the Central Committee. A parallel study of the D. C. curriculum has been carried on with subcommittees outlining the various subjects. At the request of the League four alumnae associations have awarded scholarships for the intersession at Teachers College in June.
Plans are under way for making a survey of the nursing situation in the District as a joint project of the Graduate Nurses’ Association and the League to be financed by the Graduate Nurses’ Association.
A demonstration of a bedside clinic as a method of ward teaching was arranged by the Education Committee.
Other topics of discussion were as follows: Group Hospitalization Plan, Trends in Nursing Education, The Place of Nursing in the New Social Order, and The Fifteenth International Red Cross Conference.
Problem: Whether or not the League should function as the education department of the Graduate Nurses’ Association.

FLORIDA

Members: 13
Activities: Setting up a short course to embrace all branches of nursing education to be conducted in cooperation with the state board of nurse examiners and the General Extension Division of the University of Florida. The object of this course is to afford an opportunity to Florida nurses to keep up with the latest discoveries in the field of nursing and modern technique in nursing procedures.
Problem: Keeping up an interest in membership.
GEORGIA

Members: 42
Activities: Membership campaign; publication of three League Bulletins containing instructive material of League activities; formation of a committee to work on the establishment of a university school of nursing.
Problem: Lack of interest in joining League and organizational work.

ILLINOIS

Members: 341
Activities: Revision of By-laws now in progress, with assistance of parliamentarian; voted $25 each to Isabel Hampton Robb Memorial and McIsaac Loan Funds; curriculum committee appointed and working; promotion of courses at University of Chicago; voted income this year (approximately $600) from University of Chicago Graduate Nurses' Fund for fellowship in Nursing Education at University of Chicago; cooperative meetings with Central Council for Nursing Education, Tri-State Hospital Association, and First District Illinois State Nurses' Association; committee appointed to work with the Committee on the Child in Nursing Education of the National League of Nursing Education.
Problem: Concentration of membership in Chicago area.

INDIANA

Members: 60
Local Leagues: One.
Activities: Main project—to stimulate interest of nurses throughout the state in membership. The reports at various meetings have included one by Miss Beatrice Gerrin on Some of the Newer Trends in Nursing, and one by Wilkie Hughes on Staff Education. At a joint luncheon meeting of the I.S.N.A., I.O.P.H.N., and the League, Dr. Harriett O'Shay of Purdue University spoke on Mental Nursing. Six meetings were held throughout the year.
Problem: Reaching League members in remote part of the state. We send copies of papers read at League meetings to certain members unable to attend.

IOWA

Members: 89
Activities: For the first time, two meetings were held, one at the time of the Iowa Hospital Association's convention in Council Bluffs. It is hoped that local meetings can be planned next year.
Problems: To make the League profitable because members complain that it is not doing anything for them; to put the Bulletin on a firm foundation and to make it worth while to members.

KANSAS

Members: 45
Local Leagues: One, Kansas City.
Activities: Two institutes; study classes sponsored by education committee.
Problem: Increasing membership.

KENTUCKY

Members: 50
Activities: Sponsored a two-day institute at the Red Cross Hospital, where the one negro school of nursing is located. The colored nurses were most enthusiastic and asked us to make it an annual affair. We did further study of records used in schools of nursing; and gathered information on the subject of university education for nurses in other places, so that we could better judge what possibilities and resources Kentucky has for giving this type of education at home.
Problem: Only a few members are willing to do any work.
Louisiana

Members: 77
Activities: Two-day annual institute held in June, 1934. First day devoted to ward-teaching program, second day to methods of teaching history of nursing. Three sets of slides from National Headquarters aroused great interest.
Annual meeting held in October. By-laws revised at this meeting. Chief features of discussion were The Relationship of the League to the Other Nursing Organizations and Value and Methods of Teaching Professional Relationships to the Undergraduate.
The Education Committee has taken steps to organize discussion groups to work on the curriculum. Plans are under way for the formation of a state Nursing Information Committee.
Problems: Difficulty in forming local leagues due to smallness of Louisiana towns; difficulty in developing League leaders in small towns; difficulty in stimulating members to read the Journal.

Maryland

Members: 103
Activities: Seven general meetings held during the year. Annual meeting held jointly with Maryland State Nurses’ Association and Maryland State Organization for Public Health Nursing. Our contribution to the program was a round table discussion of The Application of the Principles of Psychiatry in General Nursing. We were also instrumental in having Dr. Esther L. Richards, Associate Professor of Psychiatry, Johns Hopkins Medical School, address the group on Mental Attitudes in Graduate Nurses.
The most worth while accomplishment of the year was the establishment of a course in sociology at Johns Hopkins University. Sixty nurses are taking this course and are very enthusiastic. Arrangements have been made to offer this course again next year and an advanced course as well.
Problem: Keeping up interest of members.

Massachusetts

Members: 194
Activities: Annual meeting held in Boston, October 31 to November 2, 1934, in joint session with the Massachusetts State Nurses’ Association and the Massachusetts Organization for Public Health Nursing. Well-attended meeting of principals of nursing schools with members of nursing school committees.
Two-day institute in February on disease prevention, held at Boston; general meeting in April at Fall River; annual student meeting in Boston, May 5, with Major Julia C. Stimson, Superintendent of the Army Nurse Corps, as principal speaker.
On recommendation of Education Committee, League has voted to finance a scholarship for a qualified member of the Massachusetts League for an intersession and a summer session in curriculum planning, at Teachers College, Columbia.
The League is considering the formation of local or regional committees in the state.
Problem: To stimulate interest in membership, especially among the young head nurses and supervisors.

Michigan

Members: 143
Local Leagues: One, Detroit.
Activities: Institute February 16 and 17, 1935; membership campaign; distribution of information for prospective students in schools of nursing; legislative campaign with Michigan State Nurses’ Association.
Problems: Membership scattered over large area, difficult to bring together except at Institute and Annual Meeting when time is taken up with other groups (State Hospital Association); disproportion between membership and those eligible for membership in the state; consideration of other local leagues.

MINNESOTA

Members: 180

Activities: Arranging, with the cooperation of nursing organizations and the University of Minnesota School of Nursing, for the visit of Dean Emeritus Annie W. Goodrich at the University for the fall quarter, 1934; setting up of machinery for assisting with the revision of the curriculum; completing two studies on (1) preparation and professional membership of graduate nurses in schools of nursing in the state, and (2) the cost of student withdrawals from schools of nursing (these to appear in early issues of the state magazine, The Minnesota Registered Nurse); purchasing a set of history of nursing slides for loan to all schools; state-wide testing program for entrants to schools of nursing; forming discussion groups with qualified chairmen in clinical services, operating room, obstetrics, communicable disease, and pediatric nursing; making preliminary study of the pre-clinical nursing course; planning joint publicity with other nursing organizations to reach professional, educational, and lay groups. Nine executive board meetings have been held and seven programs have been presented at alternate day and evening hours, with one meeting held in the south and one in the north of the state.

Problem: Securing adequate economic support for nursing service and nursing education.

MISSOURI

Members: 86

Local Leagues: Two, St. Louis, and Kansas City.

Activities: Co-operated with the Missouri State Nurses' Association, the District and Alumnae Associations in establishing a psychiatric nursing course in the City Sanitarium in St. Louis. The salaries of a nurse director and two assistants are paid by the nursing organizations. The course of six months' duration is open to nurses registered in Missouri. This is the first opportunity for training in psychiatry in Missouri.

The two local leagues have had regular monthly meetings throughout the year.

Problem: Unsatisfactory organization of the League since almost entire membership lies in the two locals and the state officers seem to duplicate unnecessarily the functions of the local leagues.

NEBRASKA

Members: 62

Local Leagues: Two, Omaha and Lincoln.

Activities: Annual institute; eight meetings of Omaha League; monthly meetings of Lincoln League; assisting State Association in League program.

Problem: Lack of adequate funds to carry on educational programs as the League desires.

NEW HAMPSHIRE

Members: 42

Local Leagues: One.

Activities: Hanover meeting: Selection of College Students, Robert C. Strong, Dean of Freshmen and Director of Admissions, Dartmouth College; Manchester meeting: Social Hygiene in Girls' Schools, Dr. Jean C. Mendenhall, Instructor in Social Hygiene, Sargent School of Physical Education; Concord meeting: Nursing
Conditions in Massachusetts, Elizabeth Sullivan, Supervisor of Schools of Nursing in Massachusetts.

**Problems:** Too little individual interest in nursing education; lack of knowledge of the aims and functions of the League; difficulty in collecting membership dues.

**New Jersey**

**Members:** 190

**Activities:** Four regular meetings held with seven meetings of the executive committee; seven special meetings held to consider (1) university affiliations for schools of nursing and (2) staff education project; under League auspices a course in Ward Supervision and Teaching has been given by Adelaide Mayo, formerly of the University of Virginia, in ten schools of nursing in different parts of the state; League sponsored an extra-mural course offered by Rutgers University and five offered by Teachers College; a two-day institute with attendance of 293 was held in February at Women's College, New Brunswick; four meetings of instructors' section have been held; committees on state board problems and curriculum have been formed.

The Morristown Memorial Hospital closed its school of nursing in 1934, and has continued functioning with a graduate nurse service. A report from that hospital states that the hospital "has been experimenting for the last year with a graduate nursing service under motivation. Classes numbering forty have been admitted for six-month periods and a course covering one hundred and twenty hours in Ward Teaching and Ward Management has been given, in addition to courses in Community Health, Social Hygiene and Sex Education. It is felt that there is a thought worthy of development in the plan of combined teaching and nursing service."

**Problem:** Location of a few hospitals in remote parts of the state prevent active participation in activities of League.

**New York**

**Members:** 553

**Local Leagues:** Five, New York City, Hudson Valley, Central New York, Buffalo, and Genesee Valley.

**Activities:** Program for principals of schools of nursing; in-service program of education for graduate nurses.

**Problems:** Dues. Why not have National Examining Boards? Why do we have local, state, and national eligibility committees? How can schools of nursing be graded? How can all League members benefit by League activities?

**North Carolina**

**Members:** 37

**Activities:** Donation of $50 to National League of Nursing Education; regional conference held at Duke University for superintendents, instructors, and supervisors; planning an institute at Chapel Hill in connection with the University of North Carolina for twelve days the latter part of July for superintendents, instructors, and supervisors.

**Problem:** Lack of interest.

**North Dakota**

**Members:** 12

**Activities:** Working on curriculum for schools for nursing.

**Problem:** Securing members.

**Oklahoma**

**Members:** 23

**Activities:** Appointment of a field representative to contact all schools of nursing in effort to raise membership; institute held during April.

**Problems:** Increasing membership and holding old members.
OREGON

Members: 30
Local Leagues: One, Portland.

Activities: Institute on general staff nursing, their salaries, other problems, and how to solve them; speakers’ bureau, assisted by Oregon State Board of Nurse Examiners. Talks have been given to students of thirty high schools and the three pamphlets published by the Nursing Information Bureau at Headquarters have been distributed to these groups. Announcements that the three pamphlets and other information on nursing education was available at Headquarters was sent to thirty-six newspapers and magazines of the state.

Problems: Very grave shortage of student nurses due to three causes—raising of educational standards, increase in cost, and the impression which has been given to the public that there is an oversupply of nurses.

PENNSYLVANIA

Members: 346
Local Leagues: Four, Philadelphia, Pittsburgh, Reading and Bethlehem, and Scranton and Wilkes-Barre.

Activities: Week’s institute in Wilkes-Barre in June on Improvement of Clinical Education; mental hygiene section program of ten lectures in Philadelphia for which 350 registered; setting up of a state-wide program in testing for fitness for nursing; contributions to scholarship funds, Robb and McIsaac Loan; each local league has held frequent meetings and given institutes in some cases; participation in curriculum revision program by allotment of money for expenses of the state chairman for work with the Central Committee; publishing the copy of the preliminary work on curriculum revision and sending a copy to the board of trustees of each hospital maintaining a school of nursing; campaign for new members; setting up administration for scholarship fund given by P.L.N.E.

Problems: Relief of overburdened staffs of hospitals, freeing time and energy for teaching on wards, establishing community relationship, and securing interest of lay persons in improvement of nursing; distribution of nursing service, unemployment; lack of funds; difficulty in holding meetings because of great distances to be covered in some parts of the state; resentment that League does not keep more of its dues for state work, improvement of instructors and teachers in service.

RHODE ISLAND

Members: 103

Activities: Annual Institute with usual attendance of about 1,200; special courses for nurses in educational psychology and principles of teaching are being given in the Extension Department of Brown University and these subjects are being made prerequisites for the course in ward administration and ward teaching and supervision; nine all-day interschool visits with an average attendance of 12; state committee on curriculum study formed, chairman sent to one meeting of the Central Committee; cooperation with State Nurses’ Association in its legislative program.

Problems: To stimulate professional interest in our members; to find a new project for each year; to interest the schools in a standardization program.

TENNESSEE

Members: 42

Activities: Campaign to increase membership.

Problems: Lack of leadership; small groups, widely separated.

TEXAS

Members: 92

Activities: Annual state meeting; two-day institute; curriculum revision study begun in the state under the direction of Miss Olga Breihan; efforts made for 100%
faculty membership (results not very satisfying); two board meetings held; five
form letters sent to all League members during the year informing them of League
activities; two questionnaires sent to all League members and directors and instruc-
tors in schools, one on the program for the League institute and one on the aims
of the curriculum; the Education Committee has edited a page in the State Hospital
Journal.
Problems: Scarcity of members; two few meetings; distances great.

UTAH
Members: 20
Activities: Held monthly meetings at which programs were given on problems of
nursing education. Next year we hope to standardize textbooks and classwork in
the various schools.

WASHINGTON
Members: 68
Local Leagues: Three, Seattle, Spokane, and Bellingham.
Activities: Mental Hygiene program carried to isolated districts through publica-
tion in Bulletin; clinics in state and federal hospitals.
Problem: Arousing interest in isolated districts.

WISCONSIN
Members: 132
Local Leagues: Two, Milwaukee and Eau Claire.
Activities: Chief project for the year is an institute to be held during the week
of June 15 in Milwaukee; assisting Central Curriculum Committee through a local
committee; Milwaukee league held meetings monthly, the Eau Claire League less
often because membership is small.
Problem: Isolated members receive little stimulation from membership.

REPORTS OF EDUCATIONAL SECTIONS OF STATE NURSES' ASSOCIATION

ALABAMA
Members: 16
No report.

CONNECTICUT
Members: 144
Activities: Institute held in November for two days with registration of almost
500; an additional set of History of Nursing slides has been purchased for use by
the schools; meetings have been planned by the Educational Section in conjunction
with the spring, fall, and annual meetings of the C.S.N.A.; two representatives have
been sent to the general meeting of the Central Curriculum Committee; an Instruct-
tors' Club has been formed for meetings once in three months for a discussion of
problems particularly pertinent to that group.
Problems: Finding courses for graduates; securing individual participation in or-
ganization activities.

OHIO
Members: 128
Activities: Contributed to program of the O.S.N.A.; three local institutes; ap-
pointed committee to work with the Central Committee on curriculum revision;
conducted a special round table on curriculum problems; conducted a drive for new
members for the N.L.N.E.
Virginia

Members: 40
Activities: Organized section; prepared membership blanks; set up standards for membership; held a two-day institute to discuss curriculum revision and social sciences with Miss Isabel Stewart as the principal speaker; received an appropriation from the State Association budget to send a representative to the June session at Columbia to work on curriculum revision.

Problems: Making the section active; trying to convince members that we need a state league.

West Virginia

Members: 9
Activities: District is very active, programs made up of talks on interesting subjects by doctors; motion pictures of obstetrical work, surgery, medicine.

Problem: Lack of interest.

Discussion

In order that the session might be as valuable as possible and to stimulate discussion, four members were asked to speak on subjects which seemed to cover most thoroughly the problems of state leagues.

Durice Dickerson, President of the Georgia League of Nursing Education, spoke on Ways of Stimulating League Membership and suggested that one of the most important ways was to interest students before they ever entered schools of nursing. And after they enter, the highest ideals of nursing education as exemplified by the League, its history, and its program, should be kept constantly before them—in the classroom, in the library, and even in extra curriculum activities such as plays. And not only should the student be told what she can do for nursing education through the League, she should be made aware also of what the League can do for her. Emphasis should be put on the fact that the League is ready to help her solve her problems from the rich wells of knowledge stored up by the thinking minds and experience of all its members. Of course if the League is to interest these young people—the League members of tomorrow—it must present a vital, interesting, and practical program.

Other, more often-mentioned ways of stimulating membership are: by familiarizing nurses themselves with the history, functions, and program of the League; by the frequent publication of bulletins; by talks and round table discussions; by the organization of local leagues; by personal letters (although expensive, this is one of the most effective ways of stimulating membership because it appeals to the individual); by keeping in touch with nurses in isolated sections (this can be accomplished by having them send reports of their activities to open meetings and by returning to them helpful suggestions for the solution of their problems); and by providing programs which are of especial interest to local groups and especially pertinent to their most urgent needs.

Every one knows that any work is most effectively and efficiently accomplished through united effort. How much more, then, we could accomplish
if only every member of the staffs of schools of nursing and every member of the state boards of nurse examiners would join with us in carrying forward our program.

Rose Griffin of the New Hampshire League of Nursing Education spoke next on Ways of Interesting Nurses in Isolated Sections. She suggested the following: Acquainting nurses with the history of the League; familiarizing them with League functions; drawing those in isolated sections into the work of the organization through work on committees; holding meetings in parts of the state where meetings have not been held before; sending letters to members asking them to come for recreation also; publishing state bulletins; sending form letters to members giving them a summary of National League activities; providing good, live programs; and careful selection of meeting place, preferably held in educational centers.

The third topic was on Ways of Making Local League Programs Interesting and was discussed by Harriett L. P. Friend, President of the Pennsylvania League of Nursing Education. Miss Friend suggested that the business sessions should be short and well planned to leave ample time for the actual program in which topics of general interest to the community as a whole might be discussed. She thought that at least one meeting should be arranged where it was possible for League members to meet officers or representatives of the National and leaders of outstanding community enterprises such as libraries, schools, etc. Such social contacts are mutually beneficial and stimulating.

Suggestions for the content of programs were: Testing members present on the history of the National League by means of the objective test recently sent out by the publisher of the Story of the National League of Nursing Education; using the keynote set by annual meetings and institutes for the year’s program (for instance, an able paper on the selection of students set a state-wide committee to work on this subject); programs based on the recommendations of the Education Committee; a question box; topics suggested by articles in nursing periodicals; arrangement of a series of lectures on special subjects, such as mental hygiene; reports on curriculum revision; demonstrations of ward teaching; programs based on suggestions from League conventions, or from reports of the Department of Studies of the League; and reviews of new texts, talks about medical discoveries and new methods of care. Miss Friend said that when their local league had co-operated with the district association in providing for demonstrations of new methods and procedures in the care of the sick the attendance had been large and had reached others than League members.

The secret of planning any program is to make it bear on the problems which the nurses are meeting in that locality, to make it benefit the nurse not only by helping her with her particular difficulties but by showing her how she can fit in with the progress of the community as a whole and give her best help as a citizen as well as a nurse. And the program, whatever it is, should be planned in advance, with the topic, place, and date
worked out and if possible sent in some form to members. This not only fosters better organization but it is a worth while means of advertising.

Miss Edna Newman, vice president of the Illinois League, discussed the Need for Local Leagues to Promote National League Activities. She listed four difficulties which state leagues are encountering and which she believes would be abolished if local leagues were formed. These are: the difficulty of getting members to meetings; the distribution of material and information; the difficulty of getting people to serve on committees because they could not come to meetings; the difficulty of getting new members because of the lack of opportunity for personal contacts.

Mass Meeting—Carnegie Hall

Tuesday, June 4, 8:30 p.m.

Presiding: Effie J. Taylor, R.N., President.
Music was furnished by the Westminster Choir.
General Topic: Nursing Education—Retrospect and Prospect.
Greetings from Miss M. Adelaide Nutting, R.N., Professor Emeritus, Teachers College, Columbia University, New York City, were read by the President, Miss Taylor.

Thoughts on Our Seventy-Fifth Anniversary

M. Adelaide Nutting, R.N.

The League of Nursing Education brings a notable element into this meeting, by inviting us to remember that this year marks the seventy-fifth anniversary of the establishment of the first Training School for Nurses at St. Thomas's Hospital in London, England.

Our thoughts are at once centered upon the great name of Florence Nightingale, the Founder of that School, and we are carried back to a day twenty-five years ago, when under the auspices of this Society, and in this hall, there was held a great gathering to celebrate the Fiftieth Anniversary of the Nightingale School of Nursing. Those who were present will long remember that memorable occasion, the dignity and beauty of the arrangements, the eminence of the speakers, and the picture which was projected upon the minds of the listeners.

To the influence of that single school of nursing upon the care of the sick in hospitals, and in homes throughout the world, high tribute was paid, and as one of the three forces which had united to bring the science and art of medicine to its present strength and status, Florence Nightingale was placed by Dr. Polk and other speakers, by the side of Pasteur and Lister.

But what finally emerged, and remained, with those present at that meeting was the familiar vision of the great heroine of the Crimea, most impressively and sympathetically set forth with all the eloquence of Joseph
Choate, the speaker of the evening. He portrayed the young Englishwoman of high birth and wealth, gifted, accomplished, highly educated, widely traveled, whose dominant and unconquerable interest was in the problems of the sick and the relief of their suffering. Then came the Crimean War. There were the miles of old Turkish Barracks, with their unspeakable defects in sanitation, lacking every decent equipment for the care of the sick, but used as a hospital for thousands of wounded men, and in the midst of this inferno came Florence Nightingale and her little band of nurses. What followed is well known throughout the civilized world.

We can not dwell here upon that page of history save to point out that Miss Nightingale's remarkable powers of leadership, her wisdom, courage, and endurance were here lifted to amazing heights, and in work accomplished, in lasting results obtained, few records of history can surpass them. Gardiner speaks of her as "moving mountains."

Trevelyan, in his recent history of England, declares that the "real hero of the Crimean War" was Florence Nightingale, and he adds that its "most indubitable outcome was modern nursing, and a new conception of the place in society of the trained and educated woman."

But without challenging this statement, we should keep steadily in mind that the great need for better care of the sick had been uppermost in Florence Nightingale's mind long before the Crimean War. For several years she had been continuously studying the question and gathering first-hand information in all the ways open to her. How she did this, her evidence given years later, before the Royal Commission on the Sanitary State of the Army, most interestingly shows.

To the question, "Have you for several years devoted attention to the organization of civil and military hospitals?" she answered, "Yes, for thirteen years. Have visited all the hospitals in London, Dublin, and Edinburgh, many county hospitals, some of the naval and military hospitals in England; all the hospitals in Paris, and have studied with the Sisters of Charity; the Institution of Protestant Deaconesses at Kaiserswerth on the Rhine, where I was twice in training as a nurse; the hospitals at Berlin, and many others in Germany; and at Lyons, Rome, Alexandria, Constantinople, Brussels; also the war hospitals of the French and Sardinians."

What did she mean by "visiting" hospitals? She meant making a careful, thorough study of hospital construction, sanitation, organization, and administration—all of them, conditions vital to good nursing. She visited certain institutions repeatedly, and sometimes spent weeks in one particular hospital, studying its system, methods of administration, and nursing. An interesting bit of evidence of her constant preoccupation with this subject appears in an article in this winter's issue of the Yale Review. It contains a letter written in December, 1845, by Miss Nightingale to a friend in America, Julia Ward Howe. In it, she asks this question, "I wish you could tell me whether in America pupil nurses could ever be taken into hospitals merely to learn?" (Italics mine.) Clearly ideas and plans for nursing reform were
even then taking shape in her mind, nine years before the Crimean War. These years of continuous and searching study, which included an interesting period in charge of a hospital in London, constituted, in part, her preparation for the work awaiting her in the hospitals of the Crimea.

Here she was plunged at once into the awful experience of seeing thousands of men die, who might have lived had decent sanitary surroundings and conditions existed, and sufficient medical and nursing care been provided. "I stand," said she, later, "at the altar of those murdered men, and while I live, I fight their cause."

And here, through first-hand experience of an intensity and magnitude which defies description, she fortified her vast knowledge of hospitals and nursing, initiated efforts which brought the startling results in reduction of mortality, so well known and often quoted, and drew in various ways the unassailable strength, which later made her famous throughout the civilized world as its first authority on the subjects of hospitals and nursing.

This brings us to the stage of her life, with which, as teachers of nursing, we are most closely concerned, and we pass from her heroic labors of the Crimea, to her infinitely more heroic efforts to make the fullest use of the knowledge gained there. The years in the Crimea by which she is chiefly known, become, as Cook says, only a "resounding incident," in her life—"mere child's play," as she herself called it, compared with the difficult later years devoted to bringing about reforms. What gives to this seventy-fifth anniversary special interest, is, that since her death in 1910, a substantial body of quite new knowledge has been opened up to us. There is, first in time, and first in importance, Sir Edward Cook's "Life of Florence Nightingale" a treasure-house of authoritative information, now available for our study. This has been followed by a steady succession of books, articles, and biographical material, much of it from new and authentic sources, showing us how after the war, Miss Nightingale resumed her work, so tragically interrupted, and though an invalid, summoned all her deepest energies and vast resources to bring about the urgent reforms needed in both military and civil hospitals, in the care of the sick there and in homes, and in protecting the health of the people.

The range of her efforts and achievements throughout these years is lifted to an almost superhuman scale. There are her writings—books, articles, and bulky reports on hospitals, nursing, sanitation and hygiene, at home, and in India, a country in which she was deeply and helpfully interested. Seldom have I enjoyed more exhilarating hours than those spent in reading Miss Nightingale's evidence before the Royal Commission already referred to. Quite apart from its historic significance it is literally packed with information of the utmost importance, often backed by abundant statistical data to support her statements. It is shot through with comment and opinion, fresh, invigorating, and valuable, even at this date, to those concerned with the administrative problems of hospitals.

She had at all times an enormous correspondence with people of many
countries, and many letters she answered personally and at length. There was also a constant succession of visitors, seeking, obtaining, and using her advice on various matters. It was sought, for instance, in this country in the establishment of the Training School for Nurses at Bellevue Hospital in this city, and in the building of the Johns Hopkins Hospital and School of Nursing in Baltimore, Maryland.

When William Rathbone wished to start district nursing in Liverpool in 1863,—"He did," writes his daughter, "what everyone interested in the welfare of the sick has done for the past forty years in any difficulty: he consulted Florence Nightingale." Her ideas shaped the principles and plans upon which the system of visiting nursing rests. From the beginning she saw that teaching is an inherent part of the nurse's task. She called it a vitally important phase of education for which there was no existing instruction available for the people, suited to their needs and powers of acquiring and using it. "The home does not teach it," she said, "The schools do not."

Within the half-century since the above was written, great advances have been made, but let us pursue her thought further. "It may seem extravagant," she said, "to connect so small a thing as district nursing with so large a subject as our struggle with poverty," but she insisted, "the condition of the dwellings of the poor are at the root of much poverty and the State should remedy it." With what satisfaction should nurses, who have long realized the relation of poverty and bad housing to ill-health and incapacity, watch the recent efforts of governments in this country, England, and elsewhere to improve the homes of the people. Of course the right use of homes will be a matter of education for each new generation.

For this body of teachers, and for those engaged in any form of administrative work, what is of special interest, is Miss Nightingale's profound faith in education, about which she had ideas of her own. She had a grasp of certain educational principles distinctly in advance of current thought and practice. Her dependence upon education as a means of bringing about permanent improvements and reforms, is constantly evident. "Every human being," she said, "is of importance and should be employed in a way to make him feel so. . . . The desire to be something, and do something is implanted in us. Everybody should be trained for his or her work." Therefore, when in Army hospitals the food was unsuitable and badly cooked, the remedy was to establish Schools for Regimental Cooks, and this was done; when hospital orderlies proved inefficient, and unfitted for their duties, let a system of training be inaugurated, and this too was done. She went higher up, and recommended special schools for Army Medical Officers, and later these were instituted. When in an area of high mortality among infants and children the remedy proposed was the establishment of a special hospital for them, her advice was that the problem should be attacked by teaching mothers how to take care of their infants.

One of the pictures I like best to dwell upon, is that of the reading room, provided by her for the convalescent men during the war who had no
gathering place but the Canteen, and no occupation but drinking. In it were found games and amusements for the men, and at times lectures were given on interesting subjects, while later she had a schoolmaster sent out from England to give some teaching to men needing it. Started by Florence Nightingale in the Crimea, pursued at Aldershot, these were later established so securely, that no modern barracks are complete without their reading rooms. The list of her purely educational works is long.

The great example is, of course, the complete transformation she wrought in nursing through education alone. That first Training School for Nurses, established in London by Miss Nightingale seventy-five years ago, owed to her not only the idea and the impetus which brought it into being, but it owed also the whole scheme and plan of an entirely new form of education for women. She selected the place where it was to be carried on, the persons to direct it, the subjects to be taught; in fact, the complete plans of organization and administration, she carefully worked out in detail.

What we are really paying tribute to tonight is Florence Nightingale's mind—free, searching, and creative. It played over an immense area in life, and it is hardly too much to say, that it illuminated all it rested on. Her work is, for us, not a remote and splendid legend, but a constant life-giving reality. Search where you will, you do not find her falling back upon tradition and precedent for guidance. No old way was the right way unless it met the approval of her reason and intelligence.

Not only should those nurses who are intending to teach, but also those who wish to assume any serious administrative tasks look well into the pages of Miss Nightingale's richly fruitful life, and study carefully her writings. From these there is much to be learned, for she was one of the great administrators of all time. We greatly need today in our own field of labor, a larger understanding of the province and of the responsibilities resting upon those who would assume that high name, and most difficult place and office.

Mrs. August Belmont extended cordial greetings to the convention and read the following Ghost Letter from Florence Nightingale to Miss Nutting:

My very dear Adelaide,

You have set and maintained a high standard for yourself and others; this you have combined with a fine sense of discipline and a noble dedication to a great purpose. My admiration for your accomplishment and my congratulations are yours. Also, as blessings are a prerogative of age, I offer my blessing for the exceptional quality of the work you have done throughout your life to advance the cause which we both have so much at heart.

May I, my dear Adelaide Nutting, subscribe myself yours, with respectful but very real affection,

Florence Nightingale.
Mrs. Belmont announced that the American Red Cross had offered to an American nurse, to be chosen by the Committee of the American Nurses' Association, a scholarship for the Florence Nightingale Foundation Courses at Bedford College, London.

GREETINGS

JOHN FINLEY, PH.D., Associate Editor of the New York Times,
New York City

Speaking at a celebration of the hundredth anniversary of the birth of Florence Nightingale (in 1930) I recalled an experience of my own which brought her and her great work as a nurse most vividly within my horizon. I had come across Asia Minor just after the Armistice, from Jerusalem, where I had been during some months of the War (when the snows were still upon the Taurus Mountains), spending three days and nights in a freight car and one in an abandoned German Red Cross Lazarette car, and reached Scutari just across from Constantinople in the gray dawn of a raw March morning in 1919. There I was landed in an enormous unheated station (a part of which had been destroyed by fire) where hundreds of men, women, and children—refugees, soldiers, and others—awaited the arrival of day. As the light came, I discovered that I was only a little way from where Florence Nightingale began her labors as a nurse in 1854 just after the battle of Balaklava, and I could easily imagine the conditions which she found there. "Endless corridors of a gigantic barrack house, with four miles of beds, with floors so rotten that they could not be scrubbed, with no ventilation and with huge sewers beneath, incredible multitudes of vermin swarming everywhere, and everywhere want, neglect, confusion, misery."

It was into such a scene that the "Lady of the Lamp" came, this "lady of high degree," who (as Lytton Strachey, the author of the brilliant sketch of her life, said) "after a fitting number of dances and dinner parties might have married an eligible gentleman and lived happily ever afterward."

Having pictured this scene, I must put against it one brief paragraph depicting her immediate achievement: "The reign of chaos began to dwindle, order came upon the scene and common sense and forethought and decision radiated out from the little room off the great gallery in the Barrack Hospital where day and night she was at her task. . . . Her mere presence brought with it a strange influence. A passionate idolatry spread among men. They kissed her shadow as it passed." But against that background is to be put something more than personal radiatory presence and service. The whole nursing profession rises out of it. In the Pantheon de la Guerre, shown here a few years ago, there were a few nurses pictured among the soldiers and statesmen, but they are now also in every Pantheon de la Paix—which means in every community of peace. During the War I wrote for the Red Cross the hymn which was widely used and set to music, I am
proud to remember, by Professor Parker of Yale, suggesting chiefly the nurses’ ministries:

Wherever war with its red woes
Or flood or fire or famine goes
There too go I.
If earth in any quarter quakes
Or pestilence its ravage makes
Thither I fly.

* * *
I go wherever men may dare
I go wherever women’s care
And love can live.

That was written for the days when men were suffering on the “hellish rim of war’s red line.” One stanza at least should be added to speak of the other ministries alike in war and peace:

I go wherever God would go
With healing in His wings to show
What He would do.
I greet the coming planet guest
And cheer his going on his quest—
When he is through.

In numbers the nurses have grown till in the United States alone there were when I last had statistics, a year ago, more than 250,000 registered nurses, approximately 220,000 of whom are active private duty nurses, 11,000 public nurses, and 5,000 in institutions or engaged in teaching. There are more than 1,800 training schools, 22 colleges giving training courses, with 25,000 graduates yearly. There are still 150,000 untrained nurses in America, but the time is not far away when every real nurse will be a trained nurse—when the noun will need no adjective to tell what sort of noun it is.

But the contrast is greater than these numbers and the difference between a trained nurse and an untrained nurse of today suggest. The occupation of nurse in Florence Nightingale’s day was a “particularly disreputable” one. It was far from being the profession it has come to be. A “nurse” then meant a coarse, old woman, always ignorant, usually dirty, often brutal, a Mrs. Gamp, in bunched-up sordid garments tippling at the brandy-bottle or indulging in worse irregularities. In hospitals such so-called nurses could hardly be trusted to carry out the simplest medical duties. “Certainly,” says Mr. Strachey, who gives us a picture of the nurse of seventy years ago, “certainly things have changed since those days; and that they have changed is due, far more than to any other human being, to Miss Nightingale herself.”

Dr. Samuel G. Howe, who with his wife, Julia Ward Howe, the author of “The Battle Hymn of the Republic,” was visiting in the house of the parents of Florence Nightingale when she was twenty-seven years old and had not yet entered upon her great career, tells of this conversation with her: “If I were to determine to study nursing,” she said, “and to devote
my life to that profession, do you think it would be a dreadful thing?"
"By no means," said Dr. Howe, in answer, "I think that it would be a very
good thing." And a very good thing it was! The whole world should
gratefully unite in remembering her great gift to humanity as the "founder
of modern nursing."

I was several years ago in the Holy City, where the angel stood at the
open sepulchre and announced the resurrection. I think of the nurses as
angels not of resurrection but of life itself in its never-ending struggle with
disease and death. They are ever within sound of that eternal conflict—
angels of that battlefield, even in peace, stretching across and around the
earth. In memory of Florence Nightingale, who was their prototype, I
repeat the lines which I wrote in celebration of the hundredth anniversary
of her birth, and which have been dedicated to the nurses of the State of
New York:

I saw the miles of beds of agony
From Belgium all the way to Scutari—
The sick and wounded everywhere.

And through each war-filled ward by day or night
Moved in their suffering midst a Thing of Light
As 'twere the Lamp she used to bear;

Straightway their murm'ring ceased, their cries were stilled
As if some sweet, benignant force had willed
Its way, or made a potent prayer.

So does the Lamp still shine, and on the walls
Of myriad wards the soothing shadow falls,—
The nurse she trained is passing there.

Florence Nightingale was an "eminent Victorian" in another sense than
that she lived in the time of Queen Victoria. She is one of the earth's
immortal victorians.

THE EDUCATIONAL CHALLENGE

WILLIAM HEARD KILPATRICK, PH.D., Professor of Philosophy,
Teachers College, Columbia University, New York City

The challenge that confronts you is the perpetual challenge of life and
the fresh start, the chance under the demand of new conditions to re-think
the proper place and work of the nurse and the consequent need to make a
new nursing curriculum that will take due account of new conditions, new
outlooks, and new insights.

I am challenging you to re-think with me some old social and ethical
principles as we try to bring them up to date and apply them along with
some new knowledge in the educational field to your situation.
Let us begin by considering some principles that promise to be useful for life in general and for curriculum construction in particular. The word "principle," as here used, means a criticized generalization of and from the facts of experience that promises to be of help in determining policies. In other words, for us here a principle is a generalization of the facts of experience useful for dealing with the values of life.

We start with certain psychological principles and move on to the social and ethical.

1. All behavior in the organic world is a process of adjusting between the organism and its environment. This is perhaps nothing but a description of life itself. While any particular instance of behavior may result in adjustment, life itself is a continual adjusting. Under modern conditions man's environment changes very rapidly, so that our adjusting is ever more continuous and far reaching. This conception orientates us both in life and in education to expect change and to prepare for it, therefore to expect critical thinking in order to take better care of the shifting scene. It is then ever better acting on thinking that we wish.

Also all behavior is purposive, in that it works toward an end. It may also be purposeful in knowing its end and consciously choosing appropriate means. Preferences are thus at least implicit in all behavior and explicit in conduct or conscious behavior. Success and failure are in this way ultimate categories, both for life and for education. Thinking always contemplates an end. You see I am consciously denying a mechanistic psychology.

Moreover, the whole organism is involved in every significant instance of conduct. As Miss Nightingale herself said: "The human being is so constituted that he can not be helped except by having his whole being called into exercise." Thinking, feeling, impulse, physical movement, glandular action, et cetera—all are always involved—not as separate things (that would make a thunderer back of thunder), but as inseparable aspects of organic action. The whole person in all these interrelated aspects is always affected.

The conclusion of the first principle: the whole organism (person) facing a life situation—this is the unit element of the study of life and of education—the consciously adopted unit of a newer and better education. All moral conduct and all decent education must be based on the effectual recognition of this first principle and on this unit element as the expression of it.

2. The fact and process of study is inherent in life intelligently lived. Each instance of behavior starts with some stirring within or without: either a stirring to advance, to seek, to get more, with hope as its attendant attitude; or a stirring to retreat, to avoid, with fear as its attendant attitude. Wants, preferences, et cetera, arise—the "internal" aspect or side. Efforts take place—the parallel "external" side or aspect. Thinking is one of the effectual means to make the behavior more surely adequate.

Study is the effort to bring intelligence to bear on the situation. This
natural and inherent study existed long before schools and even now goes on most and perhaps best outside of schools, certainly outside of most schools. The new and better school is trying to base itself consciously on this true kind of study.

3. Learning is involved in any and all experiencing. A person faces a situation. If the situation is very familiar, little if any learning will take place. If the situation is difficult, one effort follows another until available response resources are exhausted. If by then no success, a new response may be devised, perhaps several. Any new response accepted for subsequent use becomes by that fact incorporated into the organism. That is, learning results.

There are thus two aspects to learning: (a) a new response is devised (or created); (b) this is so accepted for future use as to be incorporated into the very being of the person. A miracle here—two in fact—only so common that we take them lightly!

But further: Recall that the whole person is involved in each act—thinking, feeling, impulse, moving, et cetera. The actual devised response includes all of these. So all these aspects are included in the learning and always so. We never learn just the one named thing, but always simultaneously we are building attitudes, habits, thoughts, et cetera. The attendant learnings may and often are more important than the particular item that the drillmaster has in mind. Attitudes are especially important (and they involve all with them)—attitudes of like or dislike to what one learns, to the teacher, to the school; attitudes toward oneself as worthy or not of self-respect or the reverse; attitudes toward government, toward morals, toward painstaking care and exactness, toward taking time to think, toward intelligence as the final authority. These and their like are the learning outputs that count most of all for life.

Learning is then at bottom, creative and personal. The world may have known the like before, but to each learner it is new and fresh. And we learn what we accept and as we accept it. Under whatever guise we see it when we accept it, that we learn. It is personal to us. Acceptance is perhaps the most personal thing in all of life. We learn what we accept. Many autocrats fail to learn this lesson (because they refuse to accept its implications). They try to force things on other people and would keep them defenseless in order to ensure the forcing; but they mainly succeed in marring the personalities they thus mistreat. How many people of broken spirit, how many of rebellious hearts, how many cursed with feelings of inferiority! How many try to get even with parents and teachers by wayward conduct of various sorts!

The new and better education accepts these creative and personal learning facts as basic and builds the structure anew on them as the chief stone of the corner.

We have seen in all the foregoing how a new and better outlook on life and education sees life and education as but two names for the one process,
We call it life when we think of its continuance and the conditions thereof and the improvements we would make in it. We call it education when we think of the changes that result to those who engage actively in the process and when we would seek desirable changes for them. Life and education should then not be cut asunder with education going on apart from life and out of touch with the rest of life. However, not all of life goes on everywhere and at any one time; so we may live at one time with special reference to what education shall go on and that it may go on best. But even so, this education must be of the character and quality of life itself as active and creative as we can make it and with all due regard to the personalities engaged and to all the effects that are happening to them.

If then we would run education, we must seek life, the more abundant life, the finer quality life, the kind of life that promises best for further and later life of all concerned together as well as the present life—neither sacrificed to the other.

II

Before taking the more immediate issues of nurses and nursing education, we need to examine certain social principles for their lessons to us and our study, particularly for their bearing on democracy and education.

At least four things seem to concur to make up the democratic outlook:

1. Man must live in society even to be man in any honorific sense. We become, each a self, literally in and through our associations with those about us. Man in the better sense is thus as truly the social offspring of the group culture as he is biologically the offspring of his two natural parents. In this sense the group is prior to the individual. Society constitutes its individuals and not vice versa, though the process, thanks to creative learning, is not a fatalistic one.

2. What one man does affects others in the group for good or ill. This fact being known and applied, every normal human learns at least the more obvious of these public effects and, within limits, acts accordingly. This is the origin and nature of moral obligation and conduct. There is nothing about it any more mysterious or transcendental than any other facts of group life.

3. "Rights" are but the more seriously recognized and accepted bases of interaction among members of the group. Such rights are not fixed by "nature" but vary from group to group and time to time and depend solely for their actual sanction upon their acceptance by the people. To say that these rights rest solely upon acceptance is not to deny that we can properly question which should be accepted. The contrary is most true. We must criticize the way our "rights" work and change them if we can for the better.

4. Among the "rights" which we now most cherish is that of respect for each human individual as a person. We mean so to treat each other that each one may grow and develop into the best that in him lies. We also grant to each his share according to his ability in determining what institutions shall govern.
In this respect for personality we reach the heart of democracy and this we wish to apply directly to the nurse and nursing education. Democracy, so understood, would demand that a nurse be considered a full person in her own right to be educated, not trained, to think and act on her own responsibility as a normal person should in all human relationships. This word "training" is not a suitable term to apply to persons. The principle would also mean that a girl going to school to learn nursing should not be "exploited" for the advantage of the hospital or its patients. In fact "exploitation" now gets its definition as any personal or institutional infringement upon the right of the person, as such, both as to the treatment and as to outcome results.

III

Let us now sum up all that has been said in more specific application to the treatment of nurses and their education.

1. Nursing should, as it seems to me, be considered a profession, i.e., a vocation in which thinking and decision are pronounced elements; and each nurse should be considered as a person to be developed and expressed as such in the full sense of intelligent self-direction, and, as Miss Nightingale said, "Each individual has a capability of contributing to the whole in a way that no other nature can."

This carries with it that the prospective nurses shall be encouraged and taught increasingly to think for themselves as persons. Anything less is to degrade.

2. Since we live in a changing world and life is a continual adjusting, we must think in terms of extending the scope and quality of nursing. In the light of the growing need of social planning, we must look forward to a time when all who stand in need of nursing shall receive it as part of any decent planning, and the nurse can think of herself as a public servant helping individuals who need her service.

3. Since the individual is mind and soul as well as body, all inseparable together, the nurse must serve the whole person of the patient. This means a personal culture broad enough to meet such demands. This probably means higher admission requirements and a somewhat different curriculum. Miss Nightingale had it that "a woman can not be a good and intelligent nurse without being a good and intelligent woman." I should myself like to include as well all the elements of a rich personality.

Let us now consider the education and schooling more specifically as such.

4. If we are going to give due respect to the person as such and see education as inherent in the process of living interaction, we shall, as it seems to me, make two explicit decisions: first, that the school must be autonomous as regards the hospital, that is, education as respect for the growing girl stands superior to and separate from the necessary maintenance of the hospital—the student shall not be exploited because immediate nursing needs to go on; but, second, at the same time education in nursing can not go on except as part and parcel of nursing itself. I might quote Florence
Nightingale on this point: "Nursing proper can only be taught at the patient's bedside and in the sickroom or ward. Neither can it be taught by lecturer or by books, though these are valuable accessories if held as such (italics mine); otherwise what is in the book stays in the book." As I myself see it, study and learning properly go on only as the student and learner faces a situation which she herself recognizes and accepts as such. Then study and learning come as the inherent result of interest. We elders can help but can not control. Study and learning to be good must be essentially personal in answer to inherently felt needs.

Because this last point is not always understood, let me say a word further about it. Any particular situation of illness is of course concreteness itself. Nothing could be more so. But no experienced and informed person sees it simply so. We see it as belonging under various heads: "It is a serious case," "There is a bad heart," "His age is against him," "If it were a simple case of removing the growth, we should have little fear." These expressions tell what knowledge adds. Now the learner has to go from the concrete to such abstractions as these. Generalization is necessary. In fact, progress in learning is very largely a matter of ever better generalization. But the beginning and the setting must be the concrete case.

These two correlative principles seem to decide the question of nursing education: the learner must not be exploited, but the learning must go on in connection with actual cases; ever greater responsibility on the one hand as respect to personality; ever greater generalization concretely located, on the other.

5. The question of discipline and the like always arises in this connection. The inherent question is whether we believe in intelligent self-direction or in docile subjection to authority. Discipline itself is perfectly illustrated by the conscientious care taken by the intelligent surgeon in the operating room. If he is both conscientious and intelligent, he not only knows what precautions to take but he takes them precisely and exactly. Discipline is thus seen as careful acting on thinking. Discipline is but the careful action in the light of informed knowledge. I can not accept the idea that nurse or mother or teacher is the better off for not knowing. I can not accept the rule of "acting simply on orders." It seems clear that to have intelligent service it must be careful action based on intelligent understanding. Otherwise sooner or later significant symptoms are overlooked at some critical time. A proper discipline is conscientious acting on intelligent understanding.

IV

We conclude then as we started. Life is interaction between the organism and its environment. A person facing a situation is the key conception. Democracy and ethics agree in respecting the individual person as such. This means intelligent acting on thinking. Our educational program seeks to found itself on this biological psychology and this democratic ethics. The nurse is a person and must be educated as such, not trained; and the educa-
tion consists in ever better practice founded on ever better personal understanding.

**General Session**

*Wednesday, June 5, 9:30 a.m.*

Presiding: Nellie X. Hawkinson, R.N., *Chairman, Committee on Standards; Professor of Nursing Education, University of Chicago, Chicago, Illinois.*

General Topic: **WHAT CHANGES DO WE NEED IN THE NURSING SCHOOL CURRICULUM?**

A. **WHAT CHANGES IN STANDARDS?**

1. **THE BASES OF ACCREDITATION OF HIGHER INSTITUTIONS**

   **George A. Works, Professor of Education, University of Chicago, Chicago, Illinois**

A year ago the North Central Association of Colleges and Secondary Schools, which includes twenty states in the Middle West, made a complete change in its bases for the accreditation of higher institutions. This was not done on the spur of the moment but only after several years of careful investigation of the relationship between certain objective characteristics and estimates and measures of institutional merit. That change was an outgrowth of certain studies that had previously been made which seemed to indicate that certain of the standards in use were not so reliable indexes of institutional merit as they were presumed to be at the time they were adopted. The results of these studies together with certain other evidence accumulated over a period of years had resulted in a loss of confidence in the existing standards and steps were taken five years ago to secure financial assistance from the General Education Board for the purpose of making a careful inquiry into the whole question of accreditation. A committee, representative of the North Central Association and known as the Committee on Revision of Standards, was appointed. A grant of $110,000 was obtained from the General Education Board on condition that the Association would contribute $25,000 from its own funds. These resources were placed at the disposal of the Committee on Revision of Standards, and that body chose a subcommittee which was placed in immediate charge of the study. This group made an intensive study of fifty-seven colleges and universities.

As originally drawn, the plans called for the completion of the inquiry in a five-year period, but at the end of four years the study was far enough advanced so that the Committee on Revision of Standards felt justified in recommending the adoption of a new policy for future accreditation. The program recommended was adopted at the annual meeting held in April, 1934, and this past year, for the first time, all institutions newly seeking membership in the Association have been dealt with under the new program.
The completed report of the Committee on Revision of Standards will consist of three parts:

1. A Statement of Policy, the term used in place of the term Standards of the old program. This Statement of Policy is a concise presentation of the new criteria by which the work of an institution will be evaluated.

2. A Manual of Accrediting Procedures. This document consists of about 150 pages devoted to the explication of the Statement of Policy. It is one of the best, if not the best, documents that has been prepared in recent years dealing with the problems of college education and administration. Supplementary to the Manual are some eighty schedules that are to be filled out by the institution before a survey is made. In addition, there are score cards which are placed in the hands of the inspectors when they visit an institution. These score cards are supplementary to the schedules. The score cards are made necessary by the fact that a visit of the institutions must be made in order to secure certain types of information that are needed in deciding as to whether or not an institution should be accredited.

3. A series of monographs. Eventually there will be a series of several monographs which will contain a statement of the philosophy of accreditation and the scientific bases for the criteria that have been included in the Statement of Policy and the Manual of Accrediting Procedures.

The Statement of Policy is now in printed form, the Manual is in mimeographed form but probably will be printed within a year, and the monographs are in preparation with varying degrees of completeness. Two or three are ready to go to the printer, but it will probably be several months before all will be available in printed form.

With this background, the discussion from this point will be devoted to contrasting as completely as possible the new procedures used in the accrediting process with those that were formerly used. The main points of difference are:

1. A striking difference exists between the criteria of the Statement of Policy and the old standards in the emphasis that the latter place upon the quantitative aspects in defining a good institution of higher education. Three illustrations will help to make clear that difference.

a. Admission of Students

_Standard:_ "The college shall require for admission at least fifteen units of secondary work as defined by this Association, or the equivalent. These units must represent work done in a secondary school approved by a recognized accrediting agency or evidenced by the result of examinations. The major portion of the units accepted for admission should be definitely correlated with the curriculum to which the student is admitted."

_Policy:_ "The policy of an institution in admitting students should be determined on the one hand by the purposes of the institution and on the other by the abilities, interests, and previous preparation of applicants. An institution should admit only those students whose educational interests are in harmony with the purposes of the institution and whose abilities and previous preparation qualify them to pursue the studies to which they are admitted."
b. Library

**Standard:** “The college shall have a live, well-distributed, professionally administered library of at least 8,000 volumes exclusive of public documents, bearing specifically upon the subjects taught and with a definite annual appropriation for the purchase of new books and current periodicals. It is urged that such appropriation be at least five dollars per student registered.”

**Policy:** “The library should provide the reading facilities needed to make the educational program effective, and there should be evidence that such facilities are appropriately used.”

c. Finance

**Standard:** “The college, if a corporate institution, shall have a minimum annual income of $50,000 for its educational program, one-half of which shall be from sources other than payments by students, and an additional annual income of $5,000, one-half of which shall be from sources other than payments by students, for each 100 students above 200. Such college, if not tax-supported, shall possess a productive endowment of $500,000 and an additional endowment of $50,000 for each additional 100 students above 200. Income from permanent and officially authorized educational appropriations of churches and church boards or duly recognized corporations or associations shall be credited to the extent actually received as 5% income toward the endowment requirement, but to an amount not exceeding the average annual income from such appropriation in the preceding five years, provided, however, that this shall not apply to more than the amount required in excess of $500,000; and provided further, that colleges electing to qualify under this interpretation be subject to annual review for accrediting.”

**Policy:** “The institution should provide evidence of financial resources adequate for and effectively applied to the support of its educational program.”

It should not be inferred from these contrasts that the use of quantitative data has been eliminated from the new accrediting procedures. This would be far from the truth. On the schedules and score cards a much larger body of objective evidence is obtained than was true under the old program. The chief difference in this respect resides in the fact that the old standards were more or less automatically applied, whereas the purpose of the data collected on the numerous schedules and score cards is to serve as the bases of judgment regarding the accreditation of any given institution.

2. The Statement of Policy makes provision for a large measure of institutional individuality as contrasted with the conformity to the liberal arts type that was more or less dominant in the standards. The attitude of the Association on this question is indicated by the following quotation from the Statement of Policy:

“In its accrediting procedures the Association intends, within the general patterns of higher education, to observe such principles as will preserve whatever desirable individual qualities member institutions may have. While it is necessary to emphasize certain characteristics that are recognized as basic, such as the competence of the faculty, the representative character of the curriculum, effective administration, standards of student accomplishment, and financial adequacy, it is regarded as of prime importance also to protect such institutional variations as appear to be educationally sound. Even in these basic matters it is clear that
considerable divergence from average or optimum conditions may occur without perceptibly detracting from the essential educational worth of an institution. Uniformity in every detail of institutional policies and practices is believed to be not only unnecessary, but undesirable. Well-conceived experiments aimed to improve educational processes are considered essential to the growth of higher institutions and will be encouraged.

"Every institution that applies for accreditation will offer a definition of its purposes that will include the following items:

"1. A statement of its objectives, if any, in general education.
"2. A statement of the occupational objectives, if any, for which it offers training.
"3. A statement of its objectives in individual development of students, including health and physical competence.

"This statement of purposes must be accompanied by a statement of the institution's clientele showing the geographical area, the governmental unit, or the religious groups from which it draws students and from which financial support is derived."

As a corollary to its statement of individuality, an institution must offer evidence that it has a clientele to be served by the peculiar purposes it has in mind. This statement calls for specific indications of the geographical area, the governmental unit, or the religious group from which the institution draws its students and from which financial support is secured. The Association asks for evidence on these points in order to have a basis for the evaluation of the degree of permanence promised by the institution.

3. The Statement of Policy is more inclusive than were the standards. This increased comprehensiveness is shown by the inclusion of several criteria that are entirely new in the sense that no provision was made for them under the standards. The following are illustrations:

a. Institutional study. An institution is expected to submit evidence that it is actively studying the problems it faces as an institution of higher learning. Information is collected with reference to the number and value of studies, areas covered, personnel and general methods, publicity, and the use made of the information gathered through the studies relating to the educational problems of the institution.

b. Quality of instruction. The standards made no specific provision for a consideration of the instructional work except as it might have been included under the tone and atmosphere of the institution. Under the new policies, attention is given to the administrative concern for good teaching, the means of stimulating scholarship, adaptation of instruction to student body, marks and examination policies, and alertness of the faculty with reference to teaching problems.

c. Student personnel service. Practically no provision was made for this phase of an institution's activity under the standards. Now, definite provision is made for collecting data showing the extent and character of an institution's personnel service for its student body.

The Statement of Policy is also made more comprehensive than were the standards through the inclusion of more items under rubrics common to
both. One example will serve to illustrate this difference. The standards include under faculty the following items: size in relation to student body, training, and hours of instruction per week. Under this same general rubric, the Statement of Policy has three general divisions:

1. Faculty competence, which covers advanced degrees, years of graduate study, years of teaching experience, books published, articles written, membership in learned societies, and participation in the programs of such societies.

2. Faculty organization, including ratio of faculty to students, the preparation for the field in which the instructor is working, the faculty organization, the meetings, and the functions of faculty committees.

3. Conditions of faculty service, which includes salaries, tenure, teaching load, methods of recruitment and appointment, aids for professional growth, provisions for leaves of absence, retirement, insurance, housing, and recreation.

The new process of accreditation not only involves the differences that have been indicated, but there has been a change in the methods by which information is gathered upon which the decision with reference to the accrediting of an institution is based. For a number of years, the Commission on Institutions of Higher Education of the North Central Association has designated the Board of Review, which consists of seven persons, to consider the case of each institution newly applying for accreditation, as well as cases where for any reason the institution was not accredited without reservation. It has been customary for this Board of Review, through the Secretary of the Commission on Institutions of Higher Education, to collect certain information from any institution that was being considered for accreditation. After these data had been assembled, they were put in the hands of an inspector who went to the institution and ordinarily spent only a day. He checked up on the data that had been reported and formed his own impressions of the institution. On the basis of this experience he wrote a report of his inspection and made a recommendation as to whether or not the institution should be accredited. The Board of Review, on the basis of the data that had been collected and the inspector's report, made a recommendation to the Commission regarding the accreditation of the institution. The inspectors were not paid for this service and a charge of fifty dollars only was made the institution.

Under the new procedures, an institution applying for accreditation will make application to the office of the Secretary, and at the same time it will make a deposit of $400. An application calling for certain information is then sent to the institution. If this information seems to indicate that the institution will not be likely to receive recognition, word is sent to the president advising him to withdraw his application. It is made clear, however, that, if he desires to go ahead with the inspection, arrangements will be made to send inspectors to the institution. In the last analysis, the chief administrative officer has to decide whether or not he desires to attempt at any
given time to secure accreditation for his institution. If the application is withdrawn, the inspection fee with the exception of ten dollars is returned to the institution. This ten dollars is kept to cover the cost of the Manual of Accrediting Procedures and the work that has been done in the analysis of the preliminary report. If the president decides to attempt to secure accreditation for his institution, two complete sets of the schedules are sent to the institution, one of which is filled out and returned to the Secretary's office and the other is for the files of the institution. In the Secretary's office the data contained on the schedules are assembled and put in convenient form for the use of the inspectors.

The North Central Association in its application of this method during the past year used six persons only. They were recognized leaders in the field of higher education who had been interested in the study of problems of higher education, and most of them had had experience in making surveys. These inspectors were paid for their services. In advance of the time that they began their regular work of inspection, they were brought together at an institution that had applied for accreditation. The entire group studied this institution. As a result of this experience the inspectors came to a common basis of understanding with reference to procedures to be used and methods of evaluating the work of an institution. Following this, the inspectors were assigned in groups of two or three to several institutions. They visited each institution and spent at least three days in studying the institution and in preparing a report. This report was then sent to the Secretary's office, and from the data on the schedules and the score cards what is known as the pattern map of the institution was prepared. The map, together with the written report submitted by the inspectors, constituted the grounds upon which the Board made its decision as to whether or not the institution should be recommended for accreditation.

In order to get a complete idea of the way in which the new Statement of Policy operates, attention should be called to the fact that the member institutions are required to supply information with reference to certain items included on the pattern map each year. In advance of the last annual meeting, each institution was asked to furnish information on the items under finance and library and also to send a statement of objectives and the data on clientele. Next year it is planned to include the items under faculty. In this manner, in a period of approximately four or five years it is expected that data will be gathered on all, or at least most, of the items included in the pattern map, which is based on the Statement of Policy. These data will be the basis for the preparation of a new profile, which will displace the one based on the original study of the fifty-seven institutions. A pattern map of an institution is a graphic representation on a percentile basis of an institution in comparison with the fifty-seven institutions included in the original study.

This year, the institutions that fell below the tenth percentile on four or more of the ten items on which they made reports were sent notices that
next year they would be required to supply data on all of the remaining schedules. If these data reveal deficiencies that in the judgment of the Board of Review are adequate for calling the standing of the institution into question, the Board of Review has the power to order a survey of the institution. When a survey is ordered, the institution will then go through the same processes as have been described for an institution newly applying for admission. One of the serious criticisms made of the standards was to the effect that an institution once in the Association was likely to make little or no progress. Under the new procedures it will be possible by keeping a record of the standing of the institution on the items of the pattern map to determine whether or not over a period of years any change is taking place in its relative standing in the Association.

Furthermore, it is the belief of those who had to do with the formulation of the Statement of Policy that in the future the Association will not have to place so much emphasis on policing as it has in the past, but it will be free to devote a great deal more of its energies to the stimulation and education of its membership. If this end can be accomplished, it alone will justify all of the energy and money that have gone into the revision of standards of the Association.

2. HOW MUCH STANDARDIZATION SHOULD WE HAVE IN NURSING SCHOOLS?

CLARA QUEREAU, R.N., Secretary, State Board of Nurse Examiners, Albany, New York

If I were to comment in detail on the factors which have contributed toward the degree of standardization which we have now reached in nursing education, it would be necessary to refer to the pages of history in which the origin and foundations of our traditional practices are embedded. But it is perhaps sufficient to say that from these roots we have derived, through successive generations, the fine and enduring traditions of the profession. We find also that we have inherited practices which are outmoded, hampering, and detrimental to progress. This is a period of stocktaking, of appraising and reevaluating. It is time for us to plot, to plan, and to pursue a new course which will supply more adequately, the enlarging needs of a civilization which is placing primary emphasis upon promotion of health and prevention rather than cure of disease.

The term standard means "that which is set up and established by authority as a rule for the measure of quantity, quality, weight, extent, or value." A standard may be established by authority, custom, or general consent as a rule or model. It may be used as a basis for comparison or for the purpose of judging the effectiveness or acceptability of the product which is measured by it.

If we apply this definition in analyzing the present situation, we must ask ourselves what agencies have been established by general consent for the
purpose of measuring existing systems of education of nurses. Only those which have a definite bearing on the points under discussion in this paper will be mentioned.

First, and probably the most far-reaching in its effects on the evolution of nursing education, is the National League of Nursing Education. Through its activities a Curriculum was produced which has been a helpful guide at home and abroad in the development of schools of nursing.

Second, the laws and regulations of the individual states have been and still are of major importance in any consideration of standards. In some instances the state accrediting agencies have merely suggested the use of the League Curriculum and attempted by persuasion to induce their schools to adopt and apply its recommendations. In other states a lower minimum requirement has been established, the enforcement of which depends upon the all too meager authority given to the controlling board under its statute.

A third agency which has shared in leading toward new channels of thought and experimentation is the university school. Through the influence of a few courageous pioneers the movement toward the linking of schools with universities progressed to such an extent that the need of a regulating agency to guide the development of these schools was indicated. Thus the Association of Collegiate Schools of Nursing has come into being. Its birth should be considered as the beginning of a new epoch in nursing education. The profound effects this association will have on the development of nursing education in the future can not be estimated. Even though still in its infancy its influence is being felt through the guidance and direction it is giving in the establishment of new schools. The fixing of terms for the recognition of university schools will also help in limiting the development of those loosely constructed organizations that are placed on a collegiate level in name only.

I have mentioned three agencies which have been instrumental in formulating standards and in directing the development of schools of nursing in this country; namely, The National League of Nursing Education, the state accrediting agencies, and the Association of Collegiate Schools of Nursing. Let us consider now what degree of uniformity in standards has resulted from the activities of these agencies. The answer to this question has been given to us by the very exhaustive and enlightening reports of the Grading Committee. The wide range of disparity between the levels of the schools studied can be illustrated best by quoting a few points from the final report entitled Nursing Schools—Today and Tomorrow. To quote these at this time may seem like unnecessary probing of an old wound. But our existing ills will not be remedied by disregarding them. We do not seal an ulcer. We expose it to light. Treatment has been prescribed but it has not been applied effectively as shown by the following facts:

"There are three types of nursing schools in this country—a few very good ones which compare favorably with other professional schools; a great many
mediocre schools which at present are subordinated to the needs of the hospitals; and a few which are very poor and should be closed."

"Only 20% of the schools operate on a budget."

"Only 38% of all schools are connected with hospitals having as many as 100 patients."

"Only 43% of the schools were selecting their students from those whose high school standing was better than average."

"Twenty-nine per cent of the nurse faculty members have never finished high school, and only 20% have had as much as one year of college."

"Student nurses are probably the most overworked students in any profession."

"Half of the nursing schools have less than 160 reference books in their libraries, 7% have none, and only 11% have 500 or more."

"Most students spend more time on surgical, operating room, medical, and obstetric services and far less time on communicable and psychiatric services than is recommended by the National League of Nursing Education. There is great lack of uniformity in amounts of experience students receive in almost all services except diet kitchen."

Many other points might be mentioned but these are sufficient to illustrate the divergence in standards as well as the lack of uniformity which has resulted in spite of the suggestions and recommendations of the National League of Nursing Education.

To the list of prevalent conditions presented by the Grading Committee I would add the results of the registered nurse licensing examination. An increasing proportion of failures of the graduates of any school casts serious doubt on the standards maintained in that institution. If the results of the state tests were made public in every state, they would show that some schools never have failures while others have a failure rate of 50, 60, 70, and in some instances, even 100%. Yet both types of schools meet the minimum standards for state recognition. The names of these schools appear in the lists of those accredited in the state in which they are located but no mention is made in these lists of the results of the licensing examinations. When inquiry is received from a prospective student concerning "the schools that give the best courses in nursing" she is sent a pamphlet containing the names of all schools registered, good and bad. We generously send with it the pamphlet published by the League outlining a rather complicated code which she is invited to apply in choosing her school. Surely we are expecting unusual insight and intelligence on the part of this young woman. We place upon her shoulders the responsibility of studying and comparing facilities of all schools within a city or a state, or the country for that matter. Even the Grading Committee found this to be an arduous task. But we are expecting the young woman of eighteen or twenty years of age to display the keenest discernment and discrimination in selecting a good school. Is this not the responsibility of our professional organizations? Prospective students of nursing should be saved from the cruel disappointment of wasting time in a school which is incompetent to give its graduates a proper foundation course in nursing. Safeguards which attempt to protect the
public against the unfit nurse should also protect the student against the unfit school.

I have attempted to show not only the lack of uniform standards but also the wide divergencies which exist among recognized schools. The range is from a high degree of competency to utter inadequacy. It is shocking to reflect that graduates of all kinds are licensed to practice on the same basis. Surely it is not surprising that the public is confused.

As the state boards are the instruments through which the reorganization of nursing schools will largely be effected I wish to direct especial attention to their need of assistance and support. Boards of all states (I believe there are no exceptions) are struggling with laws which do not give them the authority to raise or enforce standards and fighting against damaging forces over which they have little or no control. The Grading Committee states, "Immediate revision of state laws controlling nursing practice should be the concern of every nurse educator." But where is the model law which will guide the states in promoting and ultimately achieving the establishment of higher standards and a greater degree of uniformity in education? A certain amount of diversity is inevitable and desirable but the wide variations which exist lead only to hopeless confusion.

An interesting parallel can be drawn between the conditions which existed in medical education in 1910 and the situation which we are facing today. In the report made to the Carnegie Foundation by Dr. Abraham Flexner, the following statement appears: "Though agreed elevation of standards by individual schools improves their own product and indirectly leavens the mass, it does not stop the making of low-grade doctors. The ultimate improvement of the entire mass will come from control of all schools through the state boards, and not merely from voluntary action on the part of the more self-respecting institutions." This statement is just as true of nursing schools today as it was of medical schools twenty-five years ago. Laws must be strengthened and unified and controlling boards empowered to guide the development of nursing schools and nursing practice if public interests are to be safeguarded. The concomitant aim should be a national accrediting agency for schools of acceptable standard.

I believe I am right in stating that a very limited number of schools will be able to qualify for membership in the Association of Collegiate Schools of Nursing. The large bulk of the schools of the country that can not meet the standards of that association will, at least for some years to come, remain the largest producers of graduate nurses. In that group there will be many schools of high calibre, deserving the support and approbation of the profession. But there will also be schools of the other type, channels through which a stream of the incompetent will continue to flow. And the result is an unwholesome dilution of the acceptable product of our schools by those who are unfit and bring discredit upon the profession. If nursing education is to be placed upon a plane of efficiency and credit, we must stem this tide by blocking the sources. The most effective barrier which could be
built would be refusal by the profession to recognize those so-called schools that exist only for service needs and graduate a product which neither the hospital itself nor the public wish to employ. Surely there must be minimum standards below which no school should fall and still receive professional recognition!

For the schools on the upper levels there should be a high degree of flexibility in the interpretation of standards. Opportunity for experimentation should be created and freedom permitted and encouraged in applying new ideas. Our present system has permitted research and innovation and this freedom has justified itself abundantly through a number of major advances. But on the other hand, the leaving of all initiative to individual institutions with little coördination of policy has resulted in failure to work out a well-rounded national system of nursing education both in basic and in graduate instruction.

The profession itself must assume the initiative and the motive power which will guide the present movement out of confusion to clearly visualized goals. The National League as the chief guiding agency, through a representative committee, could sponsor the establishment of machinery for the recognition and approval of institutions that actually accomplish the purposes for which nursing schools are organized. Through this guidance, vitality would be given to the struggling state boards that are exhausting themselves in efforts too often futile, to establish standards and to unify their educational systems.

New opportunities as well as danger signals for the nursing profession can be seen on the horizon of the new social order. Standards must be established which will safeguard the preparation of the nurse in order that she may be equipped to occupy the place which she is entitled to fill. More nurses will probably be needed when the plans of the Federal government for economic security and health insurance are consummated. Under present conditions thousands of families suffer from the lack of needed medical and nursing service because they can not afford to buy it. A health insurance plan will help to solve this problem for the patient. But any increase in the number of nurses under existing conditions must be regarded as dangerous to the profession and ultimately to the public. The whole structure of our system of education must be strengthened if we are to meet adequately these new responsibilities. Some indication of the far-reaching effects of health insurance on nursing education and practice may be gleaned from the following facts:

For a period of ten months during the calendar year of 1934, 650 nurses were employed in one state on T. E. R. A. funds. Services rendered during that period are summarized below:

- Bedside nursing calls ............... 412,825
- Prenatal calls ...................... 42,986
- Postpartum visits .................. 48,114
The general morbidity in the cases represented above was 460,165. The story told by these figures is startling indeed. Nearly half a million visits were made to persons who needed, but probably would not have had nursing care, had these funds not been available. Although much has been done toward the provision of public health facilities for all who need them, the fact remains that millions of people suffer from diseases and many die annually from causes that are preventable. General recognition of these facts has led to the formation of a nation-wide program for the extension of preventive and curative public health services. What a vast army of nurses would be needed if as much nursing service were given as the public needs! On the other hand—and this is the danger signal—what an opportunity for poor schools to admit larger numbers and to grind out new hordes of the unfit! This possibility should be recognized and preventive measures in the form of protective professional standards instituted without delay.

Reports of the Grading Committee indicate that there are now too many nurses but too few of the right kind. The facts which have been published have resulted in a reduction in the size of the groups graduated annually. A way has not been found, however, of closing some of the poorest schools. They continue to thrive, admitting as many young women as the hospital may need to staff its wards. Such schools will continue to flourish so long as laws permit them to exist and so long as the profession welcomes their graduates. My plea, is, therefore, for a national accrediting agency that can establish and maintain standards worthy of our objectives. I believe that such a venture could be made self-supporting or maintained with a little financial assistance. The average good school throughout the country is eager for help and guidance and would undoubtedly be able and glad to pay a reasonable fee for the visits of representatives of the accrediting agency.

The first step in this direction would be the formulation of standards by which the acceptability of the work done in schools visited could be measured. Since a committee is already engaged in the preparation of such material a beginning toward this end has been made.

In establishing principles of procedure we should be guided by the trends and accepted practices in general education and by the experiences of other professional groups. Standards for accrediting should be sufficiently specific to provide adequate safeguards, but flexible enough to permit growth and experimentation. They should be based upon current needs in nursing service and not upon traditional practices.

The purposes of accrediting should be to identify those institutions which offer courses in nursing worthy of recognition as such; to guide prospective students in the selection of a school of recognized standing; to establish a reasonable uniformity in nursing education throughout the country thus facilitating transfer of students, registration by reciprocity and interinstitutional relationships; to assist secondary schools in directing students into schools that are worthy of professional recognition; to stimulate all schools to continued improvement.
There is not time to enter into a detailed discussion of the standards that we would consider necessary as a working basis for the judging of the character of the school. Only brief lists of the qualitative and quantitative criteria which might be used can be given. Qualitative criteria should be evaluated through visits by one or more qualified persons. Quantitative criteria may be evaluated through data secured from records, reports, catalogues, questionnaires, and other available sources. Decision concerning the acceptability of the school for recognition should be made by a carefully chosen committee.

Qualitative criteria should include consideration of:

1. The educational preparation and experience of members of the faculty, their intellectual interests and attainments
2. The quality of instruction and scholastic work of students
3. Records of graduates in licensing examinations as well as in graduate study and in practice
4. The attitudes and policies of the governing board toward teaching, research, and scholarly productions

Quantitative criteria should include:

1. The control and organization of the school
2. Finances, including expenditures and sources of income
3. The basis on which students are admitted
4. The curriculum
5. Graduation requirements
6. Size of the faculty in proportion to the number of students enrolled
7. Teaching load
8. Physical facilities including classrooms, teaching equipment, library, etc.

I wish to direct especial attention to the first three points under the heading of quantitative criteria as they are probably of the greatest importance. If the control of the schools is vested in a governing board whose primary concern is the education of the students enrolled, other points of organization should to a great extent take care of themselves. But too much emphasis can not be placed upon the need of a fund or an assured budget adequate to administer the school according to the purposes for which it is organized. Methods used in the induction of students must also hold a prominent place in the criteria which we establish. It is apparent that much must be left to the professional judgment of persons who visit schools and those who evaluate for the purpose of accrediting. For this reason the qualifications of each person vested with such authority should receive the most careful consideration.

In conclusion I have attempted to answer the question which appears as the title of this paper by showing the lack of uniformity in the courses offered in our nursing schools today, the need of laws which will give greater authority to state boards in the establishment of higher and more uniform standards, the need of a national accrediting agency that will assume a position of leadership in directing the progress of nursing education; the need of minimum standards which any school should meet if it is to receive pro-
fessional recognition; and the need of standards which may be interpreted with a high degree of flexibility for the school on higher levels.

If my treatment of this subject has seemed to any one to be unusual, let me say that from the viewpoint of state boards we can not see any consideration of laws, regulations, or standards separated. They are all inextricably bound together.

3. WHAT CHANGES IN ADMISSION AND GRADUATION STANDARDS?

HELEN WOOD, R.N., Director of the Nursing School,
Simmons College, Boston, Massachusetts

When we begin to discuss the matter of standards we are forced, first of all, to define our own interpretation of that word, and the disadvantages as well as the advantages of accepting anything that would seem to indicate that we are thinking of a “fixed rule.” The value of standards is the guide they may give us for progressive accomplishment. The danger is in the idea that the pattern may be fixed and so limit our progress, and certainly our possibility of experimentation.

Nearly thirty years ago, when many educators were developing a real satisfaction at the standards being set up and generally adopted in the various educational fields, President Eliot saw the dangers of the path and wrote that little pamphlet on The Curse of Standardization.

It is so comparatively easy to let some one else set the pace or draw the pattern, and then put our efforts merely into “following the leader.”

We hope in our various changes under consideration that we can avoid the opposite extremes. Before the advent of the League Curriculum, what differences of opinion and practice we had regarding the course of study and the general educational program in our schools! How our state boards ever set up examinations that were of any value as a matter of testing, is something to be wondered at—and to question. Probably the matter of examination leading to state registration for its graduates was one of the greatest reasons for the desire on the part of many schools for some sort of a pattern to follow, and the League Curriculum met with a greater welcome than was at first anticipated. Although meant as a guide, it was accepted wholesale as a standard; and when a school had covered the ground suggested, it felt it had reached its goal and was pretty well satisfied with its educational progress. When this was the case, the results were—very naturally—that we ceased to grow and to change our course with changing needs.

What disastrous results might there have been if the Education Committee of the League had not been continually revising that pattern. Otherwise many would have remained at a dead level, bound down by the needs of a single institution and pattern that was accepted as a fixed standard. I believe that today finds some schools which are carefully and conscientiously trying to “teach the standard curriculum” according to the earliest sug-
gestions of the committee and who have attempted no subsequent changes. We need to be made conscious that changes are taking place in the world which are making new demands on nursing. It is with such consciousness on the part of the League that we are facing a new revision of the curriculum. We have grown in wisdom with the many changes and have already ceased to use the word "standard" for fear of its limiting influence.

"Standards" in the broad sense of the word help in more ways than merely as a guide. They give us a common measuring stick by which we may compare ourselves with others, and translate others' accomplishments in terms of our own needs. They bring us together on common ground, for mutual help in our individual problems to the end that together we may meet, through the graduates of our schools, the needs of the profession, a burden which must be laid upon every school of nursing that would call itself a school. Such a common ground should be found in our requirements for admission and of graduation as well as in the content of the curriculum.

Think what the changes in admission requirements have meant in the development of our schools. As soon as we began to have a definite plan for classroom teaching (years ago) it was evident that we needed a more uniform educational background in our student group, and our schools set a specific number of years of high school as a prerequisite for admission. Unless it was the matter of age, this was perhaps the only specific requirement. As soon as the state boards began to set up examinations, the same thing occurred, although the peculiar aspects of the situation required only the minimum rather than the optimum as a requirement.

As we have improved our teaching and enlarged our courses of study, little by little, we have raised this educational requirement for admission until a full high school course is the accepted standard, in order that we may develop a desirable educational program.

Our problem now is, in view of pending changes: is this amount of preliminary high school work sufficient? We have long been trying to convince others, and to prove to ourselves, that nursing is a profession. If so, let us look for the general plan of our educational program to the set-up of other professions. It is quite generally noted that a program of professional education must include some emphasis on the liberal side, and that technical courses shall be built on a foundation of two years of study beyond high school. This would indicate that to assume real professional standards in our teaching, our new curriculum will presuppose two years of college work. This is being done in our nursing schools connected with colleges and universities, in cases where the completion of the course leads to a baccalaureate degree, but that represents but very few of our existing schools. Do we want to make this standard our accepted standard for the average hospital school, and if so, when should we begin? A question preliminary to others in the matter of revision. It is difficult to answer this question impartially, for those who are most interested will have some particular situation and organization in mind, and these are bound to influence our judgment in the mat-
Let us try to look at the picture as a whole and visualize the typical school that represents the rank and file of nursing schools in which the majority of our nurses are being prepared to care for the sick and to assist in the promotion of health, both in homes and in hospitals.

As was the case of previous editions of the curriculum, so, I believe, it should be the purpose of the new revision—to set up a pattern for good schools, but not necessarily for the school which gives a college degree. That group is comparatively small, and in each one there must be variations of requirements and administrations as well as of teaching which will conform to the college or university with which it is connected. Undoubtedly, such a group will be working on curriculum problems peculiar to that group.

If, then, the League is to be concerned with this much larger group, generally the hospital school type, what is going to be the attitude in planning a curriculum for a professional education? Are we going to build it on the supposition that the student will have had two years of college, i.e., has passed the junior college stage? According to accepted professional standards, we must answer "yes." But I doubt very much whether we are ready to do this at present. Indeed, I am quite sure that there are very few schools whose thinking along the lines of professional education—and by schools, I mean trustees, staff, faculty, and students—which will not need to be subjected to considerable influence and even pressure before they are ready to make any radical changes, provided such are necessary.

Unless, however, we expect to suggest what shall constitute the curriculum of the preprofessional program—and the tendency in general indicates that this should not be the practice—I do not see that it will make much difference to the curriculum workers at this stage, except that they shall be guided by the general trends in professional education in order that future revisions may represent a progressive growth toward a real professional goal.

Let us remember that our League is a National League, our curriculum is to be the pattern for schools throughout the country. Our entrance requirements to schools of nursing in our various states will be made in the light of the educational facilities available in that locality. In a western state having a state university and thirty junior colleges under state control—which means supported by public funds—the requirements of two years of college work would not be difficult. But the facilities in the East are very different when the general rule is that education supported by public funds ceases with the high school.

I am inclined to think that if we consider the possibility of two years of college as a prerequisite, and are to follow the general trend of not prescribing the content of study for that two years, the things we are really looking for in our students are maturity, a broader background of general education, and established habits of study that will enable her to undertake a really serious program as soon as she enters the nursing school. Too long have we taken time to make up the deficiencies of preparation among our entering students after they are in the school.
This, of course, means a much better selection of the girls coming from high school than we have been doing in the rank and file of our schools. We must consider the problem of maturity (for which the chronological age is not the sole measure), the kind of high school record presented (in quantity, quality, and range of subject matter), the personality of the applicant, her purpose, her capacities, and her endowments of physical and mental health.

Let us take our lead from the colleges which are making some very interesting changes in their plans for admission, and are trying to get away both from the extreme of examination in all entrance subjects, and the quite as arbitrary plan at the other extreme of entrance based entirely on certification from high school.

This matter of selection is of immediate importance. Many schools have done much in this line the last few years, but it is not general enough, for too many schools (I dare say, the majority) must set the size of their classes to meet in a large part, if not wholly, the nursing needs of the hospital (a condition which can not be entirely remedied until nurses pay a tuition fee for their education as do the students in other professional fields).

What changes shall we make in requirements for graduation? We have given too little thought to anything beyond the mere passing examinations at the end of courses and the surviving of the physical demands made on the student. We need achievement tests to show what the student has really learned. We need some system of quality rating in her class work, to merely pass the grade that bounds the area of failure is not enough. (Colleges are quite generally requiring that candidates for degrees shall acquire a certain quality rating as well as the stated number of hours’ credit for work done.)

Whether the actual length of the course should be uniform enough to be incorporated in League recommendations, I am not sure. But there is an evident lengthening of many of our shorter courses to reach a three-year program in order to include necessary preparation that can not be secured in the 28- or 30-month programs. This is certainly a subject for study and probably for recommendation.

4. WHAT CHANGES IN STANDARDS OF NURSING PRACTICE?

SISTER M. OLIVIA, R.N., Director of the Nursing School, Catholic University of America, Washington, D. C.

Would that we could visualize the function of nursing as Florence Nightingale did when she returned to England as a spirit from that other world of bloodshed and human misery. More than fifty per cent of nurses are in the private duty field. How plan the curriculum to enable the individual to adjust to private nursing? Certainly, we need to know the home and family life involved. If, according to Lowie, culture in a scientific sense includes the whole of social tradition, the private duty nurse will need to know

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more of the kind of culture such as an anthropologist as Lowie, has to offer.¹ No one more than the nurse in private duty is called upon to make adjustments to different racial groups in their various cultures. It might be found that lack of success is caused more by attitudes, low ethical standards, lack of appreciation and understanding than from inability to carry out nursing procedures.

Basic lists, as compiled in An Activity Analysis of Nursing, indicate that the basic requirements for nursing practice include the curative and preventative aspects of illness in the community as well as in the hospital. In nursing, which involves activities ranging from the most common household task to the complex treatments of modern scientific medicine, there is need of much objectivity and clarification of what is basic. The Rockefeller-Winslow-Goldmark report definitely states that there is need of a basic undergraduate course.²

The 1927 edition of A Curriculum for Schools of Nursing derives activities from the care nurses are expected to give to the “widest variety of human beings in all conditions of health and disease.” Such activities are classified according to the aspect of nursing which they represent.³ Private duty nursing activities in the home do not differ to any large extent from the nursing activities in the hospital.⁴

As early as 1923, it was found that the curriculum should not only equip the nurse wishing to devote herself to private duty, but that it should afford a basis for further postgraduate work in the hospital and public health specialties. The basic nursing course is a first requisite in the education of a public health nurse. Instead of shorter courses for a few students, a minimum of social interpretation should be planned for all students. Out of a total of 288 activities reported in the Activity Analysis of Nursing, 120 were given to instruction in health and preventative measure; 44, bedside nursing; 36 with activities concerned with cooperation. The significance of the activities listed is that bedside nursing should be extended into the homes of the community; that more emphasis should be placed on health teaching and that students should become more acquainted with the social agencies of the community.⁵

Conclusion 5, of the final report of the Grading Committee, states that all professional nurses should be capable of taking part in the prevention of disease and in the promotion of health. This does not mean that all nurses should become qualified public health nurses. However, the National League of Nursing Education recommends that every nurse should be capable of contributing to the maintenance of health and the prevention of disease by:

¹ Lowie, Robert H. *An Introduction to Cultural Anthropology*, p. 3. Farrar and Rinehart, 1934.
² Committee on the Study of Nursing Education. *Nursing and Nursing Education in the United States*, pp. 163, 456, 499. Macmillan, 1923.
³ Committee on Education of the National League of Nursing Education. *A Curriculum for Schools of Nursing*, p. 47. National League of Nursing Education. 1929. (Reprint.)
"Making herself familiar with fundamental health needs and with the representative social agencies and health organizations of the community."

"Helping to protect the community from infection and other dangers to health."

"Helping to teach the community how to prevent disease and how to improve health and general standards of living."  

Communicable diseases have a high frequency rate and many nurses are lacking in knowledge of the nursing care required in such diseases as scarlet fever. Recently, I listened to a well-known nurse leader deplore the fact that fifty-two nurses had refused to accept the call to care for cerebrospinal meningitis patients in a threatened epidemic. They refused because they did not know how to nurse such patients let alone to teach preventative measures. The Committee on the Cost of Medical Care ranks maternal and infant welfare as important functions of the public health nurse. State boards are still chiefly concerned with the ill child and very little has been accomplished in child and infant welfare. Prenatal clinics are developing sporadically. Mothers are still discharged from our institutions with no more information regarding their own and infant's health than their inquiring minds have sought. If all students are to have experience outside of the institution walls, schools of nursing will probably increasingly use the out-patient clinics and social service departments of the hospitals. It is no longer enough to care for an ill person and rest satisfied that our work is done. Every patient suffering from a preventable disease should be instructed to the extent that that patient will, as far as we can accomplish it, never return to our care with the same preventable ailment. How many children are admitted to our pediatric departments for conditions of a preventable nature previously treated in that department?

In the past, the hospital aspect of nursing service was stressed (perhaps it still is). The future will call for better-prepared general duty nurses, head nurses, supervisors, instructors, and directors. Are we teaching this group the fundamentals? The basic course carries a like responsibility to those who serve within the highly specialized hospitals of today. Shall we accept as a standard that the professional curriculum of the nursing school should cover the basic requirements for general nursing practice in the main fields of nursing including private duty, public health, and hospital nursing.  

In efforts to standardize the training of nurses and to give the public the same protection as other professional groups, such as physicians, dentists, pharmacists, etc., states have enacted laws defining minimum requirements leading to the certificate of Registered Nurse, the so-called R.N. The first extensive study, Nursing and Nursing Education in the United States, found the title R.N. to be of slight protection to the public.  

1 Committee on the Grading of Nursing Schools. Nursing Schools—Today and Tomorrow, pp. 75-78. New York, 1934.
3 Committee on the Study of Nursing Education. Nursing and Nursing Education in the United States, pp. 163, 456, 499.
to say to the public that our present R.N. does not necessarily mean the nursing service it has the right to expect? The New York study revealed the fact that 2,800 young women take the licensing examination each year. About one-third are unsuccessful in passing the test, but not in the right to give nursing service to the people of the community. "The schools graduate them as competent, the state finds one-third of them incompetent. Some schools have consistently high failures; others have not." The nurses in this state refuse to take certain types of cases, e.g., mental and nervous, communicable, tuberculosis, and home illnesses. The school records show that experience is seldom given in the care of these particular conditions. There is little differentiation between the well-prepared, the poorly prepared, and the unprepared nurse, either in salary or standing. The number of graduates have resulted from the number of students needed in hospitals to supply the nursing service and not from the demand for graduate nurses. In New York, 35,000 persons are offering themselves to care for the sick who are not licensed or recognized by the state.\footnote{1} The state expects the nurse to know her field, to be intelligent and cultured, to possess a strong spiritual character upon which its citizens can depend for strength and inspiration. The nurse, as an individual, has the right to expect economic security, freedom for leisure in which she has the opportunity for living satisfactorily as a normal human being.

In a profession, there is a unity of thought and action and changes are based upon scientific study. The Second Grading reported the faculty of the schools of nursing studied as having 82\% membership in the American Nurses' Association, 19\% in the National League of Nursing Education. The League is the professional channel through which the educational interests and endeavors are given to its members.\footnote{2}

The professional journals keep us informed on the most recent developments and research in our own fields and related fields. At least, five such journals are considered necessary to the serious teacher for current use. Contacts with centers of professional education, participation in studies, committee activities and contributions through publications are some of the means for the dissemination and acquiring of knowledge in our profession. The doors of research are wide open. The new curriculum will suggest and require further study. What changes are involved in the basic professional course?

1. The basic requirements for general nursing practice to include the main field of nursing and provide a sound foundation for continued study and specialization.
2. The out-patient clinics and social service departments to be more generally used for teaching purposes.
3. All students to be given experience during the basic professional course in home nursing in the community.

\textsuperscript{1} Horner, Harlan Hoyt. \textit{Nursing Education and Practice in New York State with Suggested Remedial Measures}, p. 31. The University of the State of New York Press, 1934.
4. That experience in community diseases, such as, communicable, nervous and mental, tuberculosis, cancer, etc., be required of all students.
5. Simple health teaching to become the practice of every nurse.
6. The student upon graduation to be health-minded and be prepared to prevent disease as well as to assist in its cure.
7. The R.N. to signify protection to the public.
8. The assurance of economic security to graduates of nursing schools.
9. Professional organizations, journals, studies, and educational contacts with the best-qualified members of the profession is a means of keeping its members informed as to the best current practice.

Special Luncheon Meeting for Nursing School Board and Committee Members

Wednesday, June 5, 12:30 p.m.

Presiding: Dr. C.-E. A. Winslow, Dr.P.H., Professor of Public Health, Yale University, New Haven, Connecticut

Subject: LAY RELATIONSHIPS TO NURSING SCHOOLS

Dr. Winslow was introduced by Miss Effie J. Taylor, President.

Dr. Winslow’s introductory remarks follow:

Dean Taylor and I remember very well the period, now only a few years back, when the university with which we are connected was engaged in a very active building program. They say that on one occasion a student was showing his father about. The father stopped a minute and said, "What is that building over there?"

The student looked around and said, "What building?"

His father said, "You didn’t look quick enough; it is gone."

Now, that perhaps illustrates the fact that we live in a changing world. It isn’t changing today in exactly the way in which it was changing in 1928, but perhaps the changes are all the more conspicuous. We do not know where we are going, but we are on our way. The only thing that seems to be entirely futile is to attempt to put back the clock to 1928, or as some would have it, to 1776. We may, perhaps, guide the course of development and evolution, but we can not stop it. That seems to be the purpose of the sessions that are being held today.

You have been discussing this morning, and will continue to discuss this afternoon, the subject of What Changes Do We Need in the Nursing School Curriculum? and that assumes that changes are going on, and furthermore, from the character of the persons who are discussing that subject, it presupposes, apparently, that those changes are to be considered and are to be recommended and are to be criticized and passed upon by experts in the education of nurses. I think all of us who represent any field of education must recognize that only teachers in a particular discipline can determine the proper content and method of education.

Whenever outside groups of any kind whatsoever attempt to interfere with
the content and method of education, the results are disastrous, whether it be in the passage of evolution laws in Tennessee, or in the attempt of the senior Senator from Louisiana to control both higher and lower education, or whether it be in the forming of silly laws requiring flag worship and reactionary "ohs" on the part of teachers in the public schools.

Now, if we may grant this fact, that your whole discussion is dominated by the idea that the curriculum of nursing education should be developed by experts in that field, there is a corollary to that conclusion. This implies, I think, quite clearly that the expert in nursing education who knows what nurses need to know and how they should be taught, shall be consulted in the actual formation of the curriculum and all that goes with the curriculum and that the recommendations of the expert, whether from within the system or without, shall be accepted as the basis for the establishment of the policy of the schools.

In other words, that implies that schools for the education of nurses are organized on an intelligent and constructive and educational basis, that there are institutions designed primarily to confer professional education upon a group of people who are to practice an important social profession.

So far I think the argument is reasonably logical, but at this point it must be quite clear to most of you that we have reached a logical conclusion which is very far from representing the actual facts in the 2,000 nurses' training schools of the country. We know quite well that a very large proportion of those schools are not primarily designed and managed for purposes of education.

Now, mind, I am not talking about the difference between theoretical and practical knowledge, I am not considering the question of whether it is more important for nurses to understand the principles of bacteriology and physiology or more important to them to learn to know how to give a bath to a patient—I don't know. Most of us here, or many of us, do not know. It is a problem which only those can intelligently answer who are devoting their lives to the study and development of the technique of nursing education.

But, what I do mean is, quite irrespective of the relation of theory and practice, that the situation we face is one in which a very large proportion of the training schools of the country are not primarily organized and primarily managed for the education of the nurse.

We have had, of course, the same sort of problem to meet in medicine. In medicine, as in nursing, a very substantial part of the training given to the medical student must be of an intensely practical nature. A very large part of that training must be given in the wards of the hospital. Yet, in medical education we have, in large measure, solved that problem. We worked out contacts between the medical school and the hospital by which the medical student obtains that type of practical experience which he needs to equip him to care for patients in the future. But, if we ask whether the same thing is true in general of the nursing schools of the country, we find it is not. We find that in a very large proportion of cases the amount of theoreti-
cal instruction, the amount and the kind of practical instruction, if we may
make such a distinction, given to the student nurse is not governed by the
needs of that student nurse for educational experience but is governed by the
needs of the hospital for having service to patients performed.

As nursing education has grown up during the past 70 years in this coun-
try, it has grown up curiously in an anomalous position which one could not
parallel in any other field of higher education. The nursing schools were
first founded with the idea of improving nursing in the hospitals and they
proved so successful, the pupil nurse proved so immensely superior to the
untrained and wholly unsatisfactory attendant of the previous period, that
that very success, perhaps, has furnished an obstacle to the sound develop-
ment of nursing education, because it led the hospitals to focus attention on
the value of the pupil nurse in the case of the sick patient, often almost to the
exclusion of any consideration of the actual educational process to which the
pupil was being exposed. That had the net result of an enormous over-
production of inefficiently trained pupil nurses.

The situation is somewhat parallel to that which would occur in educa-
tion if the student in our normal schools did the teaching in the public
schools and the more teachers, the more pupils there were in the normal
schools, the less opportunities there were for any graduate having a chance to
do any education. It is that sort of situation which has grown up.

Now, there are—and we must face the fact—two distinct and separate,
but interlocking, interests at work as between nursing education and hos-
pital management, just as there are between medical education and hospital
management. They are not irreconcilable, as has been shown in medical
education, but they are different interests. The trustees of the hospital are
primarily, and rightly, concerned about giving the best possible care to the
maximum number of patients at a minimum cost. That is their business as
hospital trustees. But, that isn't education.

When a hospital inaugurates an institution which presents itself to the
pupil and to the public as an educational institution, it must, if it is honest,
set up a different machinery. It must set up at least a group of persons for
the management of that educational enterprise who are primarily interested
in education and who can represent the needs of that educational process, if
necessary, as against the needs of the hospital for the care of the patients at a
given moment.

Now, every study that has been made of this problem has led to the con-
clusion that the training school committee, or board, the independent group
of persons responsible for the educational needs of schools, is the crux of the
whole problem.

In the 1923 report of the Rockefeller Committee on Nursing and Nursing
Education it is stated that the first essential for the success of a training
school is that it must, first of all, be directed by a board or committee or-
ganized more or less independently for the primary purposes of education.
The interests of hospital management and of educational policies must nec-
necessarily, at times, conflict and unless the educational viewpoint is competently represented, the training school must invariably suffer.

In the report of the Committee on the Grading of Nursing Schools a year ago we read, "No hospital should conduct a school unless it has a training school committee, or some other controlling board whose chief responsibility is the conduct of the school." In another place it says, "Every professional school of nursing should be controlled by an educational board whose membership should be representative not of the hospital, medical, and nursing groups alone, but also of those people best qualified to serve the interests of the whole community. This board would appoint the head of the school and upon her nomination all other members of the faculty, including those concerned with the student's practical experience; the appointment of the latter would also need to be subject to the approval of the hospital."

Now, that, as I say, has emerged from every study of this problem. I think we may take it as axiomatic that while the hospital, as such, has no necessary responsibility for education, and while no hospital need operate a school for the training of the nurses, yet if a hospital does operate a school for the training of nurses and does offer itself to the pupil and to the community as an educational institution, it has the absolute responsibility to the pupil and to the public of creating an independent board of management primarily interested in the educational problems of that school.

That is why a gathering of this kind is of such remarkable significance, where are gathered together not only the nurses who have been fighting so gallant a fight for this cause for so many years, but a large and representative group of members of boards of management of training schools. It is necessary to the public as represented by boards of this kind that the nursing profession must look for help, must look for the basic support which will make possible the development of adequate educational service.

The nursing profession has the right to look to the public for that kind of support. Look over the entire field of education and you will find no other important social profession, except nursing, which is not already freely and adequately provided with educational institutions independently managed and independently endowed and independently directed for the service of the community through the preparation of qualified professional personnel.

That is not true today in nursing. It is not the hospitals that are to blame. The hospitals have, in many cases perhaps, made sacrifices of their primary responsibility of caring for the sick, of a primary and fundamental nature in order to help nursing education. It is certainly not the nurses that are at fault, it is the public which has failed uniquely in this respect to provide the proper basis for the preparation of a profession which has been said, and perhaps rightly been said, to be one of the most peculiarly outstanding and characteristic professions of this particular period in human history.

So, you who are serving on the boards of institutions of this kind are not only paying, or rendering a vital service to the community, but also paying
a debt that is long overdue to the nursing profession in bringing them the support that they have a right to request and to demand.

Now, this is one phase, this service of lay persons on boards of training schools is one phase of a wider movement, of a highly significant movement. The voluntary service of individual citizens to the cause of social welfare is what it is. That, again, is a rather characteristic, American thing. Many of the things that are done in Europe by governmental authority are, in this country, done through voluntary effort. Our community chests and all that they stand for are, in my judgment, contributions of the very first importance to the difficult art of living together in community life.

It is particularly in the field of public health nursing that this service of the board members to the community has been recognized and developed to a high degree.

I think it was something like ten years ago that the first institute for board members of public health nursing organizations was held in New Haven, when 200 or 300 board members, representing organizations from a wide section of the country, came together for three days to discuss the technique of their responsibility as community representatives who had undertaken to foster this particular form of social service.

That movement has grown and spread. These institutes have been held all over the country. A special section of the National Organization for Public Health Nursing has been organized to mobilize voluntary interests of board members in learning their jobs as community trustees. They have prepared a manual for board members. They got a section in the Journal of the National Organization, and finally, there has been appointed as a member of the staff of the National Organization for Public Health Nursing, a representative of the board member group to serve as a continuing center in the National Organization for Public Health Nursing for the mobilization and the education and the training of these voluntary reserves in the fight against disease.

**WORKING WITH LAY BOARDS**

**Evelyn Davis, A.B., Assistant Director, National Organization for Public Health Nursing, New York, New York**

I am delighted to have the opportunity to pass on to the group represented here some of the thinking and some of the information that we have been working on in the field of public health nursing as to just what part the lay person has to play in furthering this whole program of community service.

The historical background of the lay person in the field of welfare, it seems to me, has passed through three stages. In the first place, before we had any professional lay trained people, or technicians in any field of welfare, it was all done by the lay person, the kindly neighbor, the friendly visitor, the church group, the club, and so on. The lay person soon realized
that it was required to have technical knowledge and professional experience
to minister to the sick, to teach health, to formulate plans for family rehabili-
tation, child welfare, and so forth.

So, it was the lay person who made it possible to employ professionally
trained workers in agencies to carry on this program of welfare and also
made it possible for various training courses to prepare the professional
worker, to carry on the service to the community, to meet the community
need.

I think that the second stage of lay participation in the field of welfare
rather pushed out the active participation of the lay person in the actual
program. They were needed, yes, to raise the money to carry on the work,
but the actual work in the program itself was more carried on by the pro-
fessional worker. Soon the professional workers themselves realized that
after all they could not do the job alone, they needed their work, their pro-
fession interpreted to the community, because after all we can advance only
as far as a community is ready and willing to go. They needed a group of
people closely in touch and informed about the organization and the program.

So, today, in the last few years it seems to me we have had what we call
a partnership relationship of the lay and the professional, a partnership of
equals, I would like to say, equal in the fact that both groups, professional
and lay people, are interested in having the highest type of service to meet
the community needs.

Now, the lay person, of course, functions in many ways in a program of
nursing. He may be a board member, committee member, or volunteer
worker, but in the few minutes that I have to present this topic this after-
noon, I want to discuss merely the question of the committee member as it
relates to a program of nursing education.

What are the contributions of a lay person in a field that is so highly
technical and so professional? I think those of us who are lay people some-
times wonder just what we can do in this whole program.

Well, a committee, or board, primarily is the group that gives a program
continuity in the community. Mr. MacLean, of the Family Welfare Society,
so aptly calls the board, or the committee, the "life stream of the organi-
zation." They represent the permanent residents of the community who are
furthering this particular service to their community.

The lay person can also help to interpret to the community the professional
worker. They live there and know some of its problems. They are people
of influence in the community and can give the program backing. They can
bring in a fresh point of view to the service. I think all of us who work
in one field become, sometimes, so immersed in that particular field that we
need new points of view brought to the subject. The board members and
committee members coming into this program from other interests and other
groups can do that very thing.

They are responsible for the financial support, either directly or through
the community chest, the drives to carry on, or the tax fund to carry on that service.

Lastly, there is the question of interpreting back to the community the organization and the program that it is carrying on in order to have the community understand it.

The program can not take advantage of these contributions from the layman unless we think through, I think, very carefully just what are the responsibilities in connection with committee functions and what are some of the principles that might be outlined. So, briefly, may I just point out that the responsibilities are both that of the lay person and the professional worker. I think the professional worker has three very definite responsibilities towards committee organization and committee function.

In the first place, I think it is very important to be thoroughly convinced of the value of a committee, to realize that the committee is an integral part of the whole set-up, not to begrudge at all any amount of time and energy that goes into organizing and developing that committee or that board.

A second responsibility on the part of the professional worker, or the director, in this program is to educate our committee members. I do not like the word "educate" exactly, because it is really orientation, it is informing them about the work of the organization that this committee is administering or advising in that program. When I say "advocating" I mean keeping them closely in touch with the program of the agency, with the department in the field of nursing education, with the reports and the material that is available through this National League in this whole field.

It is their responsibility to bring to the committee members in the individual agencies the developments in this whole program, bring it to them in interesting reports, in interpretations that can be easily grasped, because most of your board and committee members haven't a great deal of time to spend directly on studying this whole field. They can be educated in the field through you as the professional director of the service.

Then, lastly, there is the responsibility of your professional worker toward your committee, delegating to the committee certain responsibilities and jobs to do. I know it is much easier sometimes to do it yourself than to delegate it to a member of the committee who are discussing this particular thing, or to find interesting jobs in the organization for volunteer servers, but I am thoroughly convinced that all of us are more interested in some program in which we feel we have in some sense participated. Through this feeling of having group thinking and group discussion in our committee meetings, and some opportunity to serve in some capacity, in jobs in the organization, our committee is going to be kept more closely in touch with the program.

Now, what is the lay person's responsibility? In the first place, I think it is extremely important to recognize that service on a committee has a definite responsibility, that it does mean attendance at meetings with regularity, participating in group thinking, being willing and ready for change and development, being ready and anxious to get in touch with the develop-
ments in that field, and keeping closely in touch with your own organization's program. I wish that our approach to the prospective committee members would be more with the idea of a challenge, not just, "Won't you serve on this committee, or board; you really won't have very much to do, but we would like to have you as a member of the committee."

It seems to me that we must recognize that our committees are working committees and that if we are not going to have very much to do actually in the program, what is the need or formulating an active committee?

In conclusion, the principle that we have found extremely helpful in relation to the organization of the board, is that it is important to have some plan of membership. Our board and committee should be representative of the community if they are going to bring in these various points of view, some opportunity for bringing in new people from time to time on the committee so that our group does not become too static, an opportunity for having definite information given to the committee members when they came on the board.

You would be amazed how little is done in introducing a new member on the committee to the work. We seem to assume that because they live in our city or community that they are going to know just as much about the hospital program as we do. Yet, there is a need for having some definite program outlined for the new members.

We must realize that, after all, the relationship of the committee and the professional staff is one of partnership, each with their special contribution, thinking through together the program of nursing education; each one realizing his responsibilities, and together, it seems to me, that the participation of the lay person offers this opportunity and privilege to serve in a program that is doing so much to help and develop the community attitude.

THE NURSING SCHOOL COMMITTEE

MARGARET ASHMUN, R.N., Director, School of Nursing, Orange Memorial Hospital, Orange, New Jersey

The first report of the Grading Committee states that "it is believed that the basis for substantial improvement in nursing education must lie in the recognition of the fact that the training of the nurse is an educational enterprise and that, like all such enterprises, it can only be carried on successfully when controlled and directed by groups of persons primarily interested in the particular kind of education in question."

Most hospitals control their nursing schools. Many authorities agree, however, that the ideal school of nursing should be separately endowed and independently managed, as other educational institutions are organized.

Since most hospitals do control their schools, and since the hospital board has for its chief concern the care of patients and the financial burden of
the hospital, a special board or committee is necessary, whose chief concern is the education of the student.

The difference between the nursing service or care of patients and the school of nursing or the education of the student, must be strongly emphasized. In the same way, a nursing school committee differs from the service committees of the hospital board.

A committee of five, seven, or possibly ten members is considered to be adequate. Such a committee should consist of:

At least one member of the hospital board
At least one member of the medical staff
At least one member chosen from the field of education

Ex officio—President of hospital board
Director of hospital
Principal of school

The remaining members should include such other people as best understand the nursing needs of the community and the educational needs of a profession. It is suggested that an alumna of the nursing school and a director of a public health service would be valuable members of this committee.

It is to be hoped that if there is only one member of the hospital board represented on the committee, that such member is not also serving on the finance committee of the hospital.

It is to be expected that the physician appointed will be progressive and thoroughly in sympathy with nursing education, and that the educator selected will also be progressive.

The chairman should be a well-informed and forceful leader. Each member should be assigned definite activities for which he or she is responsible.

The committee as a whole should keep up to date in the trends of nursing education, have courage and foresight, and be imbued with something of the pioneer spirit, for there are many trails yet to blaze.

Such a committee should meet regularly. The functions of such a committee are briefly:

1. To select the dean or principal of the school, one qualified to meet the requirements of the school of nursing, and then give her full authority to carry on her work, such as appointing faculty, arranging curriculum, etc.

2. To study the needs of the school, as a school. To see that the number of students admitted to the school is no larger than the adequacy of the experience offered, and to insist that the nursing load of the hospital be carried by nursing service—graduate nurses and subsidiary workers.

To encourage and approve affiliations in other hospitals for special experience: public health, mental, and communicable disease nursing.

To see that the school has all it needs to carry on its work—a sufficient staff, sufficient and up-to-date equipment, facilities, adequate library, etc.
3. To secure and authorize the expenditure of funds which will be sufficient to put the school on a dignified and safe economic basis.

To insure this, the school should be on a budget, one that provides not only for running expenses, but an allowance for extra curriculum activities, and includes sufficient allowance for a full health program for students, for adequate and comfortable living conditions, and makes provision for loan funds and scholarships. It is also advisable that the budget allow for the expenses of one or more members of the faculty to attend nursing conventions.

4. To interpret to the hospital board the aims and policies of the school and adjust any conflicts which might arise between the hospital and the school.

It is quite evident, we are sure, to you lay committee members of nursing schools, that much is expected of you, and that thousands of graduate nurses are looking to you for assistance. Your help in the past is well known and appreciated, but the nursing schools of today and tomorrow in the changing order need still more help. The National Curriculum is now undergoing revision. The success which is hoped for it, in the education of our students, will be as equally dependent on your cooperation and understanding as it will be on our nurse educators.

THE SCHOOL COMMITTEE AND THE HOSPITAL BOARD

C. W. Munger, M.D., Superintendent, Grasslands Hospital, Valhalla, New York

For brevity, my discussion of this subject will be limited to the school of nursing which is an integral department of a hospital, functioning as one of the divisions of the organization of the superintendent of the hospital and subject, like all the other activities of the hospital, to the control of the board of trustees. Schools under independent or affiliated boards are not unknown, but are a minority group. May we dismiss them with the observation that such set-ups, in the proper environment and if properly supported, merit careful study?

Hospital boards should, and usually do, give the superintendent of the hospital responsibility for the execution of the policies of the board in relation to the hospital. Boards almost invariably establish committees whose duties include the study of the institution’s principal activities. Committees are expected to report to and advise the board upon their respective assignments. Committees common to most hospital boards are: Executive, Finance, Buildings and Grounds, Purchase, and Nursing and/or School of Nursing.

Our present interest is in the latter committee or committees and their relation to the board and to the nursing school.

The final report of the Committee on the Grading of Nursing Schools says, “Every professional school should be under the control of some form
of managing board, whose primary concern should be the conduct of an educational enterprise. The board should not regard the school either as a side line or as an adjunct to some other organization or business.” This pronouncement is something of a jolt to time-honored practices in many most honorable hospitals. The school of nursing has been looked upon as one among the several hospital departments and has been directly controlled by the hospital board.

The same report goes on to say “when this principle is applied to nursing, it means that professional schools of nursing should be controlled not by hospital boards, but by educational boards. Excellent as many hospital-owned schools have become, it seems necessary to emphasize that no school can flourish on a professional plan when its policies are controlled by a hospital board.” I would follow Dr. Winford H. Smith, Director of Johns Hopkins Hospital, in believing the last sentence a too-sweeping statement, one with which I can not entirely agree. Although I can not follow the Grading Committee completely, I am perfectly frank to say that many, probably the majority of, nursing schools have been operated as hospital service departments first, and as educational enterprises, secondarily.

Short of abandonment of many nursing schools, there is no immediate possibility of organizing all of them on this independent educational basis. The idea of Assistant Commissioner Horner of the New York State Department of Education whereby colleges would control the schools with hospitals used for gaining practical experience, has many virtues, but the plan can not soon be realized. It seems, therefore, that, for our hospital schools, we should adopt plans of control which will preserve and promote the educational functions so necessary to professional training.

What, therefore, is the best manner of conducting a school of nursing which does have to remain an integral department of a hospital, subject to the final control of the hospital board? What committee set-up will suffice to keep the school in step with the hospital as a whole, and at the same time protect its educational ideals and functions from serious encroachment by the other aims and needs of the hospital as a whole?

It may clarify matters to say that the board should definitely agree to look upon nursing of sick patients and nurse education as separate and distinct functions. This distinction can be emphasized and perpetuated by deliberately organizing two committees. First, let there be a group of members of the board known as the committee on nursing, to interest itself in the nursing care of patients on floors and wards of the hospital. Secondly, let there be a committee on school of nursing to which the board gives broad powers as to that function and whose membership is carefully selected for its fitness to supervise an educational effort. Unless the hospital board has an unusual membership, the committee on school of nursing can not be recruited from it. The thought of doing so should be abandoned at the outset. If a person
thoroughly qualified for the chairmanship of the committee is to be found in the board, all right. If not, a suitable citizen should be drafted for this duty and promptly elected to the board. Around this key person, organize the school of nursing committee, seeing to it that the professions of education, nursing, and medicine are represented and that other members are recruited who can represent the community and can interpret the school to it. The Grading Committee and others have published excellent suggestions for the make-up of such a committee.

Since nurse education is an important function under the hospital board, it would be well to elect other suitable persons from the committee to sit upon the board itself. There should be enough such members to keep the board educationally minded.

The board should establish a definite section of its budget for the school. I believe that, to keep organization lines clear and to prevent friction in the hospital organization, the superintendent of the hospital should have the same relation to the school budget as to that of any other department, but that the budget for this activity should be presented by the director of the school and the superintendent to the school committee and presented in turn by the committee to the board. The expenditure of the school budget by the director of the school should be in consultation with the superintendent and the school committee, the latter being given broad powers in connection with its section of the budget. Both director of the school and superintendent of the hospital should be ex officio members of the school committee.

I believe, with the Grading Committee, that schools would, ideally, do better as separate organizations from hospitals. How could the majority of them exist at present under such plans? Independence will require separate support and, in spite of the shortcomings of hospitals in their relation to the schools, they have been the only means of securing funds for nurse education on a large scale. With economic conditions as they are for the public, for education, and for hospitals there seems no chance immediately to change our time-honored methods.

It is my belief that poor schools in hospitals of inadequate clinical facilities should be closed. I believe the good and the better-than-good schools will have to continue as adjuncts of hospitals. If, by clear thinking, we can set up our board and institutional organizations so as to aid nurse education and not stifle it, we will assist the cause of an important profession. The more fortunately placed can realize the ideal of independent education soon, perhaps. The average community will have to await the gradual adjustment of matters. In the meantime, we must not be idle; let us extend every effort to do the best possible job with the resources which we have, adjusting and improving them for the better education of the nurse.
General Session

Wednesday, June 5, 2:30 p.m.

Presiding: Isabel M. Stewart, R.N., Chairman, Central Curriculum Committee; Professor of Nursing Education, Teachers College, Columbia University, New York City

General Topic: WHAT CHANGES DO WE NEED IN THE NURSING SCHOOL CURRICULUM? (Continued)

B. WHAT CHANGES IN EDUCATIONAL AIMS?

1. PROPOSALS OF THE CURRICULUM COMMITTEE IN RELATION TO THE AIMS OF EDUCATION

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

In one of the old school readers which some of you may remember there was a story which began, "Aim high, this is a good motto but one must aim wisely as well." The moral is then driven home by the tale of Mary, the milkmaid, who built a whole series of brave air castles out of the expected proceeds of her pail of milk only to have them crash around her when the pail tipped over.

The Curriculum Committee has aimed high and has dreamed a few dreams but has tried to keep its feet on the ground and its eye on the realities of the nursing situation. None of us has any delusions about the present stability of the nursing world or the larger world of which it is a part, nor do we need to be reminded of the precarious state of our sixty-year-old system of education, the unadjusted balance between nurse production and consumption, and the still unsatisfied demands of the public for more and better nursing service. We can not go back to the old order of things but we are not so sure what direction we should take to lead us out of our present state of insecurity. Obviously some decision in relation to aims must be reached before we begin to reconstruct curricula or to rebuild our educational machinery. The first step is to review our present position and the aims which we have held in the past and then see what changes, if any, we should make in view of our present situation and the needs which we foresee in the future.

Strangely enough there is very little discussion of aims in nursing literature. People have written and talked a good deal about the what and the how of nursing education but very little about the why and the wherefore. One wonders whether this is because our aims were so universally recognized that no one questioned them or whether those in control felt it wiser to keep their aims discreetly hidden on the principle of "least said soonest mended." The literature of general education by contrast is full of arguments for and against "liberal culture," "character training," "harmonious development," "mental discipline," "complete living," "social efficiency," and many other traditional aims of education.
If we study nursing education, we can distinguish three or four dominant aims which have come down to us through many generations—the aim of discipline or training, the aim of self-effacing service, the aim of practical utility, and the aim of technical efficiency. There are many historical reasons for the bias in nursing education toward monastic and military concepts of discipline and service rather than scholastic concepts of mental discipline. It is not necessary to review these here, but we may note in passing that although methods of training have changed and educational aims have been modified somewhat in adapting them to the secular profession of nursing, these traditional aims are deeply rooted in our educational system today. Most of us still think of the ideal nurse as a selfless sort of person, not only devoted to the service of others, but asking little or nothing for herself, a well-disciplined, practically useful, technically efficient individual with almost unlimited powers of adaptation and with a wide assortment of personal virtues and abilities. The fact that we do not seem to be successful in producing a large number of nurses who measure up to these specifications raises the question whether our aims may have been set a little too high or whether it is possible to devise any system of education which will produce such paragons.

If we pursue these questions a little farther, we shall find that there are many incompatibilities and inconsistencies in our aims and methods of nursing education and also that our system does not synchronize very well with the prevailing ideas and standards of education in our own country. We shall have to admit, moreover, that ideals and methods of democracy which are supposed to permeate the life and institutions of this country, have not as yet penetrated deeply into our philosophy of nursing education, into the management of our hospitals and schools of nursing, nor into the relationships of nursing and medicine. It is true that democracy is having a rather hard time just now and some people seem to prefer living under dictatorships to exercising the powers of self-government. But most of us still pin our faith to the democratic philosophy of life and we want to proceed farther along this way, keeping closely in touch with the other groups who are also trying to face the new conditions and problems in modern society which call for a reconstruction of all branches of education.

The Curriculum Committee has reached the conclusion that nursing education needs a new aim, one that will include the best elements in the old, but will shed some of the unfortunate implications which the old aims carried with them. We seem to need a new approach to nursing education, one that is realistic as well as idealistic, one that honestly faces the facts of human nature and does not place nurses in a separate category from other human beings, whether higher or lower. We see no reason why nursing education should be set apart as something different from the rest of education, nor why our aims should be so markedly different from the aims of any other profession. We assume, of course, that each profession has its own distinctive contribution to make to the common life. In that respect
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professional aims will be different. But all professional schools are expected to select individuals who give promise of fitness for their particular type of service and then to help them to make the kind of personal and professional adjustment which will be likely to bring maximum benefits to society and the greatest growth and satisfaction to the individuals themselves.

After considering many aims of education to find one which seems to be especially well adapted to nursing and to the present period of change, we have chosen the aim of adjustment. The word means "to bring into right relationship."

The following statements may help in explaining the further meanings which we have accepted tentatively in defining the adjustment aims.

1. Adjustment as an educational process presupposes changes in the individual. To be truly educational, these changes must be for the better. The individual must not only grow up, but grow up in the right way. Adjustment and growth are therefore synonymous terms.

2. Adjustment is not an automatic process nor is it something that someone else can do for us. Other people can help guide and advise, but the individual herself must do the adjusting.

3. Adjustment is not a one-sided transaction. It should be a two-way process bringing about changes in both the individual and her environment. Adjustments between two people presuppose changes in both.

4. Adjustment in a dynamic society such as ours must be a continuous process, keeping pace with the changing conditions of life.

5. Adjustment should be progressive, taking place on constantly higher levels as the individual grows in maturity and experience and resulting in an increasing mastery of one's self and one's environment.

6. Adjustment should result in the progressive integration of the whole personality, including the physical, intellectual, emotional, aesthetic, social-ethical, and religious aspects of individual life.

This is quite different from the old idea of molding and shaping human beings in order to fit them into the existing scheme of things or "fitting typical personalities for typical grooves in a fixed order." It is an attempt to prepare individuals for life in a highly complex and rapidly changing industrial society which is committed to the idea of democracy and equality of opportunity. It definitely aims to provide for personal growth and a satisfying life for each individual as well as service in proportion to capacity for the common good.

Before committing ourselves definitely to this aim of education, we are anxious to have the whole question discussed and studied from various angles. There are some interpretations of adjustment which some of us would be unwilling to accept, and we need to be quite clear in our minds what we really do mean when we use the term. If we accept the more liberal and dynamic interpretation and apply it consistently, it is likely to lead to some marked changes in our nursing curriculum, in our system of education and in our professional and interprofessional relationships.

We shall want to consider very carefully whether it is possible to har-
monize this aim with the older aims of discipline, service, and practical efficiency, whether the new aim will tend to safeguard the patient sufficiently, whether it will make for better relationships with our medical colleagues, and how it is likely to affect the personality of the nurse herself. Administrators and teachers will want to know how their work will be affected by the adoption of such an aim and public health nurses will want to scrutinize it carefully to see how it is likely to affect their field.

The speakers who follow will help us to answer these questions and we hope will point out any fallacies in our thinking or dangers in our philosophy before we get really launched in the new course toward these aims.

2. CAN THE HISTORIC AIM OF DISCIPLINE BE RECONCILED WITH THE AIM OF ADJUSTMENT?

Willystine Goodsell, Ph.D., Professor of Education, Columbia University, New York City

Education as discipline is as old as human history and has shown a remarkable vitality, since it has persisted with few changes to modern times. The schools of ancient China, to a less degree those of Greece, the grammar schools of Rome, the abbey and cathedral schools of medieval times, and the schools of Europe and America almost up to the present day have been dominated by the idea of discipline as the end of the educative process.

It might be well to examine this conception in order better to understand its true meaning. The aim of disciplinary education was and is to shape an individual who is receptive to ideas and standards imposed from without; to train him in certain habits and skills important for him to acquire and in ready obedience to commands—in short to make of him a conforming, efficient individual of sound moral character according to the standards of his native culture. If the learner proved docile and obedient, well and good, if not, in the words of Plato in the Protagoras "he was straightened by threats and blows, like a piece of warped wood."

The implications of this theory of the aim of education are significant and interesting. In the first place may be noted the complete failure of its advocates to take account of the individual as a personality, having capacities, drives, interests, and peculiar gifts of his own. In other words, the theory reveals a total lack of respect for individuality. In the second place, the doctrine of discipline as the goal of the educative process blandly assumed that adults, i.e., clergymen, teachers, parents, and those in authority, infallibly knew what was best to be learned and how it should be learned. That is to say, there was serene confidence in the wisdom of elders concerning the purpose of education and its desirable product. This is amusingly illustrated by a scene in a popular Scotch play that was produced in New York years ago. It is Sunday in a stern Presbyterian home in Scotland and the shades are drawn, shutting out the sunlight and the flowering garden, because the mind must turn to the serious realities of predestination and possible eternal
damnation on the Sabbath. The school-boy Rab is lying on a sofa, struggling with the mysteries of the Westminster catechism, when his severe old father comes into the room. "Feyther," says Rab reading a sentence from the catechism, "what does that mean? I don't understand it." "Understood it," replied his parent, "who asked you to understand it? Larn it."

In the third place, discipline as an aim implies that conformity to external standards and obedience to external commands are the most desirable moral virtues; while uncritical acceptance of what is taught is the most acceptable intellectual virtue.

It need hardly be said that disciplinary education in its many forms originated in certain cultural conditions—a clearly marked social pattern—which gave it birth and nourished it. For almost its entire history the theory flourished in societies grounded on authority and coercion. Governments almost without exception were despotic until late in the eighteenth century. Wars and rumors of wars were rife, and armies, with their rigid military codes of discipline, played a prominent part in the life of nations. Stern discipline prevailed in the family where parents whose word was law were often more feared than loved. And within the church, both Catholic and Protestant, unyielding codes of religious belief and of conduct were laid down for their congregations and enforced by penance or stern ministerial and social disapproval. What is more natural than that discipline should be upheld as the end of education? But this is not all. Until the second half of the eighteenth century there was little or no exact knowledge of the functioning of the human mind, no psychology worthy of the name. Very generally the mind at birth was conceived as a tabula rasa—a blank tablet—which developed by receiving impressions from the outside world. It was divided into sharply distinct faculties, such as reason, memory, observation, etc. Train one such faculty, say memory, by learning the bones of the skeleton, for example, and the nurse-learner would remember better the rules of good nursing. And the harder it was to learn, the better the result.

Other conditions favorable to the conception of discipline as the aim of education must be briefly passed over. In Christian nations the Church taught the doctrine of original sin with vigor and conviction, and the teaching was rarely challenged. It was but a step from this to the theory that undisciplined youth is always wrong. Thus we find in the Westminster Confession the statement that because of the sin of Adam and Eve man is "utterly indisposed to all good and utterly inclined to all evil." This being the case, the child must be subjected to unremitting discipline from birth lest he lose his eternal soul. Finally, it should be noted that, until the magnificent discoveries of science by exact, experimental methods had captured the imaginations of men there was, throughout society in Europe and America, an uncritical, uninquiring habit of mind which led to acceptance of knowledge already known as comprising all that it was necessary to know. This attitude was encouraged by the Church, the schools, and the universities. And it played its part in buttressing discipline as the goal of education.
Needless to say, during the whole course of social history women came in for more than their share of disciplinary education on the ground of their moral weakness and inferiority. The religious and secular literature of most ancient peoples is replete with condemnations of woman not unlike the following from a seventeenth century Japanese work called The Great Learning for Women: "The five worst maladies that afflict the female mind are indolence, discontent, slander, jealousy, and silliness. Without any doubt, these five maladies infest seven or eight out of every ten women, and it is from these that arises the inferiority of women to men." Accepting these criticisms and adding other indictments of the nature of women such as laziness and sensuality, the ancient Hindu Laws of Manu declare: "Day and night women must be kept in dependence by the males of their families, and if they attach themselves to sensual enjoyments, they must be kept under one's control..." Nor was Christian theology much more generous to women. In an ancient book of instructions to the Christian clergy and laity written in the fourth century we read: "Let the wife be obedient to her own proper husband because 'the husband is the head of the wife'... For the woman is the body of the man, taken from his side, and subject to him, from whom she was separated for the procreation of children." This conception of the status of women, held by not a few of the Church Fathers, did not prove shortlived. On the contrary, it played a significant rôle in keeping women in subjection in the family, in law, and in an economic sense up to two generations ago. It is not surprising, then, to read this advice given by an Englishman, Lord Kames, to his daughter in the late eighteenth century:  

"Woman, destined to be obedient, ought to be disciplined early to bear wrongs without murmuring. This is a hard lesson; and yet it is necessary even for their own sake; sullenness or peevishness may alienate the husband; but tend not to soothe his roughness, nor to moderate his impetuosity. Heaven made women insinuating, but not in order to be cross: it made them feeble, not in order to be imperious:..."

This being the generally accepted idea of the nature and social position of women it followed naturally that the education of girls and women conformed to this pattern. It was one long discipline and training in religious and moral dogmas, in proper conduct in their subordinate social and family rôles, and in a multiplicity of household arts, from candle-making to baby-tending, from hetchelling flax to brewing beer.

As you well know, the great chivalric and military nursing orders arose to prominence in the eleventh and twelfth centuries. The Knights Hospitalers of Jerusalem, of Rhodes, and of Malta, known as the Knights of St. John, the Teutonic Knights of German lands, and the Knights of St. Lazarus became famous, not alone as warriors but as founders of hospitals and providers of charitable relief. Each order made provision for a corresponding order of women. Thus sisterhoods of nurses grew up, composed often of well-born ladies, and in time these sisterhoods took on a strictly religious form. The

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1 Loose Hints Upon Education (ed. 1781), pp. 228-29.
sister-nurses were vowed to poverty, chastity, and obedience. Although the nursing orders had declined markedly in usefulness by the sixteenth century and were finally suppressed, their best traditions survived into modern times in the St. John’s Nursing Associations, and St. John’s Guilds and Ambulance Corps.

History makes plain that nurses’ education derived its marked disciplinary character from three sources: first, from the military orders, where rigid discipline has always been exalted; secondly, from religion, which united with the ideal of self-sacrificing service the coordinate ideal of stern discipline in suppression of natural impulses; and thirdly, from the fact that the great majority of nurses have been women and therefore a subject sex. Up to recent times the education of nurses has emphasized acquisition of practical skills, learning of a restricted body of subject-matter laid down for them, respectful deference to those in authority, and cheerful, uncritical obedience to commands.

Such was the character of education in general for thousands of years and few there were to challenge it. But deep-moving social and intellectual forces have been at work for more than a century sapping at the supports of disciplinary education. In the late eighteenth century strange ideas began to circulate regarding human rights, human freedom, and the just claims of every individual to equality of opportunity for life, liberty, and the pursuit of happiness. A new regard for human personality as such was born in western Europe at this time and has never died out in democratic societies, even though it has never fully come to flower. Obviously a democratic philosophy of life is not the friend of autocracy, and although a more or less autocratic type of education has for many years held its own in democracies like France, England, and the United States, it is being attacked with vigor on every front at the present time. Another influence weakening the disciplinary aim of education has been the triumphant march of science and the growth of popular respect for scientific method, which extols free inquiry and experimentation, testing of theories before acceptance of them—the critical mind. Together with the spread of science has gone the decline of dogmatic, authoritarian religion that has so long been a sturdy prop of the aim of discipline as good in itself.

Even more effective as a foe of disciplinary education has been the influence of the relatively new science of psychology. The earlier conception of the mind as a blank at birth, with slowly developing faculties that are set to work by sensory stimuli, the theory that these separate faculties must be rigorously exercised by drill and practice is almost as dead as the dodo.

Under the influence of the sciences of biology and physiology, psychology has developed along behavioristic lines. The human being is conceived as an organism in interaction with the environment; the mind is an instrument for effecting satisfactory relations with the multiple aspects of that environment. But the behavioristic school of psychologists is already divided within itself. The behaviorism of John Watson, who led the revolt against the old
introspective psychology, sets up as its clearly stated goal "the prediction and control of behavior." It conceives psychology, to quote Watson, "in terms of habit formation, habit integration and the like. . . . In the main, the desire in all such work is to gain an accurate knowledge of adjustments and the stimuli calling them forth. The reason for this is to learn general and particular methods by which behavior may be controlled. . . . If psychology would follow the plan suggested, the educator, the physician, the jurist . . . could utilize the data in a practical way as soon as they could be experimentally obtained. If psychology were stated in terms of objective results . . . work on the human being will be directly comparable with the work on animals." 1 Later Watson became greatly interested in the laboratory experiments of Pavlov and Bechterev with the conditioned reflex and came to hold the hypothesis that the conditioned reflex affords the key to all habit formation, including the integration of habits into complex learned acts. In this theory of adjustment little is said of intelligent understanding of the situation of controlled thinking in the interest of realizing an aim. Thinking in Watson's view is only "implicit behavior" substituted for overt action and consisting mostly of subvocal speech movements.

It is not difficult to understand how such a conception of adjustment, which emphasizes training an immature individual to make specific responses to specific stimuli, would lend itself to the venerable aim of discipline as the goal of education. Substitute formation of worth while conditioned reflexes, for training and practice in useful skills and you would seem to have the same old disciplinary methods in a new garb. The mantle of Elijah has fallen upon Elisha.

For this and other reasons a new conception of adjustment and how it is brought about has been winning an increasing number of adherents in recent years. The so-called "new psychology" regards the human organism as primarily dynamic, having within itself original wants and drives that impel it to activity. The Watson school of behaviorists treats the stimulus as the datum or starting-point and the resulting behavior as the end-point of psychological inquiry. Thus we have an S— R bond psychology. The newer "organismic" psychology is described by Thurstone as follows:

"Here the starting-point of conduct is the individual person himself. He wants certain things, he has cravings, desires, wishes, aspirations, ambitions, impulses. He expresses these impulses in terms of the environment. The stimulus is treated by the new psychology as only a means to an end, a means utilized by the person in getting the satisfactions that he intrinsically wants. This is a very basic contrast. In the older schools of psychology we have the characteristic sequence: the stimulus—the person—the behavior. The behavior is thought of mainly as replies to the stimuli. In the newer schools of psychology we have a different characteristic sequence: the person—the stimulus—the behavior. The stimulus is treated merely as the environmental facts that we use to express our purposes." 2

1 Behavior: An Introduction to Comparative Psychology. (1914.)
2 Thurstone, L. L. The Nature of Intelligence, p. 6.
Thus the newer psychology postulates at the outset a dynamic living self with impulses to action that bring it into contact with the multifarious stimuli of the environment. Those reactions that bring satisfaction of inner drives and wants tend to be repeated, those that fail to bring such satisfaction tend to be eliminated. Out of successful adjustments to environments, i.e., such adjustments as satisfy the impulses of the organisms, are derived meanings which may be used to make blind urges increasingly intelligent and purposive. In this psychology, thinking plays a prominent role as the instrument of successful adjustment. Thinking is the use of meanings acquired in the course of making earlier adjustments to meet a novel situation presenting difficulties to which the organism is not yet adjusted. By application of older skills and meanings (or ideas) to the doubtful situation a solution of the difficulty, in other words a satisfying adjustment, is usually achieved and the individual has added a new meaning, a new reaction to his mental and motor equipment. This kind of activity is essentially creative so far as the individual himself is concerned. By his own intelligent effort he has discovered a novel meaning and effected a novel response to a situation presenting obstacles which enables purposive behavior to function smoothly once more.

Even at the risk of boring my hearers with ideas they already know and accept, it has seemed worth while to analyze in some detail the organismic, purposive psychology winning acceptance today because it is directly related to the current conception of adjustment. From this psychological point of view adjustment is always purposive, always concerned with the satisfaction of inner dynamic impulses by the effective use of ideas, skills, and thinking. And these urges have an ever-widening range and intelligent purpose, from the mere satisfaction of hunger to the driving social desire to secure the welfare of mankind by the reconstruction of a competitive society. In the course of effecting these satisfactory adjustments the individual not only changes himself but changes some part of his environment, be it hospital or home, nature or society, so that it better meets his needs and purposes. As one writer has happily phrased it: "By acting on the external world and changing it, man changes his own nature. Through control of the environment he educates his own educator."

It is not difficult to understand how such a psychology is the determined foe of a narrow discipline as the aim of education. Emphasizing as it does purposive behavior which springs from the individual's own desires, ambitions, hopes, plans, and aspirations, stressing the process of thinking as the only sure method of adaptation, an "organismic" psychology points the way to a new aim of education. And this aim is intelligent adjustment to the multiple demands of life. With such a goal in view the work of educating human beings, be they children, nurses, teachers, or what you will, is much the same. It consists in placing individuals in situations that challenge thought and skill, in helping them to set up desirable ends, and to think through the problems involved, in encouraging them to adapt the means at
hand to the purpose in view. In the last analysis such education is self-
education under guidance.

But what, you may ask, becomes of discipline? Is it not important that
individuals shall be skillful, efficient, and responsible in the performance of
tasks, especially when these are concerned with the care of the sick and in-
jured where life and death may be involved? Indeed, yes! Skill, an abiding
sense of responsibility, and practical efficiency are of the greatest conse-
quence in all significant work.

Part of the important task of education is to evoke and develop these
attitudes in every learner. If students, with a serious end in view, such as
becoming superior nurses, are placed in situations calling for thinking
through problems, for intelligent adaptation of means to ends, this educa-
tion furnishes the best possible training in skill and responsibility. To be
sure, those learners who have no vital interests, no serious purpose, may drop
out by the way. But it is a fair question whether disciplinary education
could or should hold them in line. If a person is to adjust to life, she must
make her own adjustments; if she is to be responsible, she must have ample
opportunity to make choices under guidance; if she is to form useful habits,
she must understand their purpose and meaning and learn for herself that
they are indispensable in achieving her ends. No satisfying adjustment to
our present complex, difficult society can be made without discipline, but it
should be the only kind that is worthy the name—self-discipline with an
end in view.

It is pleasing to know that the great founder of the nursing profession
had no narrow conception of the function of discipline in education. Her
writings contain not a few statements emphasizing the value of thought, of
intelligent understanding of practical situations prior to action. I shall quote
only one:

"Women long for an education to teach them . . . the laws of the human
mind and how to apply them . . . and they long for experience, not patch-
work experience, but experience followed up and systematized to enable them
to know what they are about."

What is this but intelligent adjustment to the demands of an exacting
and honorable profession?

3. CAN THE ADJUSTMENT AIM BE RECONCILED WITH THE
AIM OF SERVICE?

C. RUTH BOWER, R.N., Principal, School of Nursing, Western
Pennsylvania Hospital, Pittsburgh, Pennsylvania

The question I am to discuss is: "Can the adjustment aim be reconciled
with the aim of service?"

Since schools of nursing were first established, there has been no question
but that the general aim of nursing education is professional service. Un-
fortunately for too long a period service was wrongly interpreted. For too long a period the training given was such as would allow student nurses under direction to serve economically the needs of hospitals sponsoring the schools. Now the emphasis is changing. We are beginning to recognize that

"... if we draw a circle premature,
Heedless of far gain,
Sure bad is our bargain."

The idea of a training in the acquisition of skills necessary in the care of the hospital sick is yielding to the idea of an education that will equip a nurse undirected to serve the public in post-nursing-school days.

The new emphasis requires a modification of curriculum and of methods of instruction and supervision. Any school planning to graduate nurses to serve the public adequately must determine its curriculum and its methods of instruction in the light of its new goal. The problem would be difficult enough were the social order of the future to be the more or less stable social order of our student days, or even the social order of today. But in this twentieth century change treads so quickly on the heels of change that the only sure prediction as to the nature of the social order our present students will serve is that it will be constantly changing its pattern. Therefore, our students must learn themselves to change; therefore, adjustment becomes our watchword.

By no means are we throwing overboard the true and tried of the old dispensation. Certain skills and techniques are as essential now as they ever were; but even these may be presented in a way that will allow the student to think, to ask and answer many times the question, why, to see the need of adjusting herself and her methods of work to serve the economic and social health of the whole order.

Examine for a moment the new concept of professional service. Time was that a nurse, having cared for the physical ills of a patient and carried out the physician’s directions, could feel that her work was done. That his ills were aggravated by poor health habits, by wrong diet, by maladjustment of one kind or another and therefore might recur were not greatly her concern, for nursing was not as yet taking into account its larger responsibility. Now with the acceptance of the idea that not only the survival of the patient but his future good health is her problem, and with the acceptance of the sociological idea that the individual is not the only end, that society, too, must be considered, it is clear that individual health and social health are interdependent. Nursing education, then, must make it possible for the nurse to adjust to all kinds of persons, to understand the forces which motivate human behavior, to analyze the needs of her patients, to plan their health programs, and to see her patients and her work as a part of the social whole.

Before proceeding to a discussion of the effect of the adjustment aim on the patient and on nursing service, it may be well again to state clearly just what adjustment means. Broadly defined, adjustment is intelligence at work.
It has nothing to do with the old disciplinarian, 'Do this, and ask not the question, why.' It is a driving motive in a new order which seeks to develop an inquiring mind. Webster defines it as "the act of bringing into proper relations." Applied to nursing education, it means, therefore, an education that will make possible the bringing into proper relation the nurse on the one hand and her patient and the public on the other. This bringing into proper relations means change for all. And since, as we have said, change is the only sure predictable element in the future social pattern, nursing education must be constantly reorienting itself in order that it may play its part in the scheme for social reconstruction. It dare not lag behind. Miss Stewart defines the purposes of the adjustment aim in a recent Journal.

"Nursing education, like all education, is for the purpose of helping individuals to adjust to the world in which they live."

"Like all forms of vocational education, it has a specialized function in selecting students who show particular aptitude for service in a special field and in helping them so to adjust to its requirements that they will give their best service to society and will continue to grow through that service and also through participation in the general life of the group."

This review of the aims of adjustment and of professional service reveals that the two are harmonious and cannot be entirely separated. Indeed the aim of adjustment is actually indispensable to a superior professional service. With the whole program shot through with this idea of adjustment, applicants are chosen who have a particular aptitude for nursing, and who have given evidence in their preprofessional training of a rich cultural background. Only students with a rich background can make intelligent use of a curriculum determined by the adjustment aim. Only students of a rich background will subordinate a concern for getting through recitations, passing examinations, and piling up the required number of course credits to an interest in their work, so vital and illuminating that they see nursing as a professional-social-cultural service. Just as masons working on the medieval cathedrals consciously adapted their building skills to harmonize with the spirit of the whole cathedral, just as each worker realized that each stone he set was a keystone in the construction of the whole, so student nurses may be led to recognize that each activity they perform, each skill and technique they employ is essential in the building of a wholesome society. Indeed the chief difficulty today in our own business, political, and even professional life, is that men and women fail to consider the social bearings of their work.

It is not within the province of this paper to suggest the particular details of a curriculum for this carefully selected group. They will be determined by the Central Curriculum Committee organized for that purpose. It is within the province of this paper, however, to propose certain general guiding principles. Certainly a student should never be placed in a situation to which she cannot adjust, for the handling of which she is not prepared. Night duty, for instance, should never be assigned until the student has acquired a sufficient knowledge, theoretical and practical, to give her confidence.
in her ability to meet situations that develop on hospital pavilions by night. Patients let down at night; they look worse; often they are restless, nervous, irritable; occasionally one is delirious; the night noises and even the night silence when the patients are quiet may be appalling. It is unsound pedagogy to allow a student to attempt any task that may disturb her emotional balance. On the other hand dietotherapy and operating room technique may not be deferred. They must come early in the course. Why a special diet is ordered, what results are expected as the consequence of it—these are questions that from the earliest months of her education a student must be able to answer if she is to cooperate intelligently with the patient and the physician. Similarly, an early experience in operating room technique gives significance to basic courses, such as anatomy and physiology, pathology, bacteriology, and chemistry.

In the content of the curriculum, too, change is inevitable. The content must be both wider and deeper. With persons living in congested urban centers, particularly in these days when unemployment and empty pockets, books are accompanied by undernourishment and a train of physical ills, public health courses become increasingly important. The marked increase in mental illness, conspicuous in the present social and economic instability, demands even for general nursing some education in psychiatry and a mental hygiene point of view. A working knowledge of the laws of mental health makes it possible for nurses not only to save many from swelling the numbers in hospitals for the mentally ill, but to restore some at least to a wholesome and satisfying life. And with the acceptance of the idea that nursing is to play a part in the scheme of social reconstruction, we must offer courses in the social sciences—not detached, sterile, academic book material but a presentation, alive, characterized by an awareness of the ill and the good in government, in education, in the state, in the family—a presentation that will lead to a discrediting of the laissez-faire philosophy and to a realization that the teachings of the social sciences put to work may lead to a bettering of human relations.

Now the nurse, herself. I like to think of our students and graduates not as just nurses but as women who give a nursing service. Certainly as women in their communities, and in their general social life, they are entitled, as women in other professions, to the deep and abiding satisfaction of art, music, and literature. Any experience which enriches their personal lives makes them finer women and therefore better able to give superior nursing service.

The adjustment aim demands that instruction and supervision also change. It may be much simpler to teach in the old authoritative manner nursing skills and techniques; certainly it is more unsettling to permit inquiry and the scientific attitude, particularly when reasons for the old skills and procedures are elusive, and when students’ suggestions lead to a distrust of practices that we had counted as fixed and immovable as the laws of the Medes and the Persians. The scientific method is with us however; it is a tool of
the adjustment aim. Properly employed, it will lead us to infinitely more efficient techniques and procedures, whether they be sterilization of thermometers or the teaching of the mother in the home a simple communicable disease technique when one of her children has developed measles. One of the dangers that instructors and supervisors must avoid is the compartmentalizing of their subjects. In practically every learning situation they must reach over into the social sciences, the public health, the mental hygiene, and the cultural courses in order to present their special subjects in terms of what their students will be called upon to do after graduation, alone and unaided, as they serve a world already changed from the world of their school days. I repeat, the instructor who works in a school of nursing where the adjustment aim rules will be constantly adapting her methods. Often she will have to discard old methods and not only accept, but with an invisible hand help her students to work out, new methods. Gone are the days when having worked out a procedure, a school may neatly card-catalogue it and use it over and over again with innumerable classes. No one today dare persuade herself that what she is teaching and her way of teaching is ultimate and final. In brief, supervision and instruction must be of so high an order that the graduate nurse, even the student nurse, is not merely a well-trained puppet, taught to make certain automatic and mechanical nursing gestures in given situations, but a thoughtful person who has an understanding of the human drama.

No longer can there be any doubt that the school of nursing recognizes that service to the community is its only reason for existence. The needs of the community must provide the final criteria for the formation of its curriculum. But unless these courses are dynamic, the contents so carefully thought out that the student may make her maximum contribution to nursing, adjustment will be partial, not complete. Human beings who are properly adjusted will subconsciously assist in transforming their environment in the interests of better living and will continue to grow after the period of preparation is complete.

If the adjustment aim, through proper selection of students, through a revision and enrichment of the curriculum, through improved methods of instruction and supervision, secures a more adequate professional service, it follows that the effect upon the patient will be proportionately better. After all, the immediate aim of our work and the immediate measure of its efficiency is the satisfaction of the patient who is being helped. We all know that a cultivated person, well-poised and emotionally stable, brings into any company an influence as wholesome and welcome as sunshine and fresh air. If persons physically well are quick to feel the warmth and health of a well-matured personality, how much more sensitive are the physically and mentally ill. In the February Journal, A Curriculum Study contrasts the effect upon two hyperthyroid patients of the same routine procedures. In the one case the well-poised observant nurse won the confidence of her patient in her and in the hospital and in the evening left the patient for the night com-
fortable, satisfied, and relaxed. In the other a student, ingratiatingly friendly and self-consciously authoritative, performed the routine duties fully as well as the other nurse and thought her duty ended. That night her patient required a sedative. As it is necessary for the instructor and supervisor to explain to the student the why of various procedures, so is it equally necessary for students and for graduate nurses to orient their patients with reference to the hospital, to the clinic, or to the nursing procedures in the home. Accustomed to these procedures herself, the nurse who saw her patient as just "another hyperthyroid" failed to consider their effect upon a person unaccustomed to them; and so she failed. A nurse educated to adjust her procedures to each patient gives to each patient the cheer and comfort, the attention and explanation that his individual temperament requires. Before he leaves her care she will, if necessary, have extended her work to insure, so far as is possible, an established health program; and whenever necessary, she will bring unto him the resources of the community for his welfare and will herself cooperate with these resources. In brief, she will have as her aim the restoration to the community of a man physically, mentally, and socially fit.

This demand that nursing education must discard its outgrown traditional patterns and work out patterns suited to the life it is to serve—in other words that it be determined by the adjustment aim—is not confined to leaders in nursing education. Pick up any book on modern education or on modern social trends such as those of Dr. Kilpatrick and Dr. Dewey, and you will find many times the idea that education is not an unthinking acceptance of what is taught.

This paper may seem to be concerned largely with the selection of students, with curriculum content, with revisions of instruction and supervision, even with the ills of the social order. It is true that any answer to the question, "Can the adjustment aim be reconciled with the aim of service?" must take them into account. The paper is not, however, concerned with these matters, important as they are, per se. An incident in Emerson's boyhood is pertinent at this point. Emerson records in his Journal his going out on the beach as a boy and being charmed with the colors and the forms of the shells. He gathered some and put them in his pocket. On reaching home he found that he did not have what he had gathered. He had only dry, ugly mussel and snail shells. "Thence I learned," he comments, "that composition is more important to effect than the beauty of individual forms. On the shore the shells lay wet and social by the sea and under the sky."

So I believe that any revision of the curriculum, any change in methods of student selection and of instruction and supervision, are lifeless so long as they remain distinctly compartmentalized; but that they become a tremendously dynamic social power when they are determined by the adjustment aim. It will, I believe, insure a service motivated, as all nursing service should be motivated, by the divine principle: I am my brother's keeper.
4. How Would the Adjustment Aim Affect the Nurse as an Individual, and Her Relations with Her Coworkers?

(A Digest)

Arthur H. Ruggles, M.D., Superintendent, Butler Hospital, Providence, Rhode Island

Objectivity (which has been described by Lee and Kenworthy as "the capacity to deal with a situation or with another person without allowing one's judgment to become distorted by one's emotions") was urged by Dr. Arthur H. Ruggles, Superintendent, Butler Hospital, Providence, R. I., in his address on "How the Adjustment Aim Would Affect the Nurse as an Individual and Her Relations with Her Coworkers." Objectivity is needed on the part of the nurse, the doctor, and all the coworkers who enter into the nursing situation; in no other way can an accurate evaluation of the total situation be gained.

In speaking of the adjustment aim, he recalled in comparison the fine adjustment of the telescope, which, not fixed or static, is modifiable and capable of being adjusted to bring new worlds into view. Training, he said, is too disciplinary a concept; education must fit people for life, must be constantly adapting to the new and dropping off the old and must change its objective when desirable. He pointed out that the adjustment aim will require courage because, in departing from the old, narrow disciplinary attitude, we are turning from that which has been considered safe and conventional.

He urged better selection of nurses on the basis of personality, especially that part of personality which has to do with the objective attitude, using vocational and psychological tests and interviews in so doing. Many bad mistakes have been made, said Dr. Ruggles, when selection was made on the basis of IQ alone. We are constantly confronted with the increasingly close relationship between medicine, nursing, and social welfare, which demands a better knowledge of social conditions. Preventive medicine must not cease to make it clear that a major objective in educational procedure is that the nurse know more and more about keeping well and that in caring for the patient she must gain a clearer conception of the total individual. The day has passed when the nurse can think of her patient as a series of detached organs or areas of morbid tissue. She should never forget that the intellect and emotions of the patient often have a great deal to do with other parts of the human anatomy.

Dr. Ruggles sounded an encouraging note when he asserted that if a thing is worth while, if it is thought through wisely, it will be obtained sometime, even though not this year or next. The greatest gain that can be made in a curriculum which must be always developing, never static, and which must fit one to do better work in a changing world, is the attainment of a greater degree of objectivity.
Wednesday, June 5, 8:00 p.m.

Presentation of the Walter Burns Saunders Memorial Medal

Following the banquet, Miss Taylor introduced Miss Susan C. Francis, President of the American Nurses’ Association, who conducted the 1935 presentation of the Walter Burns Saunders Memorial Medal for distinguished service in the cause of nursing.

Dr. C.-E. A. Winslow, Professor of Public Health, Yale University, presented the medal to Miss Adda Eldredge, R.N., Executive Director, Nurse Placement Service, Chicago, Illinois, formerly Director, Bureau of Nursing Education, State Board of Health, Madison, Wisconsin.

General Session

Thursday, June 6, 9:00 a.m.

Presiding: Mina M. Boober, R.N., Chairman of Instructors’ Section; Presbyterian Hospital, Philadelphia, Pennsylvania.

General Topic: What Changes Do We Need in the Nursing School Curriculum? (Continued)

C. What Changes in Methods of Instruction?

How Should Teaching Methods Be Adapted to Better-Prepared Students?

Ruth Sleeper, R.N., Assistant Principal, Massachusetts General Hospital, Boston, Massachusetts

Changing the methods of teaching in schools of nursing today is not a matter only of changing the methods to meet the needs of better-prepared students, but of changing our methods to enable these better-prepared students to attain the new aim of nursing education.

Just what characterizes a better-prepared student might of itself be a problem for considerable discussion. In using the term, I shall interpret it as meeting the standards proposed by the Curriculum Committee. She should be a student possessed of more maturity than the average eighteen-year-old girl; a student who has had the advantage of one or two years’ general education beyond the high school level. Most important of all she would have a deeper understanding of life. She would be more keenly aware of the problems of society which she as an individual must some day face.

The Curriculum Committee has proposed, as the new aim of nursing education, the aim of adjustment. This has been defined for us as a two-fold activity: first, adjustment of the individual, and second, her readjustment of the environment.
It has already been emphasized that such an adjustment is not an adaptation which consists of fitting into a situation. On the contrary there must be an evaluation of circumstances and an intelligent adaptation or adjustment of both self and surroundings when circumstances require. This is described by Professor Kilpatrick as

"genuine experimental action which effects an adjustment of conditions not to them; a remaking of existing conditions, not a mere remaking of self and mind to fit into them. Intelligent adaptation is always a readjustment, a reconstruction of what exists." 1

It is believed that the development of this ability to adjust accompanies the process of personality integration.

"If the learner faces effectively a sufficient variety of life's situations, he simultaneously effects three correlative results which constitute integration: (1) he integrates himself as a person, (2) he organizes with many interrelations the various aspects or successive experiences so that they are available for use, (3) because of both of these in relation to actual situations, the learner becomes integrated (or interadjusted) with his environment." 2

The interdependence of adjustment and integration is further stressed by Burnham:

"Whereas integration makes adjustment possible, adjustment, on the other hand, is the normal functioning of the integrated personality." 3

It appears, therefore, that to aid this better-prepared student to adjust we must first aid her in becoming a well-integrated individual.

The integrated personality possesses a wholeness and unity. The individual, we say, shows integrity of character. There are no inconsistencies in her thought or action. Overtly, the integrated personality is characterized by a continuous reorganization of thoughts, feelings, and emotions in terms of worth while purposes. She has wide interests. Her approach to problems is made with confidence. She has learned to recognize problems in her environment and to organize her knowledge and skill to solve them. She uses her conclusions to modify her actions and assumes responsibility for whatever results.

In contrast, the disintegrated individual does not recognize the problems within her sphere, which is a narrow one. Forced to face a disturbing situation, she is unable to solve the problem and her feeling of inferiority increases. Her attempt to solve the problem is made largely on the basis of emotion. She is unwilling to accept the consequences of her behavior and protects her integrity by withdrawing into her imaginary world.

The process of integration is believed to begin in childhood, to be correlative with educational growth, to persist throughout life, and to occur through a series of integrating experiences on successively higher levels.

For a thorough discussion of the process we should need to turn to psychology and mental hygiene from which the principles of integration are derived. The newer psychology, in contrast to the old, always considers the individual as a whole. When the individual reacts, his reaction-as-a-whole is always to a situation-as-a-whole. There is an emphasis on unity and integration of the parts.

To save time, I have selected some of the principles of integration as stated by writers in progressive education. The principles chosen are those which guide in the selection of method. Others would be needed in choosing content or in planning the program as a whole.

To achieve integration, the individual must have opportunity to face a large number and wide variety of real life situations. These situations must be faced by the student herself under a wise teacher guidance. Those situations should be selected which provide the best opportunity for the learner to organize her knowledge and skills and, in the light of the ensuing problem, select the appropriate solutions, evaluate them, apply the most valid conclusion, and judge her results. It is important that the student have opportunity to test her thinking in application. It is this activity which integrates the student within herself and with her environment.

The methods of teaching which are to aid in integration appear to be those, in brief, which make provision for pupil activity in a wide variety of life situations where the student learns to use her knowledge and skills in meeting problems. Finally acting on her conclusions, she makes a good adjustment.

New aims in nursing education do not necessarily demand new methods. Old methods may harmonize with the adjustment aim as well as new ones.

The lecture method is commonly used as a device for covering a large amount of subject matter in a short space of time. It may be a means of presenting material not available to students in any other reasonable manner. It is used to motivate an assignment or a lesson. For any use, if we judge it by the principles of integration, its value may be limited by the inactivity of the student and the tendency toward complete teacher domination. However, with a mature student group possessing a keen interest and well-defined problems the former weakness may be less marked.

The recitation method includes the drill, the quiz, the oral or written review, and the usual formal recitation of assigned subject matter. Where students realize that success in recitation lies in finding the answer which most nearly meets the instructor's expectations and the "recitor" merely repeats what the class already knows, there is little pupil activity, little opportunity to consider situations of vital interest to the student, no use of the experimental method. The teacher dominates through her questions, her plan of work, her grades.

The recitation can be adapted to meet the principles of integration, if it is socialized. It is then in reality a discussion. The pupil shares in the planning and development of the class procedure; she is challenged in her
method of solving problems; she must face overt results of failure to think straight as well as failure to secure necessary knowledge. This method has been suggested heretofore in the League Curriculum for use with more advanced pupils. If we are to have more mature pupils, there is reason to believe the method might well be used from the beginning of the course. Unless the discussion is maintained on a sufficiently high level, there is a possibility that mature students may find the discussion method somewhat more interesting although less exacting on attention and mental capacity than the lecture.

The laboratory method for the sciences or nursing arts may provide opportunity for either pupil-teacher coöperative activity or teacher domination. Laboratory work sheets which indicate every step in the procedure develop student dependence on the teacher. A sheet which directs sufficiently to save failures and waste of time, yet leaves some planning and investigation to the student's initiative and discretion, fosters growth in self-direction and adjustment.

The weakness of the laboratory method frequently lies in the waste of student time because of inability to understand directions, the attempt to use complicated, unfamiliar apparatus which will not be used again in nursing, or in doing experiments the value of which is out of proportion to the time required to carry out the experiment. In the first instance, if the experiment is important enough to include at all, the student should be helped to master it. In the other two instances, we might suggest the substitution of the demonstration method.

The demonstration method really includes the demonstration as used in the nursing arts class, the demonstration as used in any of the science classes, the bedside clinic, and the excursion. In any or all of these, the demonstration may be accompanied by a lecture or it may be merely a display for student observation. The integrating effect depends to a great extent upon the activity which follows. Integration results when the student is given opportunity to test her thinking in application.

The problem or project method uses a teacher-pupil coöperative plan. The activity is purposeful and centers in some actual life situation. Planning and executing both bring obstacles which the pupil must recognize and remove before the activity can continue. The project method therefore develops ability to sense problems, provides opportunity for students to discover solutions and test some of their results. Through group activity, the student learns the value of coöperative effort and how to adjust to individuals. Real life situations which are well suited to the project method are situations such as preparation for an operation, or a delivery in the home.

The case method, as used in nursing, has made the patient the center of a study in which the student learns to select and organize all the pertinent information relative to the patient and to use this information in developing her own insight and understanding of the nursing care. This method provides pupil activity under teacher guidance; a broad life situation different in
every case study; an opportunity to see a problem in all of its relationships and to organize knowledge to solve the problem; a chance to see the relationships between principles learned and the patients' problems, to test conclusions in a small but effective way through the teaching of the appropriate principles to the patient. The case method stimulates interest, and should aid in growth in the ability to adjust through a better understanding of patients and their problems.

From this cursory examination of the methods commonly used in our nursing schools today, it would appear that all of our methods may meet the requirements of integration and the adjustment aim, in some way, if we use them correctly.

Recent adaptations of these and other methods, however, will be found to offer an even wider variety of "life situations," more opportunity for seeing situations as a whole, more chance for organization of materials and growth of insight, more student activity in the learning process.

The seminar method is a form of group discussion in which the responsibility for planning the discussion, as well as the discussion itself, is carried by the students. The plans for seminar groups include such objectives as mastery of self; mastery of subject matter; growth in the ability to see one's own problems; growth in the ability to solve one's own problems; development of ability to select, organize, and use experience in the solution of problems; and learning to see one's own problems in relation to the problems of society as a whole.

The maximum seminar group is usually about twenty-five students. The duration of the meeting, one to two hours. While students are learning the seminar method, a faculty-student committee is used to select, formulate, and organize the most significant student problems and to suggest available sources of information. As the seminar progresses, the students assume increasing responsibility for preparing the problems for group study and for conducting the discussion. As no subject boundaries are set for the discussion, each one may involve reference to any and every field.

Used in the nursing school, the seminar might begin in the first year with a discussion of student problems: adjustment to the school, cooperative living in the school community, budgeting of personal funds, and guiding principles in conduct. As the student's experience broadens and she begins to care for patients, the seminar may take a more professional tone: the influence of economic insecurity on health and disease, controllable factors in the environment, which cause disease, the relation of recreation to health, types of recreation for various age groups. Experience with children and maternity patients may again change the trend to family problems: housing and health, parent education, and the like. In the third year, the seminar discussion could lead the students to an insight into the relation of the nursing profession to the community and the larger social problems; what responsibility should the nurse take for the development of a social and civic center in her community or the relation of nursing to social legislation. The
seminar does not replace any service courses. It is an integrating center where knowledge and skills from all other experiences are organized for application.

The symposium is another variation of the discussion method. In a few schools of nursing where it is used today, the discussion and its planning remain in the hands of the instructors. In other schools, students share or even carry the responsibility for conducting the symposium. For example, a physician presents the etiology, the treatment, and prevention of the disease; the nutritionist discusses the diet, if the disease is either of dietary origin or if dietary regulation is of major importance; the nurse instructor presents both the social significance of the disease and the nursing care.

Such a symposium seems to be in reality a lecture by three experts. It has value as an integrating method, however, because the patient-as-a-whole is considered and many points of view are discussed. Through such discussion old knowledges derive new meanings, thought is clarified, and insight deepened.

Other schools use more student participation. The students are assigned each to the study of one aspect of a patient. In the symposium, the first student presents the clinical-pathological aspects; the doctor follows with a discussion of any additional facts. The second student describes the patient’s care while in the hospital; the supervisor adds to the discussion, if necessary. The third student presents the epidemiological and preventive aspects and is again followed by the physician. The fourth student has had a conference with the social worker and is prepared to give a complete social history. The fifth student explains the psychiatric aspects. If significant, the psychiatrist concludes the discussion.

It is almost easier to describe what the panel method is not, than to tell what it is. It is not a debate; it is not the discussion of a controversial issue; it is not an attempt to discover the final solution to a problem. The panel method is used where there is confusion in group thought on a topic which is important to all. No one of the group may know or be able to discover the answer but in the pooling of group thought all arrive at a better conclusion than any member could have reached alone.

The panel usually consists of several members and a chairman seated in a semicircle in view and hearing of each other as well as the audience. The members of the panel, as representatives of group thinking, discuss the issues of the topic in conversational style. When the general trend of thought in the panel is clarified, the discussion is thrown open to the audience.

This method, like the symposium, brings out individual points of view and clarifies thinking. If the topic is of interest to all, the lively conversation will draw in many members of the audience.

The panel might be used in history of nursing with a topic such as the relation of nursing to the medical profession, or discipline. In professional problems, discussion involving several fields of study might be aroused
on the topic of the attitude of the nursing profession toward social trends, old age insurance, or state control of medicine.

The concentration or comprehensive course as conducted in some colleges is an independent study or reading course. The student selects a topic in her field of major interest, or in her senior elective. The topic is broad enough to relate to several fields of study. For example, if the field of interest were medical nursing, the topic might be the rehabilitation of the cardiac patient. The student will need tutorial guidance in the study. Conferences may be scheduled at regular weekly hours when the student comes to report her progress and discuss plans for future work. The plan is not unlike the Dalton plan except, that in the Dalton plan, the student works by contract.

At the end of the course the student presents the results of her study, and takes in most colleges, a comprehensive examination. The examination, like the study, covers several subject fields as it tests on knowledge related to the problem. There is no reason, in the nursing school, why the test should not include practical techniques as well as knowledges. The comprehensive examination could also be used to test subjects, not courses, at the end of each year in the school. Such a reorganization of knowledge would integrate through the development of insight and new applications of old principles.

If we are to expect the student to think in terms of whole situations, to organize and reorganize her cumulative learnings to secure new insights and understandings in order to adjust to new situations, we must help the student to synthesize her knowledge. In the elementary schools, integration is relatively a simple matter. No course boundaries are necessary. The student sees the curriculum as an ordered whole. But as higher education necessitates larger bodies of knowledge from many fields, it is not possible to integrate the requisite knowledge, skills, and attitudes into a single great unit. Bodies of subject matter must be taught but in such a way that they do not remain isolated and useless. Teaching methods which require the student to organize related facts have already been mentioned. I should like to conclude my discussion by suggesting two methods for organization of subject matter for better integration.

The first is a type of course—the orientation, introductory, or general survey course. Its purpose is to introduce students to a large field of thought which runs through and across many of the artificial boundary lines of subjects. It gives the students a preview of the work and so enables them to see a unity, an integrated whole.

The second is the organization of subject matter into working or teaching units. Morrison, one of the earliest advocates of the teaching unit, describes it as

"a comprehensive and significant aspect of the environment of an organized science, of an art, or of conduct which being learned results in an adaptation of personality."
He interprets environment as

"not merely physical surroundings but as including our bodies, our institutions, and the great body of cultural inheritance found in literature, religion, and fine arts."

To be comprehensive the unit must have wide enough connotations to be an "economical feature in the program." 1

To be significant the unit must be important in the learning process. The unit is not a lesson plan. It is usually larger than the lesson plan. It may last six weeks or six days. It is usually a full statement of content and activities, and is planned for general use. It suggests material for development of the lesson plan.

Situations around which units might be developed in the nursing curriculum are numerous: the admission of a patient, the discharge, the diabetic patient, ventilation, care of a patient in a plaster cast, and many others.

Considering for example the situation facing the nurse who is to care for the diabetic patient: (1) the disease itself; (2) the patient's reaction to the disease, his diet, and his confinement; (3) the family's economic problem; (4) the collection, care, and testing of specimens; (5) the estimation of the dose of insulin according to order and results of the test; (6) the care of skin and feet; (7) the diet; (8) the teaching necessary to enable the patient to select and measure his own diet and administer his own insulin. The fields of study touched by this one unit include anatomy and physiology, chemistry, bacteriology, dietetics, materia medica, pathology, psychology, sociology, economics, nursing arts, medical sciences. Undoubtedly as the unit expanded, vital statistics and other fields would be drawn from.

This synthesis of all the knowledge and techniques relating to the diabetic patient into a unified or integrated experience becomes complete for the student when she has opportunity to apply the knowledge and techniques in actual situations. The ward experience is actually the most effective integrating activity in the nursing school curriculum. It is the use of knowledge and techniques which makes them integral parts of character. The effectiveness of the use is, of course, facilitated by classroom teaching but whether or not the student has opportunity to use what she has learned is dependent upon methods of ward teaching.

Sometimes colleges have used a method called the practicum. It is a form of laboratory or field work accompanied by independent study. The study is guided by an outline of activities. If we could adapt this method to ward experience our outline might include the case study, clinics or other demonstrations, and discussions. Of greatest importance in the outline would be the planned practice of nursing care and independent reading and study, the care and study of the whole patient. The nursing care would be graded to provide for increasing difficulty and responsibility as the student progressed. The practice would be well balanced. There would not be a

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large amount of time dissipated in activities which have ceased to have educational value. Every new service would include an orientation period before full student responsibility was expected.

In general education, when courses are organized into units, a culminating activity in which every student shares, is included as an integral part of the unit. Such activities include projects, discussions, examinations, and the like. In the nursing school, we can not ignore the value of the project or the need for examinations. But in our interest in classroom teaching we must not forget that the culminating activity of all teaching in nursing, the most effective integrating activity we possess, is centered in the ward situation.

DEMONSTRATION OF A METHOD OF CLINICAL INSTRUCTION FOR NURSES

ARRANGED BY MARION LEONARD, M.D., Assistant Professor of Medicine and Pathology in Relation to Nursing, and other members of the faculty, and students, Yale University School of Nursing, New Haven, Connecticut

Three years ago we began the laboratory exercise which you will presently see demonstrated with considerable skepticism for its value as an instrument to achieve our objectives. I hope we have lost none of that skepticism. It is still too early to evaluate results—we have recorded our belief \(^1\) that the only method for assaying an educational project is observation of the development of individuals over an extended period of time—but at least we are not discouraged with the apparent trend. Perhaps the most cogent argument, at any rate, to ourselves, since we do not like to believe that we are easily beguiled, is the fact that, after three years' trial, we are quite unwilling to discard our method in favor of any other as yet proposed.

May I briefly review with you what we are trying to do and then we shall proceed to a demonstration of how we try to do it. The decision as to whether we are doing what we are trying to do rests, as I see it, on the social community of the next two or three decades. I might say that this postponement of the final evaluating decision neither implies a subscription to the popular sentiment which puts the "pay off" up to the next generation; nor is an attempt to forestall criticism. Criticism is welcome and I hope we can reply with something better than "wait and see."

We are trying to develop a method of instruction designed to equip professional workers with a point of view as well as a body of knowledge which will enable them to cooperate with other professions toward a better understanding of the problems of human welfare. We are trying to integrate a mass of isolated facts and opinions into a concept of a human being suffering from the experience of a certain disease. We are not trying to

make doctors or psychiatrists out of nurses nor are we trying to displace professional social workers. We believe there is abundant opportunity for useful service by individuals who not only understand the point of view of the specialists and contribute to it by accurate observation but who also have developed their own point of view embracing the interrelationship of the disease, the patient, and the community. We are trying to inculcate the attitude that Dr. Caleb Parry voiced over a century ago: "It is more important to know what sort of patient has a disease than what sort of disease a patient has." We believe that merely advising our students to entertain such a point of view is futile and therefore we are trying in the weekly seminar to establish the habit patterns which we think are desirable.

You will perceive that although the data pertaining to an individual patient are used, the exercise departs from the classical case study method in several particulars. The problem to be presented is not one of extraordinary interest involving clinical opportunities not easily duplicated and requiring unusual treatments or procedures; it is representative of the cases which comprise the main load of a general hospital—each symposium is concerned with one of the prevalent afflictions of human beings. Furthermore, we believe that the painstaking analysis of a patient and his disease should be available for more than a single student and thus the presentation is assumed by at least three students, each of whom is responsible for the careful investigation of a specific facet of the problem. We have learned that the division of the whole problem into specific facets can not be arbitrary, and thus the number of students assigned, or rather invited to participate, will depend upon the particular demands of the case. Participants are always selected from students who have actually had some considerable share in the care of the patient on the hospital wards. Since the patient in person never appears at our seminars, it is possible to select a case for discussion well in advance of the meeting and this allows plenty of time for preparation. At least two weeks before the symposium, a notice is posted on all the prominent bulletin boards of the School of Nursing. It advises all interested, and I might say parenthetically that it seems to include many beside the class that is taking the course, that at 10:30 a.m. on June 6 in the ballroom of the Hotel Roosevelt the case of Mr. John Doe, who is on Ward I, and who is suffering from peptic ulcer will be presented and discussed by three student nurses. It so happens that the three students invited to participate in today's exercise all are members of the first-year class in the Yale School of Nursing. The first student, Miss Katherine Allen, will present the clinical, pathological, and therapeutic aspects of the problem. The second student, Miss Isabel Weber, will be responsible for an exposition of the nursing care and a summarizing analysis of the whole problem in relation to the role of the nurse. Since they chose to take part, these students have had several conferences with the members of the faculty of the School of Nursing and also faculty members of other schools during the past two weeks. These per-
sonal conferences with experts in the particular fields and the independent study stimulated thereby contribute largely to whatever merit the symposium may possess as an instrument of education.

We have been singularly fortunate in having the coöperation of unqualifiedly able consultants from the field of social work, psychiatry, and nutrition. You are probably aware that Miss Elizabeth Rice, Director of the Social Service Department of the New Haven Hospital; Miss Helen Hubbell, Assistant Professor of Nutrition in the Yale School of Nursing; Dr. Lloyd Thompson, Associate Professor of Psychiatry in the Yale School of Medicine, are names to conjure with in their respective professions, as is that of Mrs. Bela Halpert, Assistant Professor of Nursing Arts, in your own.

But it will be apparent to you that the students contribute the major performance at the actual conduct of the exercises; theirs is the responsibility to present the results of their study to classmates and visitors. Today the audience is yourselves and although you are more numerous and distinctly more awesome than the usual one, I am certain you can not be more willing to criticize. It is customary for the student to be bombarded with questions at the conclusion of her remarks. With your indulgence, we will omit this feature today in the interests of time and continuity, but I shall welcome a bombardment when the demonstration is ended.

Excepting this feature, then, and possibly one or two minor particulars, such as the amplitude of our knee vibrations and the degree of mouth dryness, the demonstration today will be a faithful representation of a method of clinical instruction as it occurs once a week in the Yale School of Nursing.

MISS ALLEN: The accumulated results of a large number of post-mortem studies, notably those of Hurst and Stewart¹ at Leeds General Infirmary, reveal chronic ulcers healed or unhealed in approximately ten per cent of the autopsy population. Therefore, since it may be assumed that ten per cent of all human beings suffer at some time or another from peptic ulcer, the knowledge of the cause, course, and the treatment of the condition assumes considerable clinical importance.

Although no age group is exempt, chronic ulcers occur most commonly in young adults and in middle age. The ulcers are limited almost entirely to the region of the pylorus, although rarely in the pyloric canal itself, and are usually single. Certain people appear to have an inherent predisposition to the condition—these individuals being as a rule nervous and high-strung, and giving frequently a history of ulcers in other members of their families.

Considerable evidence substantiates the belief that chronic ulcers originate as acute ulcers which for one reason or another have failed to heal. The digestive action of highly acid gastric juice seems to be an important factor. It is highly significant that ulcers occur almost without exception in those

¹ Hurst, A. F., and Stewart, M. J. *Gastric and Duodenal Ulcer*. Oxford University Press, London, 1929.
portions of the stomach and duodenum which are habitually bathed in acid chyme. Concerning the cause of the primary lesion which makes way for the action of the gastric juice many theories have been suggested. The factor of infection must be considered for it is known that toxins produced locally or carried from the focus of infection by the blood stream are destructive to mucous membrane. Mechanical irritation of food and the habitual use of chemical irritants such as vinegar and alcohol may aid in the process of ulceration.

In a chronic ulcer actual erosion occurs and the layers of the stomach wall are destroyed, usually to the mucosa and often on to or through the serosa. An inflammatory process proceeds with its associated exudation. Necrosis takes place and is followed by healing with fibrosis. The overproduction of scar tissue and its subsequent contraction results in distortion of the walls involved.

The symptomatology of a patient suffering from chronic peptic ulcer presents a fairly typical picture. According to Dr. Bloomfield, the indigestion associated with peptic ulcer is not necessarily distinguishable from that occurring in individuals with other organic lesions or with only functional disturbances. However, epigastric distress occurring in periodic attacks is considered to be characteristic of ulcers. This gnawing, boring, burning sensation follows at varying intervals after meals and is relieved by food. Vomiting attributable to pyloro-spasm is a symptom in a large proportion of cases. There is loss of weight as might be expected from vomiting as well as from voluntarily restricted diet. Hematemesis, without which there was formerly believed to be no accurate diagnosis, is now known to occur in only twenty per cent of the cases. Constipation is usually present, while melena varies in amount from traces so minute as to be discovered only through chemical examination to gross hemorrhage revealed by tarry stools. Anemia may be the result of persistent bleeding. Gastric analysis in the majority of cases shows hypersecretion of gastric juice with a highly acid content.

In the treatment of uncomplicated peptic ulcer it must be emphasized that each patient suffering from the disease presents an individual problem. It is a recognized fact that psychic contentment is far more important than bodily rest. Thus, although it is highly desirable to require an initial period of bed rest, ambulatory treatment is preferable to the mental worry and psychic disturbance brought about in some individuals by enforced inactivity which is upsetting to them for various social reasons. The personality make-up of certain restive individuals is also contra-indicative of restraint. The ideal treatment of the disease must be modified to fit the requirements of the patient suffering from the disease. Statistics from large clinics indicate that 85 per cent of individuals suffering from peptic ulcers respond to ambulatory treatment within ten days. If such is not the case, rest in bed should be ordered.

Much of the therapy for this condition rests in proper dietary management. The indicated diet is one which will inhibit the hypersecretion of gastric juice and neutralize that with which it combines. It consists of small frequent feedings relatively high in protein and fat content, and it is made up entirely of bland foods free from mechanical, thermal, and chemical irritants. Gradual increase in amounts and variety of food and decrease in number of feedings accompanying progress. The caloric need of the individual as well as his protein, mineral, and vitamin requirements must be met. The diet is made as palatable as possible with particular regard to personal likes and dislikes. The modified Sippy\(^1\) diet used at the New Haven Hospital is a convenient one which adequately meets the requirements. It consists of hourly feedings of milk and cream to which soft eggs, crisp toast, well-cooked cereals, and orange juice are added depending upon the response of the patient. Further variations of bland foods in increased amounts given at longer intervals accompany improvement. Spices and condiments, strong tea and coffee, meat extracts, and coarse cellulose are omitted.

The diet is at times supplemented by the administration of alkaline salts in the intervals between feedings. After a brief period their effect is to stimulate production of free hydrochloric acid, and therefore their usefulness is definitely limited. If the patient is under proper dietary management, there seldom will be need of large amounts of such salts, but an alkaline powder containing magnesium oxide is frequently of great value when given in small doses for its mild laxative effect. With the administration of large doses of alkali the danger of alkalosis must not be overlooked. Symptoms such as loss of appetite, depression, nervousness, headache, nausea, and vomiting are recognized danger signals.

The proper treatment consists of discontinuing all alkalies and the administration subcutaneously or by rectum of glucose and saline for the purpose of overcoming dehydration, provoking diuresis, and replacing the deficiency of salt in the blood. For the treatment of constipation which ordinarily accompanies peptic ulcers, enemas are used with success in the early stages. Later milk of magnesia, magnesium oxide, or mineral oil to which cascara may be added as necessary are used in preference to more drastic measures which might tend to produce hemorrhage.

In addition to the use of alkalies and cathartics, the administration of belladonna is valuable for its anti-spasmodic action and for the purpose of further inhibiting the secretion of hydrochloric acid. Since infection is thought to be a factor any foci which might be construed to be the inciting cause of the primary lesion should be eradicated. As tobacco and alcohol are important accessory gastric irritants they are omitted during treatment.

By the aid of biochemical investigation and radiological studies as well as the regression of symptoms, it is possible to determine the length of time treatment should continue. Since recurrence is the rule rather than the ex-

\(^1\) Sippy, B. W. Gastric and Duodenal Ulcers. Journal of American Medical Association 64, pp. 1623-1630. 1915.
ception in peptic ulcer, the patient must be taught the tremendous importance of following his diet conscientiously for the rest of his life. The proper diet is not extraordinary. It consists of three bland meals a day, the only great differences from a normal diet being the omission of highly seasoned or coarse foods, chemical irritants, and the addition of three extra nourishments a day, one in the a.m. one at mid p.m. and a third before retiring. Dr. Sullivan^ has stated that with the permanent modification of dietary habits and the discontinuance of all alcoholic beverages a patient who has recovered from active peptic ulcers has only a fifteen per cent chance of recurrence, whereas without permanent modification it may be 40 to 50 per cent.

Chronic ulcers can be controlled by strict adherence to diet and by medical treatment, but if the accepted régime is not followed conscientiously certain complications may result. Hemorrhage occurs in approximately twenty per cent of the cases. It is true that most ulcers probably bleed at one time or another, the amount depending upon the size of the blood vessel eroded. If the erosion of an artery or large vessel takes place, bleeding will be profuse and sudden with hematemesis, and with the appearance of blood in the stools. Following the loss of large amounts of blood, symptoms of shock will be manifested and these require prompt treatment. Complete immobility is the most important factor in the control of hemorrhage since the aim is to keep the blood pressure low to prevent dislodgement of clots of blood which may have formed. The patient is put immediately in bed and kept quiet by the administration of morphine to which atropine is added to reduce the secretion of gastric juice which might digest a clot. Everything is stopped by mouth, and it might be added that cracked ice is "something." Fluids are administered by rectum or subcutaneously and ice bags are applied to the epigastrium. Feedings are reintroduced twenty-four to forty-eight hours after the hemorrhage has stopped, and are increased in quantity if no untoward symptoms result.

A second relatively common complication is pyloric obstruction which may be of two types. Permanent obstruction due to stricture by scar tissue left by the healing of an ulcer is relieved only by surgery. The temporary type, caused by spasm, congestion, and edema in the active process of ulceration, responds to medical treatment. When symptoms of obstruction appear, medical treatment is tried, but if such a procedure fails to gain response, surgical intervention is necessary.

The most dreaded of all complications is perforation. This rapid process which is due to the sudden sloughing away of an unsupported portion of the floor of the eroded area usually takes place in the anterior wall of stomach or duodenum near the pylorus. The initial symptoms of severe generalized abdominal pain accompanied commonly by vomiting, extreme rigidity and tenderness of the abdomen are due to actual perforation and the spilling of

the irritant gastric contents on the walls of the peritoneum. The recognition of these first symptoms is of utmost importance since it is at this time that an emergency operation must be done to prevent peritonitis.

In summary of the treatment of chronic peptic ulcers we may state that uncomplicated cases are chiefly a medical and dietary problem, but with the presence of complications prompt surgical intervention may be necessary. We reiterate at this point the absolute necessity of strict adherence to dietary régime following the healing of an ulcer, for as we have indicated we are dealing with a chronic disease which is more than likely to recur.

Mr. John Doe, the patient to be presented today, is a fifty-two-year-old white man who has suffered from a chronic peptic ulcer for a period of five years. His symptoms of intermittent attacks of indigestion characterized by vomiting and pain, which were relieved by food, exemplify the typical picture of the symptomatology of peptic ulcer. He had been followed by the Medical Clinic of the New Haven Hospital for two years and during this period had been kept practically symptom-free by diet and the judicious use of drugs. It is of great significance that for a period of two months prior to his admission to the hospital he had not been following his prescribed régime due to social reasons which will be discussed by Miss Marshall.

The patient was admitted to the New Haven Hospital as an “emergency” in the early morning having been awakened by severe abdominal pain. He reported that he had been vomiting almost constantly for several days. At the time of his admission he was vomiting large amounts of blood. Because he exhibited the symptoms of shock with low blood pressure, rapid pulse, cold perspiration, thirst, and palpitation, emergency treatment was immediately instituted. Shock due to hemorrhage is the result of a sudden loss of blood volume, the physiological problem involved being a disparity between blood volume and vascular bed. The ideal treatment calls for a large blood transfusion to supply the obvious need of restoration of blood volume. As an emergency measure an intravenous injection of 50 cc. of 50 per cent glucose was given, which temporarily withdrew fluid from the tissues into the blood stream, and then an infusion of 2,000 cc. of normal saline was begun. The hemorrhage was controlled by putting the patient at rest with morphine, by stopping everything by mouth, and by the application of ice bags to the epigastrium. When the bleeding had stopped, the patient was started on his ulcer diet consisting of milk and cream and the administration of belladonna whose antispasmodic action has already been described. Alkaline powders, mineral oil, and small enemas of tap water were given for the control of constipation. Ferric ammonium citrate was used for the secondary anemia which had resulted from the considerable loss of blood.

As improvement was noted within the following days, the diet was modified to contain such bland foods as soft eggs, crisp toast, and cream soups in addition to the milk and cream. However, within two weeks the patient’s condition regressed as severe vomiting began. Roentgenological studies con-
firmed the suspected diagnosis of pyloric obstruction. Due to the fact that the patient had been on strict dietary and medical régime since his admission with an unfavorable response, surgical intervention was indicated and a subtotal gastrectomy was performed. The postoperative régime consisted of very small frequent feedings for the protection of the area which had been operated upon together with general supportive treatment. His satisfactory progress warranted relatively rapid change to larger and less frequent feedings of more varied foods. By the time he was ready to be discharged the patient was taking three bland meals a day with intermediate nourishments. With adequate provision for such a diet, the arrangements for which will be made clear to you by Miss Marshall, the patient was dismissed.

We have chosen Mr. John Doe since he presents the classic picture of a patient suffering from chronic peptic ulcers, with typical history, symptomatology, course, and complications.

**Dr. Leonard:** I have little to add to the presentation of clinical pathological and therapeutic aspects of peptic ulcer, which you have just heard. Miss Hubbell will probably mention some of the special problems arising in connection with the dietary treatment of the condition, and as Miss Allen has stated, much depends on proper dietary management.

Two points might be mentioned about medications. A medicine can not be considered given unless there is reasonable belief that it is absorbed. If a patient suffering from peptic ulcer is vomiting, the fifteen drops of belladonna, or whatever dose may have been prescribed, might just as well be poured on the floor as into a patient's mouth. In such a situation we must resort to parenteral routes of administration. Belladonna can be given by rectum but it is easier and certainly more effective to give atropine, its active alkaloid, by hypodermic injection. Miss Allen mentioned the administration of salt, water, and glucose by rectal installation. There is no doubt about the absorption of salt and water thus introduced, especially if the body has need for them, but the absorption of glucose through the rectum is a decidedly controversial point. Investigators agree that if any glucose at all is absorbed it is in quite insignificant amounts. Glucose proctoclyses are still given in many hospitals—it is one of those vestigial procedures which are strangely difficult to cast off—but at least we can put our tongues in our cheeks during the useless performance.

On the other hand, it is interesting to note how some valuable procedures may be discarded. One hundred and six years ago a certain Dr. O'Shaughnessy of England published his studies on the nature and treatment of shock. For over eighty years they were altogether disregarded and not until recently has the proper management of salt and water depletion and the ensuing circulatory shock been generally familiar to the practitioners of our professions. A great deal of credit belongs to Dr. Dana Atchley1 of the

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Medical Center here in New York, not only for extending O'Shaughnessy's studies of a century ago but also for educating us in their significance to the desperately sick and vomiting patient.

Miss Hubbell: The modified Sippy diet previously described is only one of many which have been found useful in the treatment of peptic ulcer. One of the earliest used is the Leube\textsuperscript{1} diet which includes peptonized milk and refined cereal during the first two weeks. Lenhartz\textsuperscript{2} advocates iced milk and as many as eight eggs a day. Tender meats and fish are permitted after four or five days. The Coleman\textsuperscript{3} diet calls for 150 cc. of olive oil and five to six egg whites during the early stages. Despite the variety of foods included in these diets they all have more or less the same objectives, to keep the patient free from pain and allow the ulcer to heal with as rapid a transition to a more normal diet as possible.

But more and more emphasis is being placed on the development and maintenance of good nutrition which can only be accomplished by making the diet adequate with respect to all nutrients. This is not as easy to do as it would seem. Probably one-third or more of the iron is lost in the puréeing of fruits and vegetables, and it is only recently that rich sources of vitamin C, such as oranges and tomatoes, have been permitted.

However, one can not merely present such an uninteresting dietary with its daily repetition of milk, eggs, creamed dishes, and refined starches to a patient, and simply say, "Eat this, please." Think of the adjustment an Italian must make, whose diet has been rich in fried foods, peppers, and seasonings; or the patient who came into the hospital giving a history of a daily consumption of one-half pound of candy and a bag of peanuts just before supper. The very fact that the cream and milk mixture forms such an important part of the day's diet would given concern to many a patient with a low income. The development of the right attitude towards diet on the part of the patient can be markedly influenced by the nurse's understanding of his dietary history.

Miss Marshall: Peptic ulcer presents very definite social and psychiatric problems to the patient. Perhaps the most tangible problem is that of the special diet which is more expensive than ordinary diet, and which requires certain equipment such as adequate cooking facilities and an ice box in which to keep milk and other perishable supplies. Because thorough mastication plays such a part, the patient's teeth must be in good condition. This may necessitate dental repair or the provision of dental plates which he may not be able to purchase without assistance.

Before leaving the hospital the patient must understand his dietary régime consisting of the right type of foods, correct preparation of it, and regularity

\textsuperscript{1} Leube, W. A. Die Krankheiten des magen und darms. Ziemssen's Handb. d. spec. Path. u Ther. 1876, vii, Holle n ii, pp. 81-117.


of meals. The patient’s ability to purchase the diet should be checked and if found lacking, financial assistance secured. The patient must have sufficient intelligence, willingness, and ability to carry out his dietary régime because of its extreme importance in the treatment of the disease. This depends largely on the personality of the individual patient. In order to secure cooperation the seriousness of the condition must be explained to the patient, but this must be balanced by a consideration of the possibility of producing hopelessness and anxiety.

When the patient resumes his normal activity his work must meet the recommendations of his doctor. Light jobs are often recommended in which no straining or lifting is involved. In considering the job, it is necessary to know what the man actually does during the working hours rather than just the classification of his occupation. The special diet to be secured during the working day presents difficulties; for it is necessary that the patient be free to take a recess of fifteen or twenty minutes midmorning and midafternoon for his nourishment. His meals, too, must never be hurried and should be regular.

There may be habits such as alcoholism and smoking which it is advisable that the patient overcome. Good habits of food hygiene should be built up before leaving the hospital. Medical follow-up in all cases is imperative. Therefore, if the patient for any reason moves to another community provision for medical care would have to be made.

Worry, anxiety, and fear produce definite physiological disturbances in the gastro-intestinal tract as well as in other organs. Loss of appetite, constipation, and even nausea and gas formation may be produced by a state of anxiety. The leptosomic type, the long, very thin person, so often associated with peptic ulcer is usually the type given to introspection, nervousness, and worry. In such a case complete rest—mental and physical—is harder to accomplish than it would be in other types of individuals. The cause of worry should be sought for and found, then removed. If removal is not possible, then the patient's point of view toward that worry should be changed. It has been shown that peptic ulcers recur with stress and strain such as severe financial worry or a pushing business drive. The cause of such is twofold—the actual physical drive and activity plus mental strain and worry.

John Doe is a single, fifty-two-year-old American citizen. He was born in Connecticut of Irish parentage. His father has died and nothing definite is known of the whereabouts of his mother, brothers, or sisters. The patient completed the sixth grade and left school to work in several textile factories earning small wages. He has followed various manual trades. From 1919 until three years ago the patient laid underground cables in this community for a public utilities company and earned an average wage for an unskilled laborer. Since then he has had only odd jobs. The patient has a good work record, and his unemployment is due to the fact that cables are not being laid at the present time.
He never married and during his fourteen years' residence in New Haven he has stayed at the same respectable boarding house which is managed by a friend, a widow with two sons. Here the patient occupies a single furnished room and, since his irregular unemployment two years ago, he has been receiving his meals in exchange for the work he performs about the house. The landlady is a kindly, intelligent woman who has willingly befriended her roomers when they were unemployed. She allows no drinking. The house, situated in one of the better rooming house sections in New Haven just two blocks from the hospital, has fourteen rooms, nine of which are rented to men, several of whom have been there for a number of years.

Mr. Doe's financial situation is as follows: his small savings have been exhausted, and at the present time he owes about $300 for lodging. He has no insurance. The responsibility for his hospital bill has been assumed by the Department of Public Charities. It is important to note that for several months prior to the patient's hospitalization the additional milk in the special diet had not been secured because the patient was working irregularly, could not afford to buy it, and the landlady could not provide it.

The interests of Mr. Doe are few and are chiefly those which can be carried on by himself, such as reading papers and magazines and helping around the house. He has a fair level of intelligence. Life in the boarding house was apparently his only source of amusement. He has never belonged to clubs and apparently does not mingle to any extent with others. He does not drink and is quiet and orderly about the house.

He is an introspective person apparently unable to give and very inclined to reject the world. He is cool and self-centered without very much emotional display. Reticent to talk about his affairs, he gives the impression of forming strong likes and dislikes. He is nervous and inclined to worry although denying that he does. His attitude toward his unemployment is one of bitterness, feeling that the older men are being replaced by younger ones and that one can not expect an employer to take a personal interest in an employee.

Nothing whatever is known of the patient in relation to his family except that many years ago there was a misunderstanding and they consequently separated. He seems to feel closer to his landlady and her family than to anyone else. One would judge from her that her children have a kindly feeling toward him, perhaps because it was through the patient that her elder son secured employment. Because the patient is dependable, she has had him help her maintain order because she felt she could always call upon him. At the present time she is glad to do what she can in order to repay him for past kindnesses to her and her children. She has visited him in the hospital on an average of once or twice a week.

The social problem seems to be, therefore, that of a single middle-aged man estranged from his family, with few interests and resources living upon the kindness of his friend. The patient is in immediate need at discharge
of a place to go, a special diet, employment, good physical and mental
hygiene, and further medical supervision.

His medical recommendations at time of discharge were:
1. Modified ulcer diet
2. Clinic attendance
3. Limitation of activity for a month, then light work for several weeks
before returning to his usual occupation.

Through the social service department the social problems were outlined
and met in the following ways:

1. A place to which to return.
The landlady agreed to take the patient back and to provide the diet if
she were reimbursed for this.

2. Provision of the diet.
   It was necessary for the social worker to interpret the need for a special
diet to the Department of Public Charities which agreed to provide the diet,
the cost of which was to be three dollars and fifty cents per week. This is
higher than the usual cost allowed single men.

3. Interpretation of diet régime to the landlady.
   Arrangements were made for her to discuss the diet with the dietitian
before the patient was discharged.

   This has been taken care of only in part—his hospital bill, special diet, and
room rent have been arranged for from public funds but the unemployment
situation has not been solved for two reasons: (a) The patient is now on
limited activity for one month and the work he does in the lodging house
is sufficient for this period of time; (b) Because of the general unemploy-
ment situation, it will be difficult for the patient to secure work due to his
age and physical condition which make heavy work undesirable.

5. Establishment of habits (mental and physical).
   The patient has a more objective attitude toward his unemployment but
will need to have his morale strengthened. His physical habits except for
tobacco, which is contra-indicated by his disease, are good. His dietary
régime is well established.

6. Medical care.
   The patient will be supervised through the clinic by the physician and
dietitian. The proximity of his home to the hospital makes this readily pos-
sible.

   The question of what will be a permanent plan for the patient is proble-
matic because:

1. The present arrangement is entirely dependent upon his landlady
   whose children later, probably, would not feel the same obligation which
   she does.

2. His age, lack of skill, and the present economic situation would likely
   preclude further steady employment even if his physical condition permitted.
3. Lack of resources within this community for adequate extended care to meet this problem.

Thus a practical arrangement has been made temporarily for this patient so that his medical régime can be adequately carried out. The future problems inevitable with a patient of this type must be met as situations arise. Therefore, the medical social worker will continue as an advisor to the patient. His dietetic care will be supervised by the clinic dietitian and his medical care by the clinic physician.

Miss Rice: In considering the social aspects of peptic ulcer, and this case in particular, there are several points which I would like to emphasize:

First—in relation to peptic ulcer in general.

The problem of special diet brings up three important considerations:

1. The importance of making certain that the patient and the person who is to arrange the patient’s diet understand explicitly not only what the diet is, but why it is so important that the diet be given. This means that before the patient leaves the hospital, he and, in this case his landlady, should be taught the diet. There should be no lapse in securing the required foods after the patient leaves the hospital.

2. The necessity of checking constantly with the patient to make certain he is still able to secure the diet. This is especially important in cases of peptic ulcer which, as has been explained, will need special dietary régime over a long period of time. It is not sufficient to make certain once that the patient can have the required food but this should be constantly checked. This is more necessary today because of the instability of income which allows the patient to provide the necessities one month but possibly not the next month.

3. The difficulty of adjusting the home régime of a single man in a lodging house to a special diet is such that immediately the social aspects of this problem should be studied. The problems of preparation of food, of equipment for refrigeration, of regularity of meals, of variety in diet all come to the fore in this particular disease.

4. The advisability of remembering that after all plans are made and the wherewithal provided that there will be certain recalcitrant individuals who because of lack of "stick-to-itiveness"—a real character lack—can not be counted upon to play the game fairly. However, one should be sure to have ruled out the more tangible obstacles before resorting to this discouraging conclusion.

Second—in relation to this particular case.

1. The importance of removal of worry has been referred to. In this particular case, that worry was largely financial but I wish to emphasize that worry may be due to other reasons than financial, reasons which are more difficult to determine because less tangible and less definite, but may be even more insidious in their results. It is, therefore, usually important for such
cases to have a careful social study made by the social worker to determine these causative factors.

2. The necessity of making clear to a relief department from which additional money is requested for the patient's diet exactly what the diet consists of, the cost above a normal diet, and how important the diet is in the patient's medical care. With this clearly stated by the person referring the need to the relief department, most relief departments will understand and will allow extra money for the diet. It is unintelligent to expect the relief department to take on this extra expense without such an interpretation.

3. The possibility of using the public health nurse or the nutritionist of a public health nursing organization in such cases is a resource to remember. In this case this was not necessary because both the patient and his landlady had been adequately instructed by the hospital dietitian, but in cases where this is not done, or where it is necessary to supplement the instruction, this is a most valuable resource.

Miss Marshall's presentation, I am sure, made clear that there are several possible social problems to be considered if the treatment of a case of peptic ulcer is to be effective.

DR. THOMPSON: At the risk of a little repetition I would like to emphasize again the physiological disturbances; especially those related to gastro-intestinal functions that may occur in emotional states such as anxiety. The diminution in saliva during stage fright and the loss of appetite and constipation of the chronic worrier are commonplace examples. Throughout the digestive tract secretion and motility may be inhibited or accelerated.

Cannon has given us a scientific background for such statements in his book. Henry has shown by X-ray studies that in cases of depression with anxiety motility of the lower bowel is diminished. The contribution of Cushing to the neurogenic theory of causation of peptic ulcer should be mentioned. For years Cushing had noted occasional acute perforations of the stomach wall following certain operations at the base of the brain. These observations led to the suggestion or theory that since emotions are mediated through basal brain structures it may be that chronic emotional states acting on these basal structures produce some changes in the gastro-intestinal wall.

In psychiatric practice we see many cases of anxiety states with symptoms simulating peptic ulcer and sometimes the differential diagnosis is extremely difficult. The point is that our present knowledge indicates that relief from worry or anxiety is of considerable importance in the treatment of peptic ulcer. This is particularly true in serious cases where hemorrhage or per-

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foration is imminent. Then tranquility and confidence in the nurse is essential.

In regard to the patient under consideration, I must say that he is an excellent example of leptosomic physique. In spite of a superficial appearance of a fair social adjustment, the history and our observations indicate that he is an introspective, sensitive, and somewhat cool individual without much inner emotional resonance. Because of this innate endowment he has been unable to make emotionally satisfying contacts with others. He left his family early in life and has had very little to do with his relatives since then. He didn't join the army and he never belonged to churches or lodges. Apparently marriage was never seriously contemplated. His only friend is his landlady. It would be interesting to know his early attitude toward his mother because this might give us some idea of his attitude toward women in general and the nurse in particular.

Alexander¹ in a psychoanalytic study of cases of peptic ulcer came to the conclusion that these people have one common characteristic, namely, an unsatisfied wish or desire to receive from others. Their rejection of the world or their lack of capacity to receive may account for this. Since the stomach is essentially a receiving organ this theory is at least a very interesting one and the patient under discussion obviously illustrates this theory. He illustrates also the fact that an understanding of the total personality and not just those organs concerned with digestion will produce more efficient and intelligent nursing.

Miss Weber: In order to care for a patient with a peptic ulcer skillfully and sympathetically the nurse must know the characteristics of the disease, must realize that the course is long continued, the treatment may become monotonous, and must consider that the patient's individuality always colors his reaction to the disease.

Mr. Doe had been treated in the medical clinic for two years and had adjusted himself to the situation of a chronic illness, but because of various social reasons he had broken away from his dietary régime and found himself in difficulties. When severe abdominal pain and vomiting occurred he came in the early morning to the emergency room of the hospital. This was a dramatic episode in his illness and he needed prompt attention, sympathy, and reassurance.

After the preliminary examination by the doctor, the patient was transferred to the medical ward and treatment was started at once. The first nursing notes on the chart reported that he was restless, his skin was cold and moist, he was nauseated, vomiting blood, and his pulse was 110—all these were signs of hemorrhage. To prevent shock, the foot of the patient's bed was raised. He was kept warm with extra blankets and hot water bottles which the nurse tested to meet the required temperature of not over 120°. His bed was kept smooth and dry with fresh linen. Ice packs were applied

constantly to his epigastrium. His blood pressure and pulse were taken accurately every fifteen minutes and charted immediately on his graph. If there had been any change of five to ten points, the nurse would have reported it at once to the doctor.

The doctor started a transfusion of 500 cc. to increase the volume of blood. An intravenous injection and hypodermoclysis of 1,000 cc. each were given in order to supply the tissues with fluid since nothing was allowed by mouth. Small amounts were used at a time to avoid raising the blood pressure sufficiently to renew bleeding. The nurse prepared the equipment for these treatments, obtained the right solutions of normal saline and 5 per cent intravenous glucose, and kept them at body temperature during the treatment. She prepared the areas of skin for the injections and massaged away from the clysis needles while the fluid was being absorbed.

For several days the patient was kept absolutely at rest. The doctor's orders required that he lie flat. We did not turn him for back rubs nor to change his bed. He was raised by one nurse, and another rubbed his back from beneath. Fresh pads were slipped under him. If there had been a blood clot, moving might have dislodged it. The doctor ordered the omission of the routine bath for two days so we made the patient comfortable with the minimum amount of effort on his part. Since sleep is one of the best methods of obtaining rest, the patient was watched closely at night for signs of restlessness and when he needed it, codeine gr. 1/2 was given. During these first days the nurse tried to secure utmost confidence from her patient by being quiet and capable in her attitude and nursing care. Whenever she left the patient, she placed the bell cord conveniently within reach so he could signal for her return without delay.

Since his gastro-intestinal tract needed rest for several days, nothing by mouth was ordered. Special care was given with lemon juice and glycerin every few hours to keep his mouth pleasant. This patient had an upper false plate and although at first he felt it was imposing on the nurse to allow her to wash it, he learned to appreciate her care. He breathed through his mouth and we noticed that his lips became dry, so we applied white vaseline.

Close observation of the patient was important, especially during these first days. He was vomiting coffee-ground material and his pulse rate and temperature continued to be elevated. All feces and vomitus were observed and saved and if any fresh blood or tarry stools had been noticed the doctor would have been notified immediately.

By the third day the patient was allowed to turn. He had been on his back so long that his back and bony prominences needed not only a cleansing bath but special care with castor oil and zinc stearate. The reddened areas were rubbed with extra care and any excess pressure was prevented by the use of small pillows under his shoulders and the curve of his back, by applying pads of cotton and gauze around his joints, and by placing a rubber ring under his buttocks. The ring was turned often and the cover changed because he complained that it got so warm.
By considering his special desires we tried to make the patient happier. We made an effort to regulate the lights, window shades, ventilation, and extra blankets before he asked for them. He worried if his urinal was not kept in his stand. Every time it was emptied we made an effort to return it without his mentioning it. Mr. Doe had a special way of combing his hair by wetting it with a dampened wash cloth. After I learned his method, I tried to remember it every morning without his reminding me.

The nurse may help to prevent visitors from tiring the patient by tactfully suggesting to them not to stay too long and not to discuss matters which might worry him. This was not a particular point with this patient because only his landlady who in his terms was "the best woman on earth" came to see him. On one of her visits, I inquired about Mr. Doe’s diet and she informed me she had had a conference with the dietitian and understood about it. She told me, too, that the patient had given her his copy of the ulcer diet bulletin which he had obtained from the medical clinic.

When fluids were begun by mouth belladonna was given to relieve pylorospasm. We watched the patient closely as drops of this medication were increased from five to fifteen three times daily. We described to him the symptoms which he might expect from this drug. Had he developed excessive dryness of mouth, dilated pupils, flushed dry skin, extreme thirst, hoarseness, or rapid pulse we would have reported it at once to the head nurse, as well as described these symptoms in the patient’s chart, before the dose was repeated.

On the third day after admission the patient began his peptic ulcer diet régime. From his care in the out-patient department he was already familiar with the importance of small frequent feedings so primary teaching was not necessary, but the opportunity was seized to reiterate that the success of his diet depended on his eating regularly and slowly, chewing thoroughly, and avoiding anything mechanically, chemically, or thermally irritating. This patient liked to smoke but accepted the restriction when it was explained that tobacco was not conducive to the healing of his ulcer. He was started on 30 cc. of equal parts of milk and cream given every hour and gradually worked up to a 90 cc. feeding. We were cautious about giving the right amounts at the right time because habits of regularity established by the nurse are carried over by the patient. Mr. Doe was quiet and uncomplaining but alert to the importance of his diet and he would remind the nurse if his feedings were not punctual. Because this diet tended to be constipating, he received one Sippy A powder daily. This consisted of ten grains each of magnesium oxide and sodium bicarbonate and acted as a laxative. This took the place of small enemas which had been necessary at first.

The patient’s reactions to his feedings and his refusals were charted, and as he responded to therapy, his diet was increased. When vomiting had ceased, additions were made to the milk and cream feeding. No feeding was to exceed 180 grams. On alternate hours 90 grams of cereal, strained creamed soups, soft cooked egg, puréed vegetables, mashed or baked potato,
custard, or jello were added. Orange juice helped to provide vitamin C and water was supplied freely. Because ice water gave him cramps, tap water was kept at the patient's table within his reach. We discovered he could drink more easily through a glass tube and we tried to keep this clean. A moderate amount of salt was added in cooking of all foods, but the salt shaker was omitted from his tray. Mr. Doe was six feet, two inches tall and was poorly nourished, weighing 120 pounds when he should have weighed 180. His diet provided for 3,000 calories. With bed rest reducing the quantity of food necessary to meet energy needs, it allowed him to gain.

The repetition of the same foods and the lack of seasoning becomes monotonous. The nurse had the opportunity of serving the meals as attractively as possible and discovering his special preferences. I found out that he did not like his eggs undercooked so I made a note on his diet card that the other nurses would notice, and I reported to the dietitian his dislike for carrots and his fondness for peas. Fortunately, with this patient there were no complaints about the milk and cream feedings, but if he had not liked milk or had become nauseated, thin gruels, peptonized milk, or junkets could have been substituted.

About the eighth day the patient was allowed to take his own bath. We tried to save him by placing the equipment for his bath conveniently and reminding him to take his time. As the patient improved, the nursing care assumed a new aspect. We wanted to keep him not only physically comfortable, but occupied and cheerful. He did not like to talk about himself, but seemed informed about every subject opened and entered politely into conversation. He described his landlady's flower garden, her "begonias and petunions," as he called them. He did read the daily paper and discussed current topics easily. He was fond of mystery stories and read books obtained from the hospital librarian. Because he had a tremor of the hands, it was easier for him to read when I put the book on the over-the-bed-table.

On the tenth day the patient was allowed out of bed. We changed his environment by taking him in a wheel chair to the solarium. By now he was smoking in limited amounts and for financial reasons he rolled his own. An additional nursing problem arose—that of keeping his unit free from tobacco.

After the patient had progressed favorably according to all clinical examinations, we noted that he began vomiting again and his stools showed evidence of blood. As soon as signs of hemorrhage had stopped the doctors directed that Mr. Doe have a gastro-intestinal series. We prepared him for X-ray by seeing that no purgative nor enema was given the night before to alter peristaltic action and by omitting food and water on the morning of the first X-ray. An effort was made to prevent worry on the part of the patient by explaining to him that this procedure was necessary and by promising as little discomfort as possible.

The X-ray showed pyloric obstruction and it was decided to operate at once. The patient became quite worried and nervous. His apprehension
subsided somewhat when he was reminded that the chief surgeon was to operate on him. He was prepared for his transfer from the medical to the surgical ward with the assurance that he would not be far away in the adjoining building and would receive the same care. His nurse escorted him to the operating room and stayed with him until the anesthetic was started.

After a subtotal gastrectomy had been performed, the patient was sent to the surgical ward. The nurse here carried out the postoperative orders of blood pressure, pulse, and respirations every fifteen minutes for two hours and then every thirty minutes for two hours. Morphine gr. 1/4 was given every four hours as it was needed to relieve pain and quiet the patient. Measures were taken to prevent any upper respiratory infection by turning the patient from side to side frequently and by giving routine carbon dioxide and oxygen inhalations for forty-eight hours followed by a blow bottle which required the patient to breathe deeply and expand his lungs. After the patient was conscious he was placed in Fowler’s position.

The fluid intake was increased as before with proctoclyses of tap water, 300 cc. every four hours, hypodermoclyses of saline, 750 cc., and infusions of 5 per cent glucose in the amount of 250 cc. Including both preoperative and postoperative treatments, this patient had seven infusions, seven transfusions, and ten clyses.

As before the operation, rest and comfort were special considerations. His progress was complicated by continued vomiting and abdominal distress. When these were reported to the doctor a continuous lavage was set up to wash out his stomach. The nurse observed the return flow, watching particularly for blood, and kept the tube free from obstruction by frequent irrigations.

The patient was disoriented postoperatively and the nurses were vigilant that no bodily harm should come to him. All his needs, especially at night, were anticipated lest in his confusion he try to get out of bed.

I observed his abdominal dressing for any bloody or other discharge. If the patient had complained of any pain around his wound or we had noted any rise in temperature such symptoms would have been reported because they might be signs of infection.

Mr. Doe’s postoperative course continued satisfactorily. There was no elevation of temperature after two days, his abdomen remained soft, and his incision healed. The patient had no complaints and there was no blood in his stools. For ten days he was on a special postoperative diet which allowed for motor rest of the stomach by small amounts of nonirritating foods given frequently and gradually increasing from one-half ounce to three ounces every hour. The patient advanced to the same diet he had had before his obstruction. After five days of favorable response to this treatment he was discharged on a diet consisting of six feedings of bland food—three meals including such foods as scraped beef, minced lamb, white fish, well-cooked vegetables, and a variety of desserts as puddings, custards, ice cream, and jello, and three intermediate nourishments, such as weak cocoa, eggnog, or
creamed soup. It was a diet adequate in the essential food constituents and with sufficient calories to allow him to gain weight.

My experience in nursing Mr. Doe has clarified for me the essentials in the care of any peptic ulcer patient:

First, the importance of observation of the patient and reporting of his symptoms. This includes subjective symptoms such as nausea, pain, the patient’s mental attitude, and it includes objective symptoms as signs of hemorrhage, vomiting, and his reactions to the diet and medications. Specimens particularly must be observed. All vomitus and feces are to be saved and a report made promptly if anything unusual appears.

Second, the correct treatment for peptic ulcer. This includes giving the right diet and medications at the proper time. The nurse serves the diet attractively, encourages the patient to eat all given him, and attends to his special preferences. Special treatments might be necessary, such as those indicated by complications of hemorrhage, pyloric obstruction, and perforation.

Third, the importance of the formation of good hygienic habits both physical and mental, for the patient while he is in the hospital.

Fourth, teaching the patient. He should be taught the importance of a permanent diet régime, to avoid infections, to take special care of his teeth, to avoid constipation, to establish hygienic habits, and to get plenty of rest. The nurse should stress the necessity of follow-ups at the medical clinic and make sure the patient understands about them. She should acquaint him with the possibilities of the visiting nurse service which is available if he needs home nursing at any time.

Fifth, the importance of making a program possible for the patient. In the case of Mr. Doe, all the agencies concerned co-operated to provide him with a home, care at home with financial support, with medical care, and with an understanding of his own situation, and the need of his own interest in his progress.

When I finally said good-bye to Mr. Doe in the corridor of the hospital and heard him say, "Thank you for everything. I haven’t met an unpleasant person since I’ve been here," I felt that this patient was leaving the hospital in a contented mood, well-instructed for his own guidance, and with his future course well planned and made possible.

MRS. HALPERT: There is little to add to Miss Weber’s presentation. It need only be pointed out that Mr. Doe’s hospitalization represents but one episode in his chronic disease. The nurse has been responsible for observant, accurate, and gracious care of Mr. Doe during his hospital stay. But the challenge to nursing is wider than this—Mr. Doe must be protected from a recurrence of his ulceration. The nurse’s care and teaching of the patient must be directed towards preparing him for his return to the community and for his wise and safe direction in the future.

The skill in nursing techniques, the training in recognition and description
of symptoms, the opportunity to participate in the treatment of a patient with a common disease—all these are valuable to the nurse. Even more important has been her opportunity to become acquainted with a fellow human being and his friends, to learn how his future course is planned and protected by the aid and advice of all the individuals cooperating in his care, and to direct her nursing considerations towards the same ultimate ends.

**General Session**

*Thursday, June 6, 9: 00 a.m.*

Presiding: Anna D. Wolf, R.N., *Director of the Nursing School and Nursing Service, New York Hospital, New York City*

**General Topic: Maintaining Standards of Hospital Nursing Service.**

**A. In Hospitals with Schools**

Henrietta M. Adams, R.N., *Director of Nursing Education, University of Washington School of Nursing, Seattle, Washington*

What can the school of nursing do through its curriculum, organization, administrative policy, and personnel practices, to aid the hospital in maintaining the standard of nursing care given its patients? Maintaining the standard of nursing service in the hospitals affiliated with the school is not the primary responsibility of the school of nursing. However, since we agree that students can not be taught the essentials of good nursing practice where good nursing is not being practiced the school has an interest in the maintenance of a desirable standard and a responsibility in establishing a system of cooperation which will operate toward that end.

For purposes of discussion may we admit the following premises:

1. That an educational institution is responsible for, and conducts the school of nursing through a board representing education, nursing, hospitals, and community;

2. That this institution together with nursing students bears the actual cost of the nursing education program within the hospitals concerned;

3. That the hospital primarily responsible for maintaining nursing service to its patients is prepared to pay the full cost of such service whether the work is to be done by graduate nurses, subsidiary workers, or student nurses;

4. That the part of the professional curriculum affecting the particular hospital previously agreed to by the affiliating parties specifically states the main divisions of nursing practice, such as medical, surgical, psychiatric, communicable disease, etc., which shall be provided the student within that hospital as well as the period to be spent in each type of practice together with weekly hours of nursing service and classes.

Given a school of nursing, a set curriculum, and a hospital practice field, how may the school effect the maintenance of desirable nursing service?
Let us first consider six points in the organization and administration of the school program which may effect the hospital nursing service.

1. The educational institution conducting the school should separate the foundation courses, such as biological and social sciences, from the professional division which includes nursing and allied medical courses. It is necessary that the nurse have an understanding of anatomy, physiology, bacteriology, chemistry, physics, sociology, etc., but it is unreasonable to ask the hospital to house and feed her and jump her off and on wards while she attends background classes of this type. The student can secure these courses on the campus before entering the hospital. Keeping classes in the professional division of the school related to the nursing practice situation will aid the hospital in conserving its nursing service resources and maintaining standard care.

2. The educational institution should supply the direction of the professional curriculum within the hospital. If the educational director is responsible for checking credentials, handling interviews and correspondence of students applying for admission from the campus to the professional division of the school, she saves much time and expense to the nursing services office. Likewise, the registration in all classes, and assignment each quarter by the education office, of students accepted to various hospital services, has the effect of providing nursing service with a definite number of workers of known background and ability. The superintendent of nurses need not waste her time and energy wondering whether it is best for Miss X to go to medical or surgical floors. She can take it for granted that Miss X’s welfare was considered by the school representative when the ward practice assignment was made. The superintendent of nursing service may confine her energy toward wondering what effect Miss X’s ward practice will have upon the standard of nursing care given patients wherever she was assigned.

The school has an obligation to provide the student proper preparation before ward assignment. Classes in theory should precede demands to give nursing care. If class in the subject has been missed for any reason of illness or absence, teaching must be supplied individually. In any case, the student needs direction on the ward before carrying any new type of case.

3. To guard the interests and promote the welfare of both patient and student, an instructing supervisor for each division of nursing service should be appointed by hospital and school. Service and education must meet at the bedside. The superintendent of nurses, responsible for the hospital service, and the educational director, responsible for the professional school program, would both be sadly handicapped at this point if it were not for the instructing supervisors who are charged with functions delegated by both parties.

The instructing supervisor of surgical nursing is responsible for the teaching and nursing service administration on all wards devoted to surgical cases. There is a person with similar responsibility on each of the other services as medicine, obstetrics, pediatrics, out-patient, etc.
There are no factors so important in the maintenance of nursing service or nursing practice standards as these instructing supervisors. Each is at home on her division. Her office and her records are there. She is assisted by and works through the head nurse of each unit. She inspects, receives reports, guides all members of her personnel, teaches and trains, and tests their progress in nursing practice whether they be students, orderlies, staff nurses, or head nurses. She has one subject to teach and it is related to the care and needs of her patients. Given the necessary administrative organization and backing, it is possible for her to master her job and keep it up to standard.

In matters primarily nursing education, such as course planning, content of classes, student records, and grades, she is directly responsible to the nursing education office. Matters primarily nursing service she takes to the superintendent of nurses. Aside from elementary nursing procedures common to all hospital divisions, she has the responsibility of recommending details of nursing procedure which are carried out on her division, or revision of existing procedures.

4. A weekly group conference of supervisors with the superintendent of nurses and educational director provides machinery for standardizing methods of nursing and routines of nursing care. This kind of meeting has proved an effective administrative tool for coördinating practice on all services. Informally conducted it provides a clearing house for mutual problems, a place for discussion of changes in student class and work assignment schedules which would affect nursing service and development of plans for progress of both service and education.

5. A clinical education supervisor, paid one-half by the school and one-half by the hospital, should assist in the development of standards of nursing technique and practice throughout all services. Prepared copies of procedures should be made available for all wards and all students. She should teach in classroom and ward the elementary nursing procedures common to all divisions and assist the instructing supervisors with the development of procedures used on their particular divisions. She should have time allowed to be two or three hours daily in the hospital ward, watching how nursing is practiced. Here she can observe obstacles to good nursing, need for the development of new techniques, and bring suggestions for consideration in the weekly supervisor's conference. Students presenting special problems in maintaining nursing service standards can be assisted. Those unable to make reasonable progress may fail and be barred from reregistration the following quarter. Temporary conditions of nursing service which place unusual strain upon the student's ability may be reported to the nursing education office and alter judgments regarding student progress.

6. Students registered for nursing practice courses should be subject to the same rules that apply to scholastic failures: Official warning of poor work at midterm with special help given by the instructing supervisor and her head nurses. If the student fails in spite of this, she is automatically
dropped from the school. She has the right to petition the Dean's office for reinstatement. The head of the school then has the responsibility of recommending permanent withdrawal from nursing, one term suspension, or immediate reinstatement for a second trial.

Students understand the need for satisfactory work in all practice and classroom courses every term. They are rated frequently and receive quarterly grades in all courses. This is an incentive for them to maintain the standard of their work. A student on the warned list is subject to special house restrictions, must attend study table, and can not take part in student activities. Since nursing practice makes up the largest portion of the total credit hours on her program, satisfactory ward work is necessary to keep her status in the school. If the student is to be held to a definite standard of work, her administration of both school and hospital should agree to provide working conditions essential to nursing practice of a professional standard.

This brings us to the question: What conditions are essential in maintaining a desirable professional school standard of nursing practice?

Even with a curriculum calling for a known content, quantity, and quality of nursing practice, proper school and hospital administrative organization with responsibilities clearly defined and delegated, with carefully set-up machinery for cooperation, extreme conditions may arise which defeat the ends sought.

Affiliating parties should set up and agree to keep within reasonable limits in matters of joint concern. For example, the work load of any member of the personnel should be reasonable. We have stated that the instructing supervisor is a vital factor in the maintenance of standard service, yet there is a limit to her effectiveness in her dual position. Overburden her with class hours and she becomes a poor administrator of nursing service, overburden her with nursing service administration and she becomes a poor instructor. Probably her teaching load should not exceed 8 hours a week without assistance. She may be asked to supervise three to five head nurses, but assistance should be provided in periods of high census. Similarly the head nurse may be expected to carry ward administration and student practice follow-up on a unit of 30-40 patients with a limited number of students. Assistance will be needed if patient or student census is increased.

The ratio of patients to bedside workers or the number of hours of nursing service supplied per patient per 24 hours should be sufficient to allow maintenance of the standard nursing service.

The Grading Committee report, Nursing Schools Today and Tomorrow, states that no school should be conducted in a hospital which tolerates less than three hours of nursing service per patient per 24-hour day by graduate and student nurses. Whether this standard is more or less than necessary to provide good nursing in all types of services probably requires further study. However, the school should request that the hospital determine the
average amount of service necessary for good care and this standard should be required on units where students practice nursing.

The graduate nurse should supply enough of the required nursing hours to stabilize the service and allow systematic rotation of students from unit to unit and case to case. The Grading report states no hospital should have more than six students to each graduate staff nurse. We find the Harborview Division of the University of Washington School of Nursing can absorb from one to three students at the bedside per graduate staff nurse. The one to one ratio is by far the most satisfactory for both school and nursing service purposes.

Students are systematically assigned one or two types of patients each week, making it possible to review the symptoms and the nursing care needed for each case. Since students should have more time than graduates to observe patient's condition and to solve unfamiliar nursing problems the number of their patients should be limited. Nursing service standards suffer or the student can practice only bare routine work if she is required to care for as many patients per hour as the graduate does. Under conditions at Harborview Division five bed patients are routinely assigned each student daily. The instructing supervisor with the head nurse may adjust the general limit considering the needs of the student and the special service. The number may be increased to seven if one-half the cases are convalescent or chronic patients. Their load may be reduced to four bed cases for students having difficulties or newly assigned to the ward unit.

It is admitted that this limit could not be accepted dogmatically for all hospitals since many factors enter into the number of cases a student can carry effectively.

The plant at Harborview, King County Hospital, is modern with segregated services, small ward units, and centrally located utility, treatment, and toilet rooms. Ward maids and orderlies carry much of the simple routine duties including cleaning, supplies, etc. Janitor, housekeeping, and diet service are under a separate diet and housekeeping department. Procedures are simplified as far as possible and standardized throughout the hospital. Standard trays are used for complicated procedures. The hospital standard of routine care aims to meet actual needs of each case. Convalescent patients assist with their own bathing and general hygienic care.

Hospital plants where modern conveniences are not so readily available would require reduction of the student's daily case load. Private service, communicable disease, and very active services, would also need special consideration. However, a reasonable limit of the working load as well as working hours is necessary for maintenance of good personnel and satisfactory nursing service.

Summary. The school, to cooperate in maintaining the standards of the nursing service, must free the hospital from the necessity of providing for students who are enrolled in basic science and liberal arts classes required preliminary to the professional nursing courses.
Effective school organization administered by a resident educational director must regularly provide the hospital nursing service with the *average* number of students agreed upon for each division of the service. These students must be of known quality and maintain a satisfactory standard of work to remain in the professional school.

The registration, class schedules, and individual assignment to the various hospital nursing divisions, while planned and administered by the director of the professional branch of the school, must be within reasonable limitations prescribed by conditions of the hospital nursing service and acceptable to the superintendent of nurses.

The school curriculum and schedule for students must provide formal instruction covering the theory involved in nursing practice before or during the student’s assignment calling for that type of nursing care. Schedules and ward assignments should be posted well in advance of proposed changes in hospital services.

School and hospital together provide a well-qualified instructing supervisor for each main nursing division. These individuals are charged with full responsibility for maintaining the standards of nursing service and practice in their particular field. They teach the standard nursing care in classroom and on the ward, following student service through the unit head nurses. Each estimates the needs of nursing service on all her units and adjusts the time to be given by graduate nurses according to students she has assigned those units.

School and hospital should jointly appoint and pay a clinical education supervisor who assists in establishing standard nursing procedures and practice throughout all nursing services in the hospital. She must teach elementary nursing procedures common to all hospital divisions, follow the students on the wards, and spend a third of her time observing nursing as it is practiced by graduates, auxiliary workers, and students. Her reports and recommendations should go to representatives of the nursing school and the hospital nursing service. The weekly supervisory conference at which both educational director and superintendent of nurses are present is an excellent clearing house for discussions of nursing standards.

The work load limits of each class of personnel determined by and agreed to by both affiliating parties, should be maintained on all divisions used as student practice fields.

An example of each limitation submitted for your consideration includes:

1. Instructing supervisor teaching—6-8 weekly load hours
   Instructing supervisor administration—2-5 head nurse units to supervise
2. Head nurses, each in charge of a—30-40 bed unit
3. Proportion of students in bedside personnel—1-3 students for each graduate staff nurse
4. Amount of nursing service provided—2-4 hours per patient per 24 hours
5. Student nurse’s daily case load—4-6 cases per morning
6. Standard service hours—36-44 per week exclusive of class
This discussion has covered six points in the organization and administration of the school program which have a direct bearing upon the maintenance of hospital nursing service.

Six conditions within the nursing service have been considered essential in maintaining a professional school standard of student nursing practice.

Perhaps the greatest necessity for maintenance of good nursing practice in the hospital and in the community is positive cooperation between the educational institution and the service institution.

B. IN HOSPITALS WITHOUT SCHOOLS

HELEN A. SPARKS, R.N., Superintendent of Nurses, Sutter Hospital, Sacramento California

Many hospital administrators, worried by the burden of maintaining a first-class school of nursing on a reduced budget, and of providing a sufficient clinical experience for the student, with a depleted house census, have turned to the thought of a graduate staff as a means of answering some of their questions. Nurse educators, backed by the facts obtained by the Grading Committee, have recommended to hospitals over and over that they increase their graduate staff, or eliminate the school of nursing altogether, thus accomplishing two purposes, namely: to lessen the flooding of the market year after year by great numbers of nurses, many of whom it is impossible to employ, and to put some of those nurses already graduated to work. Many have made the change. To those who have hesitated, the usual barriers blocking the way have been: (1) Is it more expensive to maintain a graduate staff than a school of nursing? and (2) will the nursing service be as satisfactory?

It is not my province in this paper to discuss the cost of a graduate staff, as much as I would like to show you by actual figures that the difference in the cost is very little, and to add that that small difference is profitably spent in providing superior nursing service for the patient. Rather, it is my duty to persuade you that the standard of nursing service may be maintained in a hospital with a graduate staff—in fact may not only be maintained, but that a quality of nursing service superior to that offered by the student nurse may very easily be made the rule of a first-class institution providing care for the sick. Should this not be the logical course of events? Is it not to be supposed that young women, whom we, as nurse educators, spent years of effort upon in teaching the art of nursing, should be more proficient in the application of this art, than the young student who is beginning to apply her skills? It would be a sad commentary on our influence during the formative period of the student's preparation of her life's work if we did not expect her to grow in this work after she was removed from our immediate influence.

To orient you to the organization of our staff at the Sutter Hospital, it is necessary to give you some data regarding the hospital. Sutter Hospital,
which stands across the street from Sutter’s Fort, the cradle of the discovery of gold in California, had a daily average, in 1934, of 140 patients. It is a community, nonprofit organization, catering to the middle-class person, many of whom are acutely ill. There has never been a school of nursing for two reasons: (1) There are two schools of nursing in Sacramento, providing a sufficient number of nurses to care for the community; (2) the Board of Directors has always been favorable to a graduate staff as being more efficient and more economical than a student staff. This favorable attitude on the part of the Board of Directors, as well as a pride in being somewhat different from the other hospitals in the vicinity, has made it possible to put into practice the very best ideals of a graduate staff. They started out, ten years ago, with the conscious idea of establishing a nursing service which was superior to that offered by the student nurse. The way has not always been easy, for there were many influential doctors and persons interested financially, who felt that the only way to conduct a hospital was to have the nursing done by the student nurse. It is to the credit of the far-sighted men on the Board of Directors that they have not allowed this opposition to the graduate staff to prevail. Now, there is no one who questions their wisdom.

In maintaining a standard of nursing service which is superior, there are several conditions which are fundamental, it seems to me: (1) The standard which you expect to provide must be determined. It cannot be left to chance, and succeed. This is the same principle as determining one’s curriculum in advance in a school of nursing. (2) There must be a set-up or organization which you expect to provide must be determined. It can not be left to chance, (3) There must be sufficient follow-up work and supervision to know that the plan of superior bedside nursing is being accomplished. I would like to develop these subjects under the different headings.

DETERMINATION OF STANDARD

Every right-thinking board of directors and superintendent of a hospital want the patron of the hospital to be a satisfied customer. They realize that a satisfied patient means favorable advertising for the hospital, and therefore, increased census. What they do not realize many times is that the caliber of the nursing service, more than anything else, determines whether the patient is going to be satisfied or not. Too many times, in the past, economies which have made it impossible to furnish good nursing service have been forced upon the nursing staff, and they, in turn, have suffered the blame for a poor nursing service for which they were not responsible. In a school of nursing the director has the power to control the type of bedside nursing through the instruction and supervision given her students. This is not always as simple with a graduate staff. Nurses, coming from many and varied schools of nursing, must have presented to them in a very definite manner the type of nursing service demanded by that hospital. Therefore, as I have said before, there must be a definite, comprehensive plan of the type of nursing service desired by the hospital, and subscribed to by the management, to serve as a foundation upon which to build.
A Set-up in Which Good Nursing Care Is Possible

Selection of staff. Each applicant is selected upon her background of professional and cultural preparation, and is in addition required to be (a) eligible for registration in California; (b) a member of the A. N. A.; (c) able to present evidence of having had recent hospital experience.

After the nurse is employed she must register in California and become a member of the California State Nurses' Association. Preference is always given to the nurse already registered in California, provided she presents the same background of experience as the one not already registered.

There is no question in my mind but that the type of nurse interested in general staff nursing has improved tremendously in the last five years. There are several reasons for this, among which have been the dearth of available positions and the desire on the part of the nurse for the security which the steady position offers. But, I believe the outstanding reason is the fact that nurses who really enjoy bedside nursing have come to realize that employment on a general staff gives them the opportunity to have the thing which they like best in nursing, which is the intimate contact with the patient. At any rate we have been able to have a considerable waiting list of very eligible young women.

No nurse is accepted on the staff permanently until she has served a three-month period of relief. This "probationary" period, as it may be termed, gives her a chance to see whether she is going to enjoy working on our staff, and gives us time to decide whether she meets our standard of nursing. About 75 per cent of those who have been employed for the relief period have been accepted upon the permanent staff. This relief period serves, in reality, as the orientation period for the nurse. She is instructed in the traditions of the staff and in her duties as a member of the staff in reference to patient, doctor, fellow-worker, and hospital. This instruction is the province of the supervisor who has charge of the division on which the nurse is placed.

Sufficient staff. Many splendid nurses in the past have refused to join a general staff of a hospital because of the fact that they felt they could not give the right kind of care to the patient because the impossible in amount and work was expected of them. We have found that the average graduate can give good nursing care to five average patients each morning. If the patient is having heavy treatments demanding much time and effort, then the nurse is responsible for fewer patients, her surplus work being absorbed by the other nurses on the division. Besides the nursing staff of a division, which is determined on the basis of one nurse for each five patients, there is a nurses' aide, who makes empty beds, runs errands, takes patients to surgery, X-ray, et cetera, and a part-time maid who is responsible for the flowers and the pitcher of water at each patient's bedside. Every effort has been made to cut down the nonnursing work of each graduate. Each nurse is responsible for the complete care of her patients while she is on duty, including treatments, medications, dressings, et cetera. We have found that
such a system, besides being time-saving, establishes a bond between the patient and the nurse which makes for better understanding and cooperation.

Hours of duty and salary. The hours on duty are eight, six days a week, with the day off each week, known at least one week in advance. There are three relays of nurses, 7:00 a.m. to 3:30 p.m.; 3:00 p.m. to 11:00 p.m.; and 11:00 p.m. to 7:00 a.m. The 11:00 to 7:00 staff is, in almost all instances, permanent, by choice of the nurses on those hours. All other nurses take their turn for the 3:00 to 11:00 period. The salary, at the beginning is ninety dollars a month, plus meals and laundry. All nurses live outside the hospital.

The fact that the nurse can maintain her own small apartment, or share it with another nurse, that she works only eight hours a day, that she has opportunity to go to concerts, the theatre, or entertain in her own home, like any other business woman, has raised her estimation of herself very much. The change in the attitude of the whole staff since we have established the straight eight-hour day is most noticeable. Some of the nurses are now enabled to live in the outlying districts, where they may have cheaper rent, and enjoy the hobby of a garden. We have proven beyond a doubt that anything which raises the morale of the nursing group raises the standard of the bedside nursing of an institution. And certainly nothing has raised the morale of our group so much as giving the nurse the opportunity to live like any other business woman.

Staff education. Staff education should answer two purposes with the graduate staff, I believe. It should: (1) Serve as a means of orienting the new nurse to her environment—helping her to adjust as quickly as possible; (2) provide a means through which she may grow professionally, while she is on the job.

The first phase mentioned is, of course, given to the new nurse on the staff, and is largely an individual matter, since nurses do not come on the staff in groups. The end result is almost always worth the individual effort, however, for it is a great joy to watch the shy, unadjusted young graduate, who as yet is frightened to death and who doesn’t know what it is all about, blossom into a dependable, capable person with poise and charm. By skillful, sympathetic guidance during this adjustment period many a young graduate is established in right habits of nursing which serve her as assets during her entire professional career. Since most of this individual instruction falls upon the supervisor, it also serves the dual purpose of developing the supervisor’s teaching ability, and of making her realize her own importance in the scheme of staff organization.

The program of staff education for the group varies from year to year according to the plans outlined through conferences with the group itself. For the coming year a series of medical lectures organized around diseases which are prevalent in Sacramento have been planned. Each subject will be presented as a unit by a physician who gives cause, symptoms, treatments, prognosis, et cetera; a pathologist who presents laboratory and X-ray findings,
illustrated by slides, et cetera; a nurse who discusses bedside nursing care; and an equipment-room nurse who gives the care and cost of apparatus used in the treatments, et cetera.

Nurses are encouraged to attend educational meetings, institutes, conventions, et cetera. Visits to other hospitals are urged upon the supervisors at the expense of the hospital. Monthly conferences of the supervisors and head nurses are held, at which administrative and nursing problems are discussed.

It is not always possible to incorporate an enthusiasm for new methods and ideas in the whole staff, but if some of the group get the vision of growth while in service they will do much to inspire the others. The administrators must constantly keep before themselves the ideal of providing opportunities for learning for the graduate, otherwise the staff will tend to settle down into the routine work, with little effort spent upon learning how to do new things.

ADEQUATE SUPERVISION

I have heard the criticism made that graduate nurses resent the supervision of a well-regulated nursing service, and that it is not possible for a supervisor to be as well informed on the quality of the nursing service with a graduate staff as with a student staff. I do not think that this is altogether true, although I think that the supervision of a graduate staff is more difficult for the individual supervisor, since she is not trying to teach the graduate the exact way of doing a procedure, or making a bed, for instance. The skill of that nurse in bed-making was determined many months before, and the habit firmly fixed in her mind when she was a student nurse. If the end result meets all the requirements of a well-made bed, we do not quarrel with the graduate as to how she arrived at the end result. It takes a broad-minded tactful supervisor to blend the different ways of doing a treatment taught to nurses from ten different schools, into something of a uniform procedure, which is applicable to our situation.

In conclusion, then, I would summarize as follows:

A superior nursing service is more easily maintained with a graduate staff than with a student staff, because, (a) the majority of graduates doing general staff nursing today are really interested in the bedside care of the patient. Therefore, they are giving of their very best in this care; (b) it is reasonable to conclude that a graduate can do more finished, skillful nursing than a student; (c) the routine of nursing service is not interrupted by the graduate's attendance at class, therefore there is a more consistent program of nursing service at all hours of the day.

However, to make this service superior, certain working conditions must be maintained: (a) there must be a sufficient staff of graduates, each with a background of professional and general education, chosen for their fitness for the work which they are to do; (b) hours of duty and salaries must be commensurate with the responsibilities involved; (c) some system of staff education which will make the staff nurse realize her importance in the program of good nursing service is necessary.
An interest in good bedside nursing on the part of the administrative group is imperative. Upon this group devolves the follow-up work and the supervision which is just as necessary with a graduate staff as with a student staff.

**DISCUSSION**

**LILA J. NAPIER, R.N., Superintendent of Nurses, Bronx Hospital, The Bronx, New York**

Hospitals with an all-graduate staff can use many well-equipped young women but will they come into our hospitals to give bedside nursing service? At present our main source of supply is the smaller hospital nursing school. The training of the nurse for bedside care of patients and her interest in doing it is of vital importance in maintaining nursing standards in the hospital employing only graduate nurses. I realize that I have raised a controversial point here as to the source of supply of the graduates in the future who will give the bedside care in our hospitals.

Many of our difficulties would be nearer solution in the hospitals using a staff of graduate nurses if we could more nearly approximate the standards of the Sutter Hospital, Sacramento. Miss Sparks has shown her method of the selection of the staff. She has a choice of eligible nurses, first because of a larger available supply due to the economic situation and second, which is probably the more important reason, she presents almost an ideal program for making service in the hospital attractive by providing a low patient-nurse ratio, eight-hour duty, adequate remuneration, and freedom of choice as to living conditions.

Failure to provide these things does not seem to me entirely adequate to explain the difficulties of the nursing director in the larger cities to secure a permanent staff of high ability and interest in doing the bedside nursing. Even with the depression, giving us the larger numbers from which to choose, many of the difficulties remain. I believe that there are some things that we must face squarely and then work forward toward a solution. We recognize the fact that the graduate staff will always be a more or less transient one.

The average nurse upon the completion of her training does not look forward to bedside nursing in a hospital as a career. Graduate nurses applying for staff positions in most hospitals in New York at the present time can be roughly classified into three groups. One group is made up of special duty nurses who find the security of a staff position in a hospital more attractive than the uncertainties of private duty. Another group is composed of recent graduates of hospitals in smaller cities who can not be absorbed into the personnel of their own hospital or in their local private duty field. A few of these see in working in a larger city, opportunities for cultural, educational, and professional advancement, but this is a very small number. The third group is made up of nurses, the older graduates usually, who spend a few months of each year working on a hospital staff with no feeling

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1 Somewhat condensed.
of obligation for the job as such, interrupting their terms of service for any personal reasons that may arise.

An attempt to get some clue to the attitudes of the nurses in these groups towards themselves and their work was made by giving 106 graduates on the nursing staff of a hospital in New York City a questionnaire which resulted in the following: 72 nurses returned the questionnaires; 64 felt that further study of nursing subjects was advisable; 49 felt that they would be interested in having lectures or discussions of nursing subjects; the majority felt that once a month was often enough for these lectures. An attempt was made to evaluate the interests of these nurses other than professional; 24 reported no interest outside of their work. In this hospital there is an educational atmosphere. The medical staff is alive and willing to give of its time yet the response to a series of lectures and discussions in which the nurse has a share in planning, on medical and nursing subjects, was an average attendance of 15.

This little sidelight into the attitude of mind of the staff nurse and an understanding of her present reasons for hospital service and her lack of permanency has its implications in a consideration of the problem of keeping up standards of nursing service. We do not accept the situation as unchangeable, but while we are trying to understand the why's and wherefore's of it and while we are developing new ways of meeting it either by change in nursing education or in the hospital as an employer, the necessity for furnishing good nursing care to our patients goes on. It seems well, therefore, to emphasize again two things especially, which Miss Sparks says have helped in their hospital: (1) That the new staff nurse is at the beginning of her term of service carefully inducted into all the techniques and requirements of the hospital in which she is going to work and of her particular job; (2) constant and well-directed supervision.

If in addition, some feeling of loyalty can be built up to the institution which the nurse is serving, by some as yet undiscovered means the problems confronting us in keeping our nursing service a good one will be nearer solution.

**General Session**

*Thursday, June 6, 2:00 p.m.*

Presiding: Sister M. Berenice Beck, R.N., *Catholic University of America, Washington, D.C.*

General Topic: **What Changes Do We Need in the Nursing School Curriculum?** (Continued)

D. **What Changes in Curriculum Structure and Pattern?**

1. **To Provide Better Articulation with General Education**

   F. B. O'Rear, Ph.D., *Assistant Professor of Education, Teachers' College, Columbia University, New York City*

   Our topic calls for discussion of the articulation of two kinds of education, general and professional, with special reference to the education of nurses.
Education of any kind is, of course, a highly personal matter, a matter of individual experience and development. It is one of these most inconvenient possessions which can not be purchased ready made, acquired by proxy, or stored unused without deterioration. It must be both caught and wrought, it must be self-styled in long last analysis, and it must at all costs be burnished with use. Thus no two individuals’ educations are ever the same or even nearly identical in their details. An education exists in the thinking, feeling, and acting of its creator and possessor, in his being and becoming. No individual totally escapes an education and for no one of us is it ever wholly perfected. Indeed, few persons seem to approach at all closely to the realization of their capacities for self-development—for education. The majority resist it firmly and with accelerating effectiveness as age advances, seeking that complete complacency wherein is found intellectual decline. Society has seen fit to establish institutions (schools and colleges among others) which are intended to provide more favorable environment and more adequate stimulation than the average individual would probably otherwise enjoy in furtherance of his own education. Professional schools are themselves no exception, since they too can do no more than provide an environment and certain stimulation under which professional students may create their own professional educations. Like many other collegiate institutions, professional schools are prone to forget that their fundamental educational tasks are to lead the student to educational waters and to make him thirsty.

The purposes which prompt an individual’s activities in pursuing his own education vary extensively from time to time and may be quite at variance with those purposes activating his fellows. Indeed, they may not be clearly defined nor recognized by the student as controlling factors in his actions. Activity and experience for its own sake or for the passing purposes of the moment, the desire to experiment and to explore may carry the individual far. One need only to observe a normal child for a period of time to see the absorbed inquiring mind about its business. True, a large part of our attempts at formal education contrives to blunt the edge of curiosity and to cool the passion to inquire. But even the most bored college sophomore may surprise an inquirer, if skillfully approached unawares, in a revelation of the remarkable persistence, against odds, of interest in intellectual pursuits and a desire to explore (in areas of his own choosing, to be sure).

Of course, one may also observe inclination toward specialization very early in life. Indeed, activities in exploration and in specialization commonly alternate as bases for personal emphasis, the former tending to diminish in demand upon time of the individual as he grows older, and the latter increasing in proportion. For most of us, neither exploration nor specialization demands our exclusive attention to the complete neglect of the other at any time and it must be noted at once that many phases of each complement and reënforce activity of the other type. The time of appearance and duration of special interests may vary widely. As the individual matures, learning for living and learning for earning may enter as
two of the definite and recognized bases for specialization of his educational activities.

Education is, then, a continuing, ongoing experience within which professional education may be distinguished as that period wherein the individual student's recognized paramount concern is specialization toward the earning of a livelihood by practice of a chosen profession, whether or not such concern excludes for him all other purposes. The term general education is commonly used to include those periods of education in which, unfortunately, institutional and personal objectives are often not clearly defined, or in which the individuals' interests are largely formative, explorational, and certainly nonvocational. Occasionally one finds included therein, more or less clearly stated, concern for civic, social aesthetic, and personal development toward more complete living. Strictly speaking, it is difficult to conceive of truly general education since purpose, more or less specific, tends to enter a student's consciousness. If one means thereby (a) an individual educative program conceived and dedicated to the simultaneous development of one's capacities along the lines of all of his maturing interests or (b) a program, explorational in a very large area of human experience, pursued antecedent to selection of a specific vocational objective, one includes a portion or excludes all of professional education, as the case may be. For purposes of this discussion, the term general education is very loosely used to refer to any and all educational activities pursued primarily for other than professional purpose.

Articulation is defined by Webster as "the act of joining together, a state of being joined."

Our real question, then, is what can be done, institutionally, to aid the student in making the best possible "joint" between his professional educational activities and the whole of his antecedent educational experiences. One thing seems quite clear. The unity must be achieved by the student and must appear in his own thought and action. For a given profession, such as nursing, a number of subsidiary questions appear, related to this main question of articulation. Among these may be listed the following:

a. At what stage of personal and social maturity may students generally best begin specialization toward the profession?
b. Does a given amount of prior general educational experience definitely contribute to successful participation in professional education for this profession?
c. If so, is this amount warranted by the opportunities and the rewards of the profession?
d. Can general and professional education be profitably carried on in parallel? In alternation? In fusion?
e. If in more than one way, which is most productive professionally?
f. Is one way best for all prospective practitioners?
g. What implications for content and organization of curricula may be discerned in the specialization of purpose of professional students?
h. Is any one specific form of administration and institutional organization implicit in the purposes of professional education? In content and organization of curricula?
i. Has the organization and position in society of the profession itself any implications for the articulation of the two kinds of education?

j. What relation, if any, is to be found between the conduct of accreditation procedures and attempts at articulation?

Obviously, a paper such as this can make no claim to the presentation of answers to these questions. Indeed, in the realm of professional education, there is little or no controlled experimentation upon which to predicate adequate answers to some of these questions. Nor is highly sound and reliable subjective judgment possible in these matters since no one, to the writer's knowledge, knows with equal intimacy and completeness the observable outcome under the several alternative programs possible. In short, we are still in the realm of individual, and probably biased, opinion on these matters. The writer does indeed admit, without undue pressure, upon occasion, to rather definite opinions upon most of them.

Perhaps it is useful, for purposes of discussion, to set forth a few of these personal opinions which now seem tenable. One may hazard such statements of belief even though one of these opinions is that we should not continue to operate solely upon the basis of individual opinion. Some of the others may be stated briefly as follows:

a. That articulation, like education, is actually accomplished within the individual student's thinking and acting;

b. That, at present, at least two years of general college work seems reasonable as a basis for professional work in nursing, even though the degree of maturity reached by different individuals within such a period of study will undoubtedly vary widely;

c. That students, for a professional school, should be selected in terms of promise or capacity for and interest in the pursuit of professional objectives, rather than in terms of technical competence in or prior preparation for that specific pursuit;

d. That the professional school for nurses should take the prospective nurse, who shows such capacity and promise, "as is" and move toward the professional goal sought by school and student in common, rather than attempt to prescribe prerequisite studies;

e. That the professional curriculum should, therefore, be complete and self-contained rather than reliant upon so-called pre-professional courses;

f. That the professional curriculum should be regarded as an alternating specialized period of study rather than either as parallel or fused with a program of general education;

g. That the specific purposes of a given school or division should be determined, pursued, and amended by the staff, the administration and/or the constituency of the school in question, in the light of its own university and community setting, rather than by any central or external agency operating for professional education as a whole;

h. That appraisals and accreditation of institutions should be undertaken only in reference to specific purposes and objectives, institutionally stated, and then only upon careful scrutiny of comparable data by competent judges personally conversant with local conditions;

i. That results of such ratings be stated primarily in terms of relative accomplishment of an institution in meeting its own stated objectives;

j. That so long as necessary functions are performed in some manner, administrative organization and control need bear no single relationship to purpose
and objectives but may with comparable results be widely variant in terms of other factors in a local situation, such as tradition, personalities, budgetary restrictions, and/or plant;

k. That, whatever the form of administrative organization, the materials of instruction should be organized around foci chosen as peculiarly appropriate for the specific purposes of the individual institution;

l. That, for a professional school, these foci should be found in professional situations, incident to practice of the profession considered in its broadest aspects and in its social setting;

m. That, in a professional school, around such foci should be centered the teaching, research (both pure and applied) and at least some phases of the application of professional knowledge to human affairs;

n. That a professional school should organize its materials and facilities in such fashion as to integrate and inter-relate the component parts of its program and minimize dichotomies between subjects and situations, facts and functions, precepts and practices; that the foci of curriculum materials should be professional situations, professional issues, professional experience areas, rather than areas of knowledge, units of technique, scientific procedures, or social concepts and theories; that the approach should be functional as contrasted with factual, experiential as contrasted with expository—in short, professionally centered;

o. That current tendencies in the direction of increased social control of preparation for and practice of the professions impel increased attention within the curriculum to the problems of the profession in its social relationships, and increased care in the selection of students with more extensive cultural background, greater understanding of social problems, and greater zeal to make their profession serve human need.

A number of other tenets might be added. The foregoing list, tersely stated, seems tenable in the light of present knowledge, and is held subject to change without notice, upon accrual of contrary evidence.

Perhaps the position here expressed may be made a bit clearer if a slightly different approach is made to the questions of organization and articulation of nursing education. If one were permitted, without let or hindrance, to fashion a school of nursing to his complete satisfaction, what sort of social institution would it be? If one were inclined to accept the tenets set forth in foregoing paragraphs, it would seem that such an institution would be organized as a senior college or perhaps as a school of graduate status. It might appropriately be included in a university organization, to its own advantage because of superior university facilities, although its separate organization and equipment (probably at increased cost), would by no means be impossible. It should be a highly autonomous but also deliberately coöperative enterprise. Its policies and procedures should be determined by its own faculty and administrative staff, subject to coördination with other university schools and to confirmation by its trustees and/or its constituency. It should control exclusively or in coöperation with schools of medicine, dentistry, and pharmacy, its own laboratory and practice facilities, including an adequate hospital. Its academic requirements for admission would be very simple—merely the completion of two, three, or four years of general college work according to its level of organization. It
would bend its energies to the development of adequate tests of capacity and promise in the professional field of nursing, with strong emphases upon certain qualities of character (such as reaction under physical and emotional stress, discretion, and human sympathy) upon certain social attitudes (such as those on the place of the profession, its responsibilities, and rewards) and certainly upon personal physical fitness, coordination, and manual dexterity. It would seek in its students capacity and the will to achieve rather more than an existent competence or a prescribed set of exposures to specific knowledge. It would center its curriculum upon professional issues, professional problems, professional situations rather than upon bodies of subject matter as such. It would seek its articulation with preceding and subsequent experience in developing the capacities of its chosen students, aiding them to proceed from where they were to where they wished to be, removing or minimizing a deficiency here, expanding an unusual ability there. True articulation would be sought in the constant more adequate interadaptation between school and scholar, between curriculum and candidate for the profession. The school would, through its faculty, set its own specific objectives. It would be appraised, and accredited, in terms of those stated purposes, on the basis of its graduates' technical competence and the quality of their professional performance in the society in which they serve.

A word or two in closing. Your pattern of organization, were you to write it, would be different from that outlined herein, and no one could strongly say you may. As stated at the outset, we lack a body of experimentally derived fact upon which to base judgment. We have almost no controlled experimentation, past, present, or in prospect bearing upon the relative effectiveness of differing patterns of organization, coordination, or administration upon the quality of work of professional students. We have innovated and experimented almost not at all in professional education. We have built few extensive experience tables in this field and have devised relatively few techniques for appraisal of results.

It appears that the time has come when a number of the professional organizations of this country should set about answering the questions as to what constitute preferable forms of professional education by inaugurating and promoting extended programs of controlled experimentation and controlled subjective appraisals of varying programs. Perhaps the question of articulation may, in large part, be resolved in such a process. Herein lies both an opportunity and a challenge. The National League of Nursing Education may well set the pace!

2. To Bring the Curriculum in Harmony with Newer Aims and Standards of Education

MARGARET TRACY, R.N., Director of the School of Nursing, University of California, San Francisco, California

In order to answer the question proposed by our title, it seems well to examine briefly our present educational practices to determine in what ways
they differ from those in other educational fields. When we have done this, we can subject our own standards more fairly to the measuring rod of general education.

Many of us today believe that we should keep in mind the statement of the Revision Committee—the curriculum should be based upon two years of education beyond the secondary school. This immediately places upon us the responsibility of making our decisions in the light of the best practices of our leading colleges and universities.

We should be guided also by the central aim of our own scheme of education. If a practice which we are now following seems best to promote the attainment of our goal, it should be retained, even if it is at variance with general educational practice. We need must go through a period of experimentation. We will make mistakes, but if we can make our standards and practices harmonize more nearly with those in other fields of education, we will build more soundly for nursing. Former Dean James E. Russell of Columbia has said, "The only guide for the professional school is the needs of the practitioner. The minimum standard is the preparation that best fits the novice to take the next step on leaving school. The amount and kind of technical training that should be provided in the professional school are fixed by these conditions. The one inflexible requirement is that what is needed in practice must be taught. That school does best which fits its product to the successive steps in their professional careers in confident, intelligent, and skillful fashion."

Our own Grading Committee, in its final summarizing report, lists eight essentials which every professional nurse should know and be able to do. Four of these are not provided for in our present curriculum to any appreciable extent. Nor do current practices in nursing education provide any foundation by means of which our students are fitted to take the "successive steps in their professional careers in confident, intelligent, and skillful fashion." I refer to the community aspects of our work, interpretation of social as well as physical symptoms, mental hygiene, disease prevention, and health teaching. True it is that a public health slant can be given to all our teaching if we provide instructors who themselves have this viewpoint. Nevertheless, in only a few schools in this country is such emphasis given. In only a few schools are all of the students given any opportunity to practice in a community nursing agency. If we learn by doing, and we afford our students no opportunity to do, we can not expect them to emerge community-conscious health teachers from a curriculum preponderantly devoted to curative medicine and nursing. In a total of 825 hours devoted to formal class work in our present curriculum, less than a hundred are spent in the study of any phase of community nursing. Of the twenty-nine months of the thirty-six left for clinical instruction when we have subtracted the preclinical term and vacation time, a maximum of six months is recommended in this field, two months in the out-patient department, and an elective which it is
suggested "might be spent in some community nursing organization." I want you to note the elective.

The first change, therefore, which I would suggest is needed to bring our curriculum in harmony with the newer aims and standards of education, is a reallocation of time and emphasis, so that our graduates will be better able to meet the community demands made upon them. The recent survey of Public Health Nursing in this country showed that an overwhelming majority of the public health nurses now practicing had no preparation for their work other than that supplied in their basic training. We must place more stress upon the preventive and educative trends in the fields of health. We must see that every nurse understands the trends, and is able to take part in the community program for maintaining physical and mental fitness.

In our better universities today the tendency is to reduce the hours of class work carried by the individual student. Usually fifteen to seventeen units per semester are considered a maximum. One, or at the most two, laboratory sciences are permitted in a single semester. Students are encouraged to devote more time and thought to fewer studies, and to participate in those extra-curriculum activities which are recognized as essential to the development of a well-rounded personality.

Freshmen are especially guided in their selection of subject matter and guarded against an overloaded program of study. What of our present practices in nursing schools? Our curriculum at present recommends a weekly schedule of twenty-two hours of class and laboratory work, in addition to sixteen hours of practical work in the wards. The subject matter includes four major physical sciences as well as four other subjects. All this in the first term, when the student is making her adjustment to a totally new situation; when she is being subjected to the emotional strain of daily intimate contact with life and death. In his masterly report of the survey of nursing education in Canada, Professor Wier makes the following recommendation: "The great majority of student nurses should be given longer time for independent reading and investigation. Without this opportunity sound education is practically impossible."

The second most essential change which must be made in our curriculum, therefore, is the reduction of the class load carried by the individual student, so that it is more nearly in line with generally accepted educational practices. Nor have we taken into account that, far too often, the teaching is done by overburdened, inadequately prepared instructors in make-shift laboratories, and with pitiable library facilities.

We might well consider making the basic sciences prerequisite for admission to our schools of nursing, utilizing the splendid facilities offered by our universities and colleges. The time in the nursing school could be spent much more profitably in helping the student make the necessary application of this fundamental knowledge to the nursing problems she encounters.

With its many faults, our system of nursing education has had one outstanding virtue. It has provided in the field of curative medicine at least,
the necessary practice for the student. There is an increasing tendency in
education to organize subject matter around the activities of the students.
Dewey, in his Democracy and Education, has pointed out to us why there is
this movement in education today. "The knowledge that comes first to
teachers and remains most deeply ingrained is knowledge of how to do."
Again—"The problem of the educator is to engage pupils in these activities
in such ways that while manual skill and technical efficiency are gained and
immediate satisfaction found in the work, together with preparation for later
usefulness, these things shall be subordinated to education, that is to in-
tellectual results and the forming of a socialized disposition."

My third suggestion for harmonizing our standards with those of educa-
tion in other fields is to utilize more fully our clinical teaching. This will
necessitate greater consideration of the clinical experience as an integral part
of the curriculum. It will involve not only a more careful planning of the
entire course, but a better selection of experience for the student in the in-
dividual service. With our modern case study method of teaching, each pa-
tient represents a problem through the solution of which the student's care of
that patient is evolved, and her own knowledge of all phases of the situation
is fixed. We need to limit the number and variety of problems presented
to a student at one time. We need to give her more time for the study and
solution of the problem, as well as the putting into effect of her conclusions.
We need to limit the physical output required of her, so that she will have
more energy and time to devote to such study. We need to transfer about
fifty per cent of the teaching now done in isolated classrooms to the wards
and to the clinics, and to the practice field in the community, so that she
will have that immediate help in her problem-solving which will enable her
to achieve a satisfactory solution. Incidentally, we will have to provide more
and better-qualified teachers in our clinical fields.

The three changes I have suggested are not impossible of attainment: a
shift in emphasis, so that the finished products of our schools will be better
able to function as health workers in the community; an abandonment of
our spoon-fed cramming methods of teaching, in favor of a more rational
program based upon the laws of learning; and a better utilization of our
most valuable asset, the clinical field, to the end that in the acquisition of
certain mechanical skills, the objectives of our educational program may be
achieved.

I say these are not difficult of attainment. They will be attained, however,
only when nursing schools are schools in the truest sense of the word. When
students are selected because of their intellectual, emotional, and moral fit-
tness for the practice of nursing, not because they are an economic asset to
the hospital which provides part of the practice field, we will have the first
essential of a real school.

If we add to that highly qualified instructors, physical facilities which will
enable them to teach effectively, and a curriculum which affords opportuni-
ties for learning through well-balanced classroom instruction, directed ob-
servation and practice, and independent study and thought, we will have the optimum conditions for the administration of a curriculum never static but constantly changing to meet the demands of a moving world.

It would seem not only futile but immoral to spend time and energy in constructing a curriculum for those so-called schools which have neither the desire nor the facilities to produce a high type professional worker for the practice of nursing.

We should not be timid in eliminating those practices in our schools which are the results of expediency and are not based upon sound educational standards. As an association charged with the responsibility of fixing and maintaining standards, we can not afford to compromise.

3. TO SECURE BETTER INTEGRATION AND ECONOMY OF LEARNING

CLARA BROUSE, R.N., Secretary, State Board of Nurse Examiners, Columbus, Ohio

Integration—that dissonant but apparently highly esteemed term in modern education—may include as it relates to nursing, the understanding in the student's mind, of the total physical and mental condition of the patient, combined with ability to use efficiently nursing measures to restore health and produce mental comfort, that the patient may return to society alert to the health needs of himself and his family.

A student must have a great desire to gain knowledge, if she is to become a good nurse, and this felt need is a good beginning for learning. Luckily, nursing schools retain relics from our military heritage and have autocratic power in most instances to eliminate a student who seems unfitted in scholarship or temperament to attain the basic skills, and retain the basic fundamental information to enable her at all times to give safe care to the sick. Upon a firm foundation of the physical and social sciences she should be guided to build her nursing toward the highest professional and personal development of which she is individually capable. If each subject in the curriculum is considered a part of nursing itself, her goal will be clean cut from the beginning. A human being needing nursing and help is a real situation—and if the student has entered the school with sincerity, her response to the situation will be one of great desire to know what to do and how to do it safely, in that particular situation. The student nurse should have met certain standards in general intelligence, emotional tone, health, and aptitude for nursing before any school accepts her.

Her preliminary education in social and biological sciences, English, nutrition, hygiene, mathematics, should be sound whether obtained in college or high school but, as its purpose may have seemed but vague to her, much of it will already have been forgotten by the time she enters the school of nursing. The professional school must tie each subject to its practical application in nursing, that its place in the curriculum will be unquestioned.

For economy in learning, therefore, the first basic essentials are good
nurses who are also good teachers, upon the faculties of schools of nursing. If her teaching is to be truly effective, the promising young graduate R.N. should be encouraged to try her wings in private duty in hospital and home; in public health to know the vast needs for health education among people at large; and in hospital positions of minor trust, before she should be encouraged to prepare herself especially for teaching in a school of nursing. She will then know the actual needs of her students as nurses, and if she has imagination, can make every subject live in terms of nursing. Young teachers should have opportunities to grow in their early positions, by the cooperation, advice, and encouragement of the educational director or the principal of the school. Only after she has had guidance and experience in her work should she accept responsibility in a school where she must carry alone the heavy responsibility of adapting the curriculum to the facilities of a small school and using of resources outside of the hospital intelligently.

I hope in the pattern of the new curriculum the student will be introduced much earlier to the actual patient, that she may develop by contact with good nurses, and imitation of good nursing, the manner and manners most conducive to desired response on the part of the patient. Dr. Cushing, I believe, said this can only be acquired by long observation of the sick extending over a period of years. Her nursing skills may be meager and most hesitant but she will be acquiring a valuable fund of impressions through each and all of her senses, and her needs of formal work in the classroom will become vivid and real.

For economy of actual learning, I would have the young student take fewer subjects in the classroom at first and give her more time upon wards to acquire information and an appreciation of the need for information, if her only contact with patients was feeding of the helpless, and reporting their wants to nurses in authority.

Economy in learning at least presupposes that learning has taken place and that essential information, appreciations, and skills have become a part of that integral unit we call a nurse. Perhaps other state boards have had Ohio's experience, and find that the weakest spots of learning have been in first-year subjects which one might term, pure science, e.g., anatomy, drugs and solutions, bacteriology, and chemistry. As soon as the clinical subject matter is put into actual practice it becomes fixed and subject to ready recall. Nursing in obstetrics, pediatrics, medicine, and surgery, is a sure and perfect tool for the handling of a patient as evidenced by state examination returns.

The same cannot usually be said of questions upon muscles in anatomy. However, if muscle names were translated in the classroom from Latin into English; and if they were put into action then and there, to see if they actually lived up to their names; if they were felt by the students upon each other in contraction and relaxation; if they were teased out of a piece of meat; or drawn with their attachments from the dissection of a frog; or were modeled in miniature from plasticene, they would become items of real interest. If later they are met both actively and passively in massage; used
intelligently, and again by name as patients or beds are lifted or moved, they will be learned permanently and in relation to their functions. So will come an intelligent understanding of overriding and muscle pull in fractures and the reason for splints, pulleys, weights, and frames will be actually integrated with anatomy and nursing.

If we can extend what we now try to cram into four months over the first year in the school, and keep our students thinking about fewer subjects at the same time, but repeatedly each week upon the same courses, probably more of what we are pleased to call the curriculum will become a part of the student. For instance, bacteriology five days a week will be better learned than bacteriology once a week for five weeks. It is no wonder that nurses have developed mental compartments as a defense mechanism, to try to keep their valuables of information safe when they have bacteriology Monday, history Tuesday, hygiene Wednesday, chemistry Thursday and ethics Friday as a jazz accompaniment to a daily diet of nursing principles and practice, and anatomy and physiology. Of course, I apologize to this group for such an inference, but it has been almost that bad at times, has it not?

Upon the first year's essential courses we build our real nursing. It is here the medical specialists' point of view and the nursing textbook are compared with the sick patient in the bed who is either just as the book says he is, or who deviates from the classic picture. He is given special medication and treatments, turned, fed, kept content, and encouraged, and observed keenly and reported accurately upon charts and to supervisors with perhaps courageous insistence. And so again comes integration, that carefully constructed unified understanding which is acquired by the intelligent, alert, and sympathetic young woman whom we wisely guide as she builds her own type of nursing from the pattern of the curriculum.

A nurse must have much factual knowledge at all times, and we are justified in using more over-learning than may be necessary in other fields. If the same subject is attacked from a variety of angles in various courses of the curriculum, it can remain interesting and be more firmly mastered. Not only will there be the value of spaced practice, but of maturity, good judgment, and skill, if the completion or polishing of certain practice courses in the curriculum is postponed until late in the period of training. For example, if a four-month course in surgical nursing at the end of the first year completes that area, we assume that all the skill necessary for the nursing of the most complicated of such cases would be possible at the end of the first year.

How much more valuable that completion would be if it followed the period in the operating room. Luckily for us, the practice fields in the average hospital force such completion.

Ward practice is a most valuable aid to economy of learning. To make it effective, tools should be at hand for use—a shelf of books on the ward for ready reference, and a place where the student may use them and write her case notes; alert ward teachers who as tutors wisely guide toward a correct solution of a problem, or by actual demonstration, word, and deed show
one effective method of handling the situation. Such means are absolutely justified as a teaching hospital obligates itself to give both good care to patients, and good teaching to its students.

The effort of the modern educator to fix learning by motor activity is shown by the work manuals at present available in so many areas of our curriculum. No tendency to save the student nurse expense should prevent their purchase and use in conjunction with the texts available. No matter how extensive a reference library may be, students should be required to own one text in each area which they may mutilate by underlines and marginal notes to their heart's content.

Such simple expedients as arranging a class schedule so that the subjects requiring the greatest mental effort are placed between 9:30 and 11:30 a.m., or between 3 and 5 p.m., add to the economy of learning. Progressing from what the student knows to the new, and giving her assignments comparable to her individual ability, that she may have the stimulus of a challenge for growth throughout the course are sound methods of teaching. Each geographical area of our country has local opportunities and the soundness of the teaching will depend upon how we use what we have available. Too heavy service assignments may be just as detrimental to good nursing, as a too limited practice field.

For its interest and stimulating ideas, I am presenting an "Application of the unit method of teaching," which was developed this spring at Ohio States University by a young instructor for use in the four-week practice period of a senior nurse in the emergency and First Aid department. In brief summary it consists of three mimeographed units (I) General Nursing in Emergencies with social, professional, and legal problems; (II) Surgical Emergencies; (III) Medical Emergencies. The student had three days of finding herself before being given unit I, eleven days for its completion, nine days in surgical emergencies, and five days for medical. She classified the surgical emergencies of the department, wrote a paper comparing likenesses and differences in wounds and their treatment, and classified medical emergencies involving unconsciousness with symptoms and treatments of each. During the four weeks the instructor had ten conferences with the student, some lasting over one hour. The schedule was flexible enough to adapt itself to the interests and growth of the student, yet the guidance was firm enough to utilize the opportunities in the department, and the attitude of the student changed from one of fear to that of confidence gained. Such use of teaching in the hospital wards is a most valuable adjunct to the more formal work in the classroom as it utilizes informal and tutorial methods.

So modern experiments in the field of general education are being applied to nursing education to secure better integration and economy of learning, by certain courageous members of our profession. Like other new things, they must prove their worth, and time alone can give us that information. When nurses, developed by such measures prove themselves to be more capable, intelligent, professional women, more able to meet the nursing
and health needs of an everchanging society than our present R.N.'s, the curriculum will again be in need of revision.

**General Session**

*Thursday, June 6, 1935, 4:15 p.m.*

Presiding: Stella Goostray, R.N., Principal, School of Nursing, Children's Hospital, Boston, Massachusetts

General Topic: **How to Secure Adequate Clinical Experience**

A. **In Communicable Disease Including Tuberculosis**

Nellie S. Parks, R.N., Assistant Professor, School of Nursing, Western Reserve University, Cleveland, Ohio

Any answer to the question of how to secure adequate clinical experience in communicable diseases must be arrived at through a consideration of first, the objective of the basic professional program of which the communicable diseases form one unit; second, the field of communicable disease as seen through present conditions and indication of future trends; and third, the knowledge the nurse must have to solve the problems she meets in her daily contacts.

The changes in society which are forcing reorganization of the lives of individuals, of peoples, and of their institutions in terms of the good of the group, are setting new goals for the nurse. Her function is being broadened to include the patient in all of his relationships whether to family, associates, or community. She must be able satisfactorily to solve the problem of care or illness wherever she finds it and to take her place as a professional woman in the building of better health and more adequate opportunities for the maintenance of happy and successful living for every member of the community.

Through the centuries, communicable disease has stalked the pathway of human beings and has provided society with one of its most difficult problems as well as a constant challenge to medical practice. Very little progress was made in control until the work of Pasteur and Virchow furnished the direction which scientific medicine was to follow. Isolation by Dr. Koch of the organism of tuberculosis in 1882 ushered in a new approach to the problem of communicable diseases. Other organisms were isolated in rapid succession presenting a new challenge to medical research—that of finding ways and means of protecting individuals from the diseases caused by these organisms. Two facts were soon evident, that not all people who were contacts developed the disease, and that one attack of the disease provided immunity to later exposure. Out of these findings grew our present methods of prevention.

The stages through which the study and control of diphtheria have passed give us the general method of attack on these problems and help us to under-
stand what is happening throughout the field today. Diphtheria has pro-
gressed from isolation of the organism in 1883, to development of diph-
theria antitoxin, the first dose to be given in this city in 1895, the Schick
test for immunity, development of an immunizing agent. The last stage,
starting with toxin-antitoxin followed by anatoxin, toxoid, and the more
recent use of alum precipitated toxoid for more rapid and better controlled
immunizing programs. Community immunization programs began with the
one group under control, the school child, and was extended to the preschool
child, as the group which most needs protection. In those communities
where consistently planned programs have been set up the disease incidence
has been reduced and mortality rates have dropped rapidly. Two cities
report no deaths from diphtheria the past year.

The epidemic diseases forced themselves on our attention because of their
widespread prevalence and high mortality in childhood. Naturally these
problems were among the first for which a solution was sought.

Among the epidemic diseases which stand out in our communities in se-
verity or prevalence are diphtheria, scarlet fever, measles, pertussis, polio-
myelitis, meningitis, influenza. Smallpox has long been under control and
the common cold is perhaps farthest from solution. Scarlet fever follows
closely on diphtheria in progress toward control with isolation of the organ-
ism, an antitoxin, a test for immunity, and a method of immunization. In
those diseases for which the organism has not been identified, protective
and alleviative methods have been fairly well established, as for example,
the use of whole blood or immune serum for protection from or to lessen
the severity of measles.

Those diseases not epidemic in type have been slower in their progress
toward control. Tuberculosis still ranks as the chief cause of death in the
age groups from 25-45. As an attack of the disease in the epidemic types
established in most cases a long-time immunity, it was thought that evidence
of an attack and calcified lesions in tuberculosis would produce an immunity
to tuberculosis. This, the tuberculin test seemed to indicate, but more re-
cent work shows the positive tuberculin to indicate an allergy or sensitiveness
to the organism the result of a minimal attack and also indicates the potential
cases of tuberculosis. Though we do not have a test for immunity to tuberc-
ulosi nor a method of immunizing against the disease, it has been shown
that when every case is followed to its source and the contacts to the case
are kept under close supervision that the number of individuals who reach
adult life without an attack of tuberculosis is increasing. A few years ago
it was generally conceded that from 90-100 per cent of us had had a mini-
mal attack. According to Dr. J. A. Myers, in one community where a
former rate of 90-100 per cent had existed, following a case-finding pro-
gram the number had been reduced to 35 per cent.

The early approach to the problem of communicable disease prevention
and control was through removal of the patient from the home and control
of movement of contacts. The pest house and the quarantine system are
representative of that era. As scientific knowledge increased the pest house evolved into our modern isolation hospital so planned that all types of cases may be cared for without fear of transfer. Though quarantine occupies an important place in control, it can never be completely successful and efforts today tend toward protection of as large a part of the child population as possible through immunization. The function which the hospital has come to assume is that of a care-taking institution for those very ill or complicated cases which through lack of facilities can not be cared for at home, and to provide protection to the community when through lack of cooperation the case in the home becomes a danger to the community, control will be secured through the use of all these methods—immunization, quarantine of contacts, isolation of patient. Many groups are searching for an immunizing agent and eventually science, in all probability, will furnish us some type of protective agent for tuberculosis.

Communicable disease hospital development reached its peak in the decade between 1920 and 1930. With few exceptions they belong to the official agencies charged with the responsibility for health and disease prevention in the community and as such have reached a size disproportionate with the number of days occupancy in their attempt to meet the pressing need of protection and care where concentration of population creates a serious problem in the spread of epidemics. The yearly average of bed occupancy for these hospitals seldom reaches more than 40 per cent due to seasonal fluctuation of service. While control of the acute communicable diseases is shown in the decline in case incidence, the hospitals reflect the decline in the number of cases admitted and the daily average number of cases cared for. Recent statistics of the Council on Medical Education covering hospitals used for medical teaching, show a drop of 30 per cent in the number of isolation hospitals and more than a 10 per cent decline in daily average number of patients. As our knowledge of communicable disease increases and our methods of control become more effective, the need for the large isolation hospital for epidemic types alone will decline. More and more are we seeing the contagious disease unit as a part of the general hospital.

Tuberculosis presents an entirely different situation in the type of case, age groups involved, and the problems to be met. As opposed to the epidemic types with their short duration, tuberculosis presents a picture of long-time disability and a need for reeducation of the individual for safe community life. It was very early accepted as a problem of the community and tuberculosis sanitaria dot every state. These institutions were devoted to a type of living aimed at cure and provided for large numbers. New methods of treatment supplementing the best of the old type whereby the number of cures is being increased and the length of time required is being reduced somewhat are making new demands on the sanatorium both for beds and facilities.

Emphasis on surgical procedure in tuberculosis is bringing more and more to the front the need of utilizing the facilities of the large medical center
with its greater opportunity for study and advancement in method of treat-
ment. Again quoting from the Council of Medical Education report we find
though the number of tuberculosis sanatoria decreased from 508 in 1927 to
496 in 1934, there has been an increase in bed occupancy in that period from
50,784 to 59,689. The growing feeling that all patients need a period of
sanitarium care to help them establish right attitudes is increasing the need
for beds. That beds are available in other institutions is contributing to the
movement toward the large medical center. However, even with a decline
in death rate and many more cures than formerly, the spread of infection
must be controlled through isolation of cases, control and follow-up of con-
tacts. That it is now possible to care for acute communicable disease with
reasonable assurance that no transfer will be made—the need for more beds
for tuberculosis than are now available in sanitarium—and the opportunity
for better facilities for care are, in themselves, starting a movement of all
communicable disease toward the larger center. We can expect the future
to bring isolation units which will provide care for all types of communicable
disease into the general hospital plan.

Communicable disease is distinctly a community problem. It is a prob-
lem every family must meet; it may complicate or accompany any other ill-
ness, its importance decreases only as the members of the family group are
provided with some means of individual protection. In communicable dis-
ease we are dealing with illnesses which reflect more sensitively than any
other the results of concentration of population. In addition, they are so
interwoven with all other fields of illness it becomes imperative that the
nurse whose function is interpreted in terms of community needs have such
preparation as will provide her with an understanding and appreciation
of the problems it creates and a knowledge sufficiently broad to help in the
solution of such problems. With such shifting as is going on within the
field it becomes evident that the preparation of the nurse must change. An
adequate experience then in communicable disease should cover prevention
and control as well as the care of those who have the disease; it should in-
clude tuberculosis and venereal, if they are not otherwise covered, as well as
the prevailing epidemic diseases.

Though the final responsibility for communicable disease is vested in the
official agency charged with the health of the community variously called
Department of Health, Division of Health, etc., the work of the department
is divided into bureaus on the basis of care of sick and prevention and con-
tral. Most large communities have contagious disease hospitals for the care
of these patients. It is not possible to care for the entire number during an
epidemic so the division of health must decide which cases must be hospital-
ized. This may mean a widely varied service or as so often happens with
scarlet fever, there may be a large number of mild cases which present a
very limited illness problem but an important problem of child management.
Immunization programs are changing the type of cases which we see in most
communities and as times goes on the classical types are disappearing and
this phase of the service should be of decreasing value. On the other hand, methods of control are increasingly important. The common contagious diseases are diseases of childhood. It is well known that most children are immune to communicable disease until the age of six months, immunity then drops quickly, rising again around six years of age. The highest mortality rate occurs between six months and two years. Protection of these children is the most important part of any health program. The nurse must have experience in immunization clinics, become thoroughly familiar with the types of immunization, dosage, methods, and effectiveness in order that she may interpret them to the family; she must have knowledge of the various methods of isolation, of quarantine, and techniques, their strength and their weaknesses. The contagious disease hospital will undoubtedly continue to furnish the bulk of the experience in that it is a controlled situation and there is concentration of material, but this service must be broadened and enriched.

Tuberculosis service, whether a part of the isolation unit or an isolated sanitarium, furnishes one obstacle to its use which we can not afford to minimize. The highest incidence in this disease is in the youth and young adult. We are dealing with young women and young men in nursing and medical schools at the age of greatest susceptibility and we are morally responsible for insisting on the use of every protective measure known today before we send students to this service.

The record which both professions have to face of cases of tuberculosis which have developed on our services, of positive tuberculins in students who entered the school with negative tuberculin tests, in general hospitals through lack of protection from the undiagnosed case is not to our credit. Experience must be provided only in those institutions where strict isolation technique is carried out, where there is a close check-up of the nurse as she goes on to the service and constant vigilance during her period of service. All communicable disease hospitals have a low incidence among their personnel compared to the general hospital. When we appreciate the fact that tuberculosis may be present two years or more without showing symptoms, the reports of tuberculosis in medical and nursing students which are coming from many schools are serious enough to make us question the validity of our thinking if we do not insist on using on all of our services whether communicable, tuberculosis, or general hospital wards, every available precaution for the protection of the students whom we admit to our schools.

To summarize, we find in communicable disease, a field so interwoven with every phase of illness, so important to the nurse who meets needs of the community, one extremely sensitive to social change, a field in which society has taken the lead, and set up available agencies, which can furnish the experience the nurse needs. This places on us as members of the profession the responsibility for securing these services from all these agencies in such way as will provide for care, prevention, and control and the best good of the community.
It has been unfortunate for nursing education that in the past there developed such a sharp demarcation between mentally and physically ill patients. The rôle of the nurse in the physical care of patients was emphasized while the emotional traits common to all types of individuals were slighted. Consequently, the opinion has been expressed in the past that the purpose of any nursing experience with mentally ill patients is primarily to develop a group capable in the care of such patients. A two- or three-month affiliation in a mental hospital does not make a psychiatric nurse. Psychiatric nursing is a specialized field and to attain proficiency in it requires more experience than may be obtained in an affiliation.

An understanding of the motivation of behavior and tact in dealing with people are essential in all nursing. It is to develop this understanding and tact and to assist in the nurse's personal adjustment to her work and life as a whole that psychiatric nursing in the basic course must contribute tools. To be more specific, it may be stated that our objective is to give the student:

1. The concept of unity of the individual; that the mind and body are parts of one whole and function as such
2. An understanding of wholesome and unwholesome reactions and the relation of these to mental illness
3. An understanding of emotional disturbances which may be manifested in physical symptoms
4. An understanding of the nurse's responsibility in furthering a positive mental health program in the community
5. An understanding of the rôle of recreation, art, music, etc., in the promotion and maintenance of mental health
6. An understanding of the extent of mental illness, social problems arising from mental illness, and community facilities for dealing with these problems
7. A general understanding of the etiology and the mechanisms of the common types of mental illness together with their treatment
8. A facility in dealing with people

The field for clinical experience must be carefully chosen. The subjecting of students to the nursing of mentally ill patients without adequate guidance has taken place in the past and it is probable that the students learned much through trial and error, but it is also probable that the trials were more numerous than is necessary and the students missed a great deal. The same type of criteria as is used in judging the educational value of any other hospital service may be employed in evaluating psychiatric service. Is the service large enough to give experience to the number of students expected? Is the type of patient varied so that the student will obtain experience with a sampling of psychiatric conditions which will offer the maximum learning possibilities? Is the atmosphere professional and educational or do the individuals who will of necessity serve as examples to the student look upon their work as routine and something to be tolerated? Will the students be
exploited or is there an adequate graduate staff? The importance of such a graduate group can not be over-emphasized. It acts as a stabilizing force and a nucleus to care for the patients so that the situations in which a student is placed may be controlled. Thus the educational value of the ward experience is ensured. Assistance in ward teaching, which will be discussed later, is likewise a function of this group. In most instances a service which fulfills these qualifications may be obtained only through affiliation. Wide clinical experience is available in our larger mental hospitals. Selected divisions may be adapted and utilized for this purpose. For a time compromise may be necessary for financial reasons and a neurological ward or selected patients in a general hospital utilized. This is a beginning and may be made of great value, but it should not be considered a permanent substitute for a comprehensive experience. This psychiatric experience should be placed in the second or third year of a three-year course. If it is received in the second year, the student will have much more opportunity to apply what she has learned to her general experience. In some instances it may be practical to divide the experience so that one part is given early in the student’s course and a second part later.

In considering the content of this course, theoretical and clinical experience supplement each other, each contributing to the aims we have set up. In the psychiatric course the following topics may be discussed:

- Etiology of mental illness
- Symptomatology
- Types and disorders of personality
- Mental mechanisms
- Affective reaction types, etiology, symptomatology, treatment, prognosis
- Organic reaction types, etiology, symptomatology, treatment, prognosis
- Prevention of mental illness, factors conducive to mental health
- The growth of mental hygiene movement
- Community problems arising from mental illness and facilities for dealing with these problems

Such a series of lectures will be illustrated by the histories and behavior of patients seen by the students and will be supplemented by clinics. Field trips may be made to representative institutions and agencies.

Instruction as to the nursing care of mentally ill patients and also as to what we may learn from this illness will become of necessity more and more clinical in its approach. Any one who has conducted classes in the care of mentally ill patients must have had a feeling of futility unless her approach has been clinical. There are even fewer factors common to two individuals with the same mental illness than there are to two with the same physical illness.

We may cite the illnesses of Mrs. B. and Miss J. Both have been definitely diagnosed as schizophrenic: Mrs. B. has been hospitalized since the birth of her baby ten years ago and there has been little change in her condition since that time. She shows little interest in her environment. Any attempt at conversation with her is difficult, as she will continue her own
monologue. She will spend long periods of time standing or lying in one position. Participation in any occupational project is automatic. If outside stimulation is too strong she will become irritable or impulsive.

Miss J. is twenty. Her family had high aspirations for her success as a lawyer and had passed them on to her. Her intellectual equipment although average is incompatible with the program set up for her. She has thus met increasing failure and now with this and the family disappointment, she does not know where to turn. If left to herself she will day dream for long periods. She will readily coöperate in any ward program but shows no interest or initiative.

Thus, although these two individuals have the same illness, the nursing problems are decidedly different. Mrs. B. has little chance for recovery and the family must adjust on this basis. With this patient the immediate program is habit formation. With Miss J. the nursing aims are to develop initiative, give security through success, and create an interest and confidence in the future. Other schizophrenic patients may show still different problems.

Thus instead of only treating the nursing care of schizophrenia in general we may choose several patients with introvert tendencies and through discussion develop the following points in relation to each:

1. Facts in the patient’s history which are indicative of maladjustment
2. Symptoms presented by patient preventing her adjustment to the community
   The relation of these symptoms to her previous adjustment
3. Program for nursing care. Responsibility of the nurse in initiating occupational and recreational projects
4. Family and social problems arising from this illness. Adjustments which will be necessary due to continued illness of the patient, or due to return of the patient to the home situation
5. Program for after-care of the patient
6. Adjustments which might have prevented this illness. Nurse’s responsibility in assisting with such adjustments

We may then show the underlying similarity in this group of introvert patients and the adaptation of general principles which is made to the program of each individual.

In the ward teaching program which is not restricted by a lack of time, as is a class, the more specific problem of nursing care may be discussed. This might include a type of approach which facilitates the coöperation of specific patients in recreational projects, the rôle of the nurse in such projects is dominant at first but gradually withdrawing as the patient gains initiative and self-confidence, or it might include the nurse’s approach toward specific symptoms such as delusions and hallucinations which complicate the nursing care. Through coöperation of the class instructors and those responsible for ward teaching there need be no limit to this coördination. Each class topic may be followed by more detailed and specific discussion on the wards.

The methods used in the formal ward teaching program are the same as those usually employed, and include morning circle, small clinics on the
wards, case study, and individual conferences. A card file listing the aims in the nursing care of each patient is also helpful in the orientation of the new student.

Informal ward teaching is an important influence in the adequate clinical experience. By this is meant suggestion as to the care and understanding of the patient which is not definitely planned but which is given as need arises during the day. A new or complicated situation may arise in dealing with a patient. The graduate will indicate to the student if she did well in handling this situation or how her approach might have been improved. If the graduate found it necessary to assist the student, she will analyze with the student the reasons why her own approach was more successful. This program for informal ward teaching emphasizes the need for a well-trained and understanding graduate staff who appreciate the needs of the patient as well as the student. An individual who has little experience or who has not crystallized her thinking in regard to her own care of patients will be able to pass on little to the student group. This need can only be met through graduate and student working together day by day. Any one discussing the situation with a student later can not appreciate all the factors present, and thus can not so clearly help her. Likewise, a student working alone without graduate assistance may not realize her need and thus it may be overlooked. The time constructive advice is needed is in the specific situation. We must face the fact that this graduate-student relationship has many of the elements of an apprenticeship system. It is controlled, however, and is only one aspect of the whole plan. As Dr. Kilpatrick said, "We learn in the situation."

If the student is to apply to her general experience what she has learned in this period of concentration on mental illness, emphasis on adjustment must not stop in the mental hospital. We learn through reacting, and to complete the program we must insure the transfer to the student’s general experience. Thus the mental hygiene approach must be integrated into the whole course. In medical lectures, for example, not only the physical problems in rheumatic heart disease and gastric ulcer but also emotional problems arising from this illness should be discussed. This will be followed in the ward teaching program of the general hospital by discussion of the individual problems of the patient with such conditions. We saw a beautiful demonstration of this integration in the symposium this morning.

The rôle of this experience in contributing to the personal adjustment of the nurse must not be overlooked. It it understood that the student has a background of psychology and mental hygiene preceding her psychiatric experience and through this she will be already familiar with normal mental mechanisms. The psychiatric experience will focus her attention on adjustment and give her an awareness of the importance of a well-integrated personality. She will see retreat mechanisms and their results and may thus more clearly evaluate her own reactions. She will see the rôle of a variety of interests in producing and maintaining mental health. Her self-confi-
dence and leadership will develop since of necessity she has been the key-
stone in group activities and in making individual contacts.

In conclusion, an adequate program for clinical experience in psychiatric
nursing has many ramifications. A good clinical field must be present; there
must be a good theoretical background so that the clinical experience may be
understood and the clinical and theoretical experience must be interwoven
through ward teaching. Lastly, to transfer this understanding of the unity
of the individual from the specialized field to the nurse's whole experience,
the rôle of emotional adjustment should be recognized and placed on the
same level as physical aspects of prevention and disease throughout the whole
basic course.

C. IN NURSING WITH A PUBLIC HEALTH AGENCY

RUTH HUBBARD, R.N., Director of Visiting Nurse Association,
Philadelphia, Pennsylvania

A satisfactory answer to the question of how students shall secure adequate
experience in public health nursing would solve, at least temporarily, one of
the most pressing problems in the field of nursing education, as far as those
of us who are engaged in public health nursing are concerned. A generation
ago public health nurses were enthusiastic over what they felt to be the
educational values in their realm and besought directors of schools of nurs-
ing to release their students for affiliations in this newly developing field.

Hesitantly at first, dubiously perhaps, with difficulty always because of
pressure within the hospital walls, directors experimented with their enthui-
astic colleagues, sending first an occasional student, then a regular group,
and finally in some instances, the entire senior class to the local public health
nursing agency for a period ranging in length from two to four months. In
the beginning the objectives of the school directors in this departure were
vague and inarticulate. They had heard of something called a public health
point of view. They discovered that students who had been "outside" some-
times returned with an understanding of their patients and an awareness of
illness as an experience with many ramifications in family life that did not
always develop during the hospital experience. Something had been added
to the student—just what it was or how it might help her in her future work
was not always clear.

Meanwhile, the public health nurses urged affiliations. This field was de-
veloping rapidly—new workers were needed—many were learning "on the
job" and those who had had some introduction as undergraduates were in
demand. The affiliations continued. They increased in number and the
volume of students receiving the experience grew likewise. In some places
nurses said that every student should receive this service during her training.
Others believed that it was valuable only for certain students, i.e., those
definitely planning to enter community nursing; those with particular prepa-
ration; those with special aptitudes. Wide variation developed in policies
governing the selection of students for this experience. Likewise differences obtained in the preparation of the student before her affiliation, the experience offered her in the public health field, the educational program provided by the agency, and the assumption of responsibility for the expenses involved.

By the time that the *Survey of Public Health Nursing* was published in the spring of 1934, and the League began its revision of the standard curriculum in the fall of the same year, certain procedures concerning affiliations in public health nursing were generally accepted as desirable although not carried out universally. It was considered advisable for the student to have had certain clinical services prior to this affiliation, as general medicine and surgery, obstetrics, pediatrics, diet kitchen, and if possible dispensary. She was to come to the visiting nurse association in her senior year, for approximately two months, being at the time wholly free from responsibility for service in the hospital or classwork in her school. The public health nursing agency was to offer a planned program of observation and experience and to provide an instructor upon whom rested the responsibility for the student's experience and supervision. Regular classes, demonstrations, case conferences, written work, formal reports to the school of nursing, the provision for joint conferences between the teaching staff of the schools and the public health nursing agency were all accepted as fundamental to a sound student experience.

The Survey showed those of us in public health nursing that we had achieved this standard in part only. The new Curriculum Committee challenges us to set even richer objectives for achievement. Today, schools of nursing are increasingly asking for this affiliation for their students. State boards of nurse examiners are urging, even requiring, it as a means of enriching the clinical experience offered by certain schools.

So incompletely have some of us understood the purpose of such an activity that within the last few years occasional VNA's have thought tentatively of affiliations as a means of augmenting falling staffs, while others, long associated with student work and fully appreciating its value, have reluctantly restricted their intake because of inability to bear the expense of the necessary teaching staff. Schools faced with the problem of meeting in whole or in part the financial outlay of an affiliation for their students have questioned their ability to do it and have begun to search for other answers to their needs. Schools meeting refusals to their requests for student openings in public health nursing agencies whose standards they approve have been faced with the problem of what to provide as an alternative. Generally speaking, private rather than public agencies have been involved in this participation in nursing education. Few public agencies have had in the past adequate educational personnel to undertake such teaching responsibility. Obviously, the schools have been faced with difficulties of selection. How could the school evaluate its prospective associates in educational responsibility? Likewise the VNA has been troubled. Volume alone has pre-
vented it from accepting all students from every school. How should the field organization evaluate the schools who desired its assistance? How should it determine when to accept and when to refuse?

May I set before you the objectives we have accepted for this part of the student’s education that we may see if they are to be attained only in a public health nursing agency?

It has been our desire, first, to give the students some understanding of both healthy and sick individuals of all age groups in their own homes, as a basis of wider understanding of human problems; second, to extend their knowledge of the health and social factors in family and community life relating to the maintenance of health as well as the development and treatment of disease; third, to increase their familiarity with existing community resources for the prevention and control of disease; fourth, to help them to adapt hospital methods to the situations and equipment found in homes; fifth, to teach them how to approach the family and help to make the adjustments needed to maintain health and to facilitate recovery; and finally, to enlarge their experience in relation to conditions and stages of illness seldom seen in the hospital.

In other words, we are interested to give the student what might be called a health approach in nursing. We wish to increase her skill and knowledge in the promotion of health as well as in the care of sickness. We desire to enable her to use this skill for those individuals and families with whom she comes in contact to prevent illness through health education. We hope that such an experience will enable her to see more clearly the place of nursing in the community health program whether it be in the hospital, clinic, home, school, health center, or industry. We are eager to have her see nursing as a part of a great movement which permeates the entire community, rather than as an isolated activity occurring in certain carefully constructed situations.

These objectives seem far-reaching and have been set with the public health nursing agency definitely in mind as the field for experience. However, when they are explored carefully, it is evident that much that is set up in them can be achieved in other experiences now available to the student. With the exception of the objective which gives the student experience in helping families to adjust to the problems of illness within their homes, the aims stated above can be integrated into the undergraduate experience available within the hospital and dispensary walls.

We have said that we desire for the student the public health point of view. To define the term is not easy, but to most of us a public health point of view assumes an ability to regard the patient as an individual having a family to whom he will return following his illness and with whom he will take up his life again. The relationship between sick and well individuals in their family life is of great importance to the health of the public in any community. A public health point of view implies a knowledge and understanding of the fundamental principles of community health. And there
follows upon this an appreciation of the importance of each individual’s welfare in the health picture of the community as a whole. The student in the school of nursing is concerned with the acquisition of knowledge which will enable her to minister successfully to the needs of those patients under her care. She is equally desirous of adding to her equipment knowledge of disease—its prevention, cause, manifestations, treatment, prognosis. Her major interest lies in acquiring this knowledge and in its use in the performance of services which will benefit those about her, giving her at the same time the confidence of experience in her chosen field.

Only recently have we included in our objectives for the undergraduate the desire that she shall acquire not only a knowledge of how to care for the sick herself, but also how to teach others to give this service, and even more important the knowledge of how to enable others to prevent the onset of illness in themselves and their associates. In the field of public health nursing, we have been concerned with this responsibility for teaching by the very nature of our activity. From the beginning of the movement, the nurse has been a visitor rather than a permanent member of the household. In a large part of the field she has been a visitor at such rare intervals that she was unable to assume responsibility for any regular part of the care of the sick individual. Early in her career she discovered how frequently illness was the result of lack of knowledge. Therefore, she was impressed with the need for positive rather than corrective teaching only. Many public health nurses have learned through trial and error such skill as they now possess in the art of teaching. For their young professional sisters they desire the early acquisition of these skills and knowledge for the benefit of the nurse herself and for the equal benefit of future patients.

The hospital is a very busy place. The student is surrounded on every side with a wealth of new information which she desires and needs to master. To integrate this additional point of view throughout her undergraduate experience is a task which can not be laid upon the already heavily burdened shoulders of her instructors. There are those of us who feel that in sending a student to a public health nursing affiliation in her senior year, and requesting that she be given experience to achieve the objectives listed above, we are asking much of a community agency in terms of intensive experience for the student. After many years of study we are wondering whether an affiliation in public health nursing is something like the frosting which is set upon a cake. We wonder whether the cake would be better if the ingredients in the frosting were mixed with the batter and a different result obtained.

If it is important for the student to understand the value of health teaching; if it is important for her to think in terms of health as well as in terms of care of the sick; if it is desirable that she have knowledge not only of the acute stage of illness, but also of the onset and period of convalescence so difficult for many individuals; if her appreciation of the place of nursing in
the community is vital, why do we wait until her senior year, giving her then a very intensive experience to supply these needs?

It seems to me that we can wisely ponder this question and that the answer may appear in the action which certain schools have taken by adding to their faculties a public health nurse upon whom is placed the responsibility for the achieving of our objective throughout training. In those schools where such a person has been added, the methods used have varied. So they will vary if other schools accept this suggestion.

But however it is done, the ultimate success will rest upon the ability of the public health person on the faculty to see and use the myriad opportunities already existing in the hospital and the dispensary, for the student to see the patient as an individual, as a member of a family, who desires to be taught; who prefers health to illness; and who has a long road to travel to attain that health after he leaves the hospital.

In all nursing we have been concerned to set up satisfactory methods of procedure. Since the hospital has been our environment we have been interested chiefly to set up these methods of procedure in a manner satisfactory to the hospital. The Curriculum Committee tells us that it is considering, for its objective, the aim of adjustment for the ideal nurse. One of the things which we have been greatly interested to give the student in her public health nursing affiliation has been the ability to adjust to the home environment of the patient. If we are anxious to give her this ability, we can provide for it in her training whether she has experience in a variety of homes or not. The public, for whom we exist, has been known to say that the average nurse can not adjust to the average home. We know that this criticism is frequently just. Whether the student plans to go into community work or desires to enter the field of private duty, if she chooses institutional work or plans to become an administrative person, she will be called upon throughout her professional experience to adjust frequently and successfully. Therefore, so vital an objective can well be planned for earlier than the senior year.

We have sent her to the public health agencies to learn to teach because we believe that teaching is a part of the function of a nurse. Yet, while in her hospital experience she has been confronted with opportunities for teaching equal if not superior to those which she meets in the home. Why do we wait until she goes outside the hospital to give her any equipment for this major function?

If we agree that our objectives may be applied to the entire course in nursing and not to the public health nursing affiliation alone, then our concern lies not with how to secure a public health affiliation, but how to achieve these aims either through affiliation or without it. Let us face frankly the fact that as educators we are responsible for the whole of the student’s preparation and not only for that which takes place within our hospital walls. We can not rest comfortably believing that all we desire her to have will be “added unto her” at the VNA. We must be intimately
acquainted with the procedures used in the public health nursing organiza-
tion to inculcate the point of view we crave. A poor affiliation is infinitely
worse than none. An organization which does not provide carefully for a
supervised orderly experience for the student may be more harmful than
helpful to her. Even if it is doing admirable work as a service agency, it
may not be equipped to undertake a nursing education responsibility.

Beginning at home what can we do? We can add a public health nurs-
ing instructor to our faculties who will assist in integrating the health point
of view throughout the course. She will find a wealth of opportunity in
the ward and the dispensary. We can perhaps provide some field experience
in a sound public health nursing agency for our instructors and head nurses
so that they will be able to base their teaching of patient and student upon
actual knowledge of home situations. We can certainly secure for our stu-
dents observation trips with field agencies to visit patients they have known
in hospital or clinic, thus making the excursion an experience with real pur-
pose readily apparent. The student who visits her convalescent cardiac pa-
tient at home climbing three flights of stairs to the apartment realizes far
more acutely the importance of the oft-repeated direction of the physician,
"Stairs once a day only," than when she simply goes out with the public
health nurse to see patients in general. If the visit is made to the home
of a mother with her first-born, who learned in the hospital to bathe her
baby, the student is keenly interested to see how practical her teaching was
and is alert to add suggestions in her next group based upon the home visit.
The visit with the school nurse to the home of a former pediatric patient
with diabetes enables her to realize how carefully the dietary instructions
must be given in clinic if a mother, already responsible for a household of six
members, is to find her new program practical even before the problem of
teaching the child to eat the prescribed food is approached. Within the
hospital set-up there exist marvelous opportunities for learning how to teach,
while the dispensary staff following patients into their homes to be sure that
clinic teaching has been understood need not conflict with existing commu-
nity services. If such visits are made under the guidance of a qualified per-
son and with the aim of being mutually helpful to patient and student, their
value can not be questioned. We can include in our case conferences and
faculty meetings a member of the educational staff of the local public health
nursing agency, thus truly sharing with that organization our mutual prob-
lems in the student program.

The hospital has a long history of association with educational programs
for both medical and nursing students. The public health nursing agency
came into being first as a service organization alone. Its recognition of its
teaching opportunity and responsibility has come more recently. Aware
now that it has a real place in the realm of nursing education the agency
must remember always its first obligation to the public to whom it has
agreed to offer graduate nursing service. For this reason public health
nurses talk about ratios of staff and students, they murmur over saturation
points, and they raise questions about an adequate teaching and supervisory staff not only to meet student needs but also to ensure satisfactory patient care. In other words, they can not honestly forget their obligation to offer sound community service. Only when an agency is offering this sound service is it a desirable field for student experience. An educational process to be valid must be based upon a sound service program. No alternative is worthy of the effort involved.

These observations upon historical development and our groping aims in present practice summarize themselves readily into certain factual statements. A public health nursing affiliation with a well-organized public health nursing agency does give the student a wider understanding of illness in the individual, of the value of health and education for health, of human relationships in illness and health, and of the place of nursing in the community health program.

A public health affiliation is not the only place where the student can gain this knowledge. It would be valuable to have the student acquire this point of view concurrently through her training rather than in an intensive dose at one time only. The inclusion of these objectives in nursing education presupposes provision for adequate teaching personnel either in the field agency or the school of nursing. This acknowledges expense. Clinical education to be sound must be based upon sound community service. The fact that an agency offers good service does not mean that it can automatically offer students valuable experience. But it does mean that a rich student program can be developed in such an environment if those responsible are interested to do it. Not every visiting nurse association is ready to take students no matter how eagerly the schools request an affiliation. Some excellent services may be too small in size to warrant the addition of necessary personnel. When a school seeks an affiliation in public health nursing it wants to be sure that the agency approached can offer that experience more satisfactorily than any other resource within or without the hospital. The school with no VNA available need not be discouraged. Upon examination it may find rich resources of experience in its own clinics. These may not be ready for students immediately but with careful development they may become valuable sources of student experience. The thing we desire for our students in a public health affiliation is neither simple nor inexpensive and wherever we secure it the results to be achieved are worthy of sincere effort and investment.

Is there then an answer to the question raised by our topic? Yes, I believe there is, but it is not a clear-cut direction which says proceed by these steps. Rather I hold that we are faced with the opportunity for new pioneer work. It lies before us to rewrite our objectives for the health approach in nursing and then to proceed in countless ways to work out for each school the best methods of achievement possible. There will not be a uniform procedure but there will be uniformity of purpose and a universal eagerness to find and use opportunities presented by each situation. It is characteristic
of the pioneer that he has the courage to advance into unexplored territory. He is ingenious also and can devise ways for meeting his needs. At present by no known means could every undergraduate student receive an affiliation with a public health nursing agency. But every student can receive experience to help her realize the objectives of an understanding of health in nursing, and public health agencies can and will adjust their educational programs to meet the need of that new group of students who come out from the school of nursing seeking an opportunity to follow closely certain individuals or families in whom they are as students vitally concerned. The affiliation as we know it today will change. It is serving a purpose in awakening public health nursing to its educational function though that educational program may take a new form in the future.

As the pioneer is courageous so he is also fundamentally honest. In the matter of the public health affiliation let us be likewise foursquare, building our plans for this educational experience only upon sound service programs in hospital clinic or field agency; being concerned first always with the welfare of the patient; placing the student under the direction of adequately prepared and truly understanding instructors; and advancing steadily through enlarged experience and vision toward the realization of all that is implied in that broad objective—a health approach in nursing.

**General Session**

*Thursday, June 6, 8:15 p.m.*

**Presiding:** Alfihild J. Axelson, R.N., Chairman, Committee on the Child in Nursing Education; Lincoln School, Child Development Institute, Teachers’ College, Columbia University, New York City

**General Topic:** The Child, The Community, and The Nurse

**A. The Responsibility of the Community for the Positive Health of the Child**

**Jesse F. Williams, M.D., Professor, Health Education, Teachers’ College, Columbia University, New York City**

Every breeze today bears health upon its wings, but the wings are printed page and the breeze is propaganda. From all sides come health advice, health literature, health foods—health in everything. "Go West, young man," said Horace Greeley, two generations ago. That was the formula for success then. Today, youth is invited to seek health as the one, sure condition of success. If independence is needed in a business, health is the silent partner in the enterprise. If imagination is demanded in an art, health is the hand maiden of the dreamer; if intelligence is required in anything, health is the essential element in the equation to be solved. Indeed, if life on earth is any measure of one’s future residence in celestial spheres, then in terms of present-day emphasis, one should possess abundant health when he passes to the great beyond.
The community's responsibility for the health of the child is not a new social philosophy developing in a new social order but the logical product of a new kind of emphasis in social thinking. As people come to regard living as the central problem in human society, then the kind of living that can go on becomes the measure of social intelligence, community standards, and individual effort.

This wave of interest in health has been sweeping over this country since the World War. Never before in history has an equal amount of human effort been given to hygienic matters as in these first decades of the twentieth century. Man in history has been so engaged in making war, scratching a living from the soil, or speculating on the nature of sin and the causes for its originality that the possibilities in human development have been practically neglected. There are examples of prophets who urged their teachings upon mankind. Some served excellently as guides to fine living but as with prophets generally, their popularity varied in direct proportion to propinquity. One of the older prophets, Moses, found success with his sanitary practices as his precepts became in part the ritual of a religion. Some try that approach today. At all events the most popular sanitarian of history succeeded where later comers failed—perhaps due in part to the episode of the bullrushes. All of us love the story of Cinderella. The universal hope of mankind to find some day the fairy godmother or to be top name on a dollar chain for some 1,500 persons accounts surely for the favorable reception given to anyone who finds the silver slipper. Hippocrates and Aesculapius knew much more hygiene than Moses but their knowledge barely touched Greek life. Mercurialis, emulating the Greeks in his De Arte Gymnastica, was an ancient and honorable hygienist but doubtless most of you never heard of him.

If one hopes to awaken a community to see its responsibility for the health of children, one may need therefore to be an Ugly Duckling that becomes a Beautiful Swan. The modern public health worker with the aid of vital statistics, charts of epidemiology, scientific laboratories, control experiments, and the exact procedures of modern science has scant success with the traditional views of people. Customary ways of thinking about health, the conventional view that health is mere freedom from disease, and the traditional devotion to making a living rather than to living block the way. The World War shook us loose from certain smug complacencies, the draft, the loss of many splendid young lives, the malnutrition among children—these were dramatic enough to arouse a people rather inclined to live as "the folks did." In these depression years, the changing value of the dollar, the loss of paper or actual fortunes have again focused the attention upon primary values. People are asking, "Of what value wealth, national power, financial leadership, production schedules, and consumption records, unless there is more health and happiness in the world?" It is in such a mood that I attempt to set forth the community's responsibility in the matter.

It should be noted at the beginning that public affairs in American life
tend to fall into water-tight compartments. We departmentalize public services in very much the same way that we build departmental walls around the divisions of education in college and university. It might appear that this was the result of a high specialization. While the exclusive attention to one service makes for narrowness rather than breadth, a more fundamental problem is present.

It is not uncommon in American cities to find the schools responsible for the training of the minds of children, the health department responsible for their bodies, and the park department responsible for their play. Community failures in such matters are numerous. It is obvious of course that such separation in administrative practices has grown out of old philosophic concepts rather than developing as practical measures in a situation shaped by necessity. The belief in a separation of mind and body is still with us in spite of all the achievements of modern science.

Many of us still regard the brain as the organ of the mind, and the legs as the organs of locomotion in spite of the adequate teachings of physiology, anatomy, and psychology. We have difficulty in learning because of prejudices and difficulty in understanding, because of custom, that the entire organism is involved in thinking, that the entire organism is involved in walking, in fact that unity prevails with respect to all functions.

It is precisely this difficulty in comprehending unity in man that renders coordination of public services so slow. Consider the controlling views regarding the function of education. Note that I say controlling views; I do not say progressive, nor scientific, nor modern views. I refer of course to the opinions of those numerous persons who are quite uninformed regarding an education of the whole man, and are quite determined to make prevail the kind of education that they do understand. They are not to be criticized for having a purpose; they merely lack an adequate view.

For these persons, education is a discipline, a training of the mind. This is its sole and sufficient purpose. Hence, in these days of necessary economy, we hear much talk about the essentials of education, and what is called the frills and fads and fancies of education. Holding that the purpose of education is to train the mind, the argument is made that reduced budgets require that there be eliminated from our schools the frills of education. And what do they propose to eliminate? The wasted time in advanced mathematics? The wasted time in Latin? The wasted efforts of dull teachers? The wasted time in routine schedules and curricula standardized by minutes rather than achievement? No! None of these things will be touched, but the art, music, and physical education, the very heart of an education for leisure, the core of learning that may make life happier, sweeter, and more wholesome, the essence of happiness for many—these are to go because we have failed consistently to understand the nature of man. If we continue to act upon the supposition that the mind is a separate and distinct category of man, we shall doubtless continue to practice absurd and ridiculous measures in the administration of public affairs even as we do our own private ones.
On the other hand, it is important to consider the school as the very center, the source from which community life springs. But community life does not exist as a separate thing apart from the lives of the individuals who make up the community. There is in some quarters a disposition to shift the responsibility for fine living from the individual to the community. There is abundant evidence to support community action in control of communicable disease, but the secret of fine community life is fine living by the members of that community.

The essence then of community life, is an education of the interests, the impelling urges, and drives to activity of the children of the community. This must begin in school. Thus, the school instead of remaining as an academic institution for the training of the mind, becomes really a social institution for the training of the whole individual, the education of the whole man. When the school eventually attains this state, we shall then consider a person who is lacking in recreational skills, who is deficient in rhythmic and similar motor accomplishments quite uneducated regardless of the profundity of his intellectual equipment. Since we make our own lives by the living we experience, and since we have to live the lives that we have made, the test of how to live will be applied more generally than it is at present. Then, we shall recognize that the person who is educated only in academic accomplishments is as illiterate for life as the athlete who is educated only to physical performances is illiterate for life.

But education is more than schooling and the whole community shapes the problem. The tragedy of the mill town is not the dust and dirt in the air, the shabby houses and noisy streets that lead only to ugliness, not the broken, wasted, disillusioned men and women but the fact that children in such communities are not learning to live a kind of life that their nature promises in every cellular arrangement and every coordinated function. The community has not discharged its responsibility for the health of children when it controls communicable disease, removes garbage, and protects food and water supply. These services we give to our cattle, hogs, and household pets. Today a decent social order is demanded to give security in old age. That’s tripe for those who want it, but social responsibility is not for the past but for the future and youth needs a social situation that will give its powers a chance to develop. We probably have but scratched the surface of man’s capacity for growth in physique, strength, expressive talents, friendship, love of beauty, and similar traits and characteristics and we will remain the quarrelsome, ugly, weak, and diseased species that we are unless a good deal more attention is given to the conditions under which we rear our young.

A policy of semisocialism in distribution of goods, and of laissez faire in procreation exemplifies the sentimentality with which we regard national welfare. A policy of road building and construction work for grown persons and curtailed schooling for youth outlines the level of social thinking and the community’s understanding of its responsibility.
Some years ago in attempting to define health I coined the phrase "to live most and to serve best." This phrase described health qualitatively and expressed the functional view in which how one lives was the controlling factor. Over the years and through them there has been an increasing acceptance of this definition and I offer it tonight to expand somewhat my notion of community responsibility in this matter.

To live most means to live most now. It is based upon the notion that life here and now is important. Those of us who are asking for better opportunities for youth, who are proposing enriched curricula in the schools, and improved opportunities for recreation, wish life to be rich and full now, full of meaning now, abundant now, beautiful now. We are quite opposed to the doctrine that one should live a poor and mean life now so that in the future one may live a rich and full life. The old idea that one should work hard now so that he may enjoy the good things of life later is both hoary and venerable, but it is also "hooey" and vulnerable as shown by the thousands that have so lived. The view I propose, says in effect, "The only way to have abundant life in the future is to live abundantly now. The only way to enjoy beauty tomorrow is to enjoy beauty today. The only way to live at your fullest and best tomorrow is to live that way today."

It is perhaps not extravagant to say that the hunger for more abundant life, richer and fuller living, is opposed to the present idea of work that so widely prevails. Not that it is adverse to believing in work, but rather it resists mightily the idea of work that so overshadows life. Our language is spotted with phrases that deify work, such as "the sweat of the brow," and this doctrine has been tied up to integrity, reliability, and other fine personal qualities. But today such a saying is merely aspirational in an industrialized society where sixty per cent of the population engage in occupations that never cause perspiration.

Some who are concerned about the social good are afraid of this new mood for play and enriched curricula in schools, because for them the old adage, "Satan finds some mischief still for idle hands to do," has a mysterious significance. They hope to get social good by tiring people out and like the poet who wrote,

"If goodness lead him not, yet weariness
May toss him to my breast,"

they hope greatly from work, fatigue, and ennui.

What seems almost essential is the development of an attitude of good humor, an unwillingness to take things too seriously. "Life is real and life is earnest!" sang the poet, but the seriousness of life is often nothing but the stupidity and dullness of grown-ups who mistake bile for seriousness and chronic indigestion for dignity and bearing. The Puritanic tradition weighs heavily upon our emotional natures and presses down the gaiety that tends in all of us to crop out.

There seems then to be only one final word to say about living most now. How we live today determines how we live tomorrow. Preferences and
habits have their inexorable wills. Nothing is more tragic than the plight of those who have amassed a competence in worldly goods but are paupers in expressive, artistic living.

The second part of my definitive phrase is another story. It relates more precisely to the individual's responsibility to society. With that I am not now concerned. My argument has been made and I have no desire to hold the platform longer. There is this to be said, however. What kind of a community is necessary for youth to live most? Briefly it will have something of or all of the following:

1. Homes with parents who know more human biology than algebra, and more adolescent psychology than classics
2. Abundant play spaces with educated leadership
3. Camps and parks as integral parts of the community facilities for living
4. Theatre and other dramatic opportunities for youth to play heroic parts
5. Sport teams, dance groups, music organizations led by those who know youth and life

Living is an art. An art takes the materials it uses and changes or manipulates them to some end; science studies them trying to understand. Science is fundamentally analytical; the essence of art is synthesis. Human living today needs more than ever the art or creative approach, because the science of our age has broken life into bits; more and more, meaning has been lost; more and more, significance has disappeared until today cynicism is the lovely virtue.

The community can discharge its responsibility to the child only as living is conceived as an art. This is not possible in a community devoted exclusively to industrial or commercial pursuits.

It is said that the most knightly of all the gentlemen at Elizabeth's court answered the young poet when he would write an immortal song, by saying, "Look into your heart and write." Were you to look into your heart and test also your thought would you ask the community to be less responsible for the health of the child than I have indicated? Or would you be inclined rather to repeat, even in these days, those lines from Paracelsus:

Are there not Festus,
Are there not dear Michael,
Two points in the adventure of the diver,
One when a beggar, he prepared to plunge,
One when a prince, he rises with his pearl.
Festus, I plunge.

B. THE RESPONSIBILITY OF THE NURSE FOR THE CARE OF THE WHOLE CHILD

WINIFRED RAND, R.N., Instructor in Parent Education, Merrill Palmer School, Detroit, Michigan

A child is born in these United States, fulfilling thereby the first requirement of a prospective president, if sex is no longer to be a determining
factor. In fact, in the year 1933 (the latest yearly figures available) about 2,000,000—or 2,064,944, to be exact—babies were born in this country. The lives of approximately 120,200 were snuffed out before they had a chance of celebrating their first birthday with the proverbial birthday cake and one candle. If Fate, or whatever one may designate the determinant, decreed that the baby should be born in the state of Washington, he had, roughly, one chance in 25-26 of living through his first year. If New Mexico were his birthplace he had, again roughly speaking, but one chance in eight.

What happens to these two million or more babies who are born in our midst every year? The census tells us that our birth rate was low in 1933 and therefore we must think in terms or many more than 2,000,000 babies, rather than less. What happens to them? What do we want to have happen to them? What can we do, and what should we do to help in the making of satisfactory citizens for this country of ours in the years to come?

Turning once again to the census we find it said that the highest infant mortality rates occur in the states where there is a large nomadic Indian and Mexican population or Negro population with little knowledge of infant care. The census certainly implies that there is a relationship between high infant mortality rates and lack of a specific kind of knowledge, a point which immediately gives us one cue as to what should be done, and historically we discovered this cue some years ago and began doing something about it.

Of the 120,000 and more babies who will die before they are a year, 60,000 and more will die before they are two weeks old, of causes due to conditions of prenatal life or related to the birth experience. Somewhat less than 60,000 of the 1,944,000 children living to celebrate their first birthday will die before they are five, of the acute respiratory infections, the communicable diseases, and gastro-intestinal disturbances. In the years from five to ten, about 16-17,000 children will probably die. To our shame we have allowed automobile accidents to appear as one of the chief causes of death in this age period. Diphtheria, a disease which we know how to prevent, is the second cause, taking the lives of nearly one-tenth of those who die between five and ten, pneumonia, influenza, and appendicitis following in order. The period from ten to fifteen is the safest period of childhood from the point of view of mortality hazard, but two new chief causes of death appear at the top of this list, namely, heart disease and tuberculosis. To quote from Dr. Stuart’s Healthy Childhood, which gives us the material from the Committee on Growth and Development of the White House Conference, “Rheumatic fever is the only disease which affects the heart sufficiently to cause death at this age. Our knowledge of this disease is still too inadequate to hope for great success in preventing its occurrence, but more can be done to protect the hearts of those suffering from rheumatic fever. Tuberculosis is a different matter, for we know a great deal about this disease and its prevention. It has already been demonstrated that intelligent effort is liberally rewarded when directed at its control.”
In the field, then, of preventing deaths among children up to the age of fifteen years, more needs to be done and much more can be done. Is there not a challenge to every nurse in this situation?

Let us go back for a few moments to our newborn baby. What is going to happen to him?—for there is much more than the possibility of death to be considered. I have brought these facts in regard to mortality rates before you not just to present the picture of children’s lives lost but to tell of those who live. For many babies, 45,000,000 children the White House Conference tells us, are going to live and are going to join that procession who are marching on toward adult life and its attendant responsibilities. What of them? What are we as nurses going to have to do with them? President Hoover told us at the White House Conference that out of 45,000,000 children—

- 35,000,000 are reasonably normal
- 6,000,000 are improperly nourished
- 1,000,000 have defective speech
- 1,000,000 have weak or damaged hearts
- 675,000 present behavior problems
- 450,000 are mentally retarded
- 382,000 are tubercular
- 342,000 have impaired hearing
- 18,000 are totally deaf
- 300,000 are crippled
- 50,000 are partially blind
- 14,000 are wholly blind
- 200,000 are delinquent
- 500,000 are dependent

There is obviously much in these figures which points the way for the nurse. But I want for a few moments to emphasize what perhaps is the less obvious opportunity of the nurse to help in the growth and development of these children—the 35,000,000 reasonably normal.

In one of the large cities of this country, which of course is not typical of our rural conditions but which can probably be considered fairly typical for urban people, 24,633 babies were born in 1934; 11,603 babies—not quite half—were born in the hospital and were consequently ministered unto almost immediately by one or more nurses; 12,598 were attended by physicians in their homes; 252 by midwives; and 200 received some other sort of reception when they came into the world. Of those who had the services of physicians in their homes, 936 also had the ministrations of the visiting nurse at the time of delivery, and 6,202 were given daily care for at least the first ten days by her. Although it is impossible to say how many of the other babies were cared for by a private nurse, doubtless a goodly number had her care. Possibly for at least 20,000 of the 24,633 babies born the nurse was one of the first influences in their lives, took them from the doctor, wrapped them up, gave the first bath, all very important experiences if they are happening to you for the first time. In rural sections of the country the picture would not be the same although the nurse-midwife in these sections may become a very important factor in the future, as she has already in other countries and in one section of our country.

It is hardly necessary to describe a newborn baby to an audience of nurses, this seven to eight pound bit of humanity which has developed in nine

* This figure in President Hoover’s speech, due to later findings of the committee, was increased to 3,000,000.
months from one minute cell to countless highly differentiated cells which together make up a human being capable of living in this complex environment, the world. Extremely different in proportion from the adult—long body, short legs, head almost as big 'round as chest and in length about 1/4 of the total length of the baby, ratio of face to cranium 8:1 for baby, 2:1 for adult, deposits of fat entirely differently placed from the deposits of fat of adults. His destiny is not only to grow, for that would bring him to adult life with the same body proportions as the baby, but his destiny is to develop into the mature individual capable of functioning very differently from the infant. He has grown and matured sufficiently in uterine life to be capable of making a beginning at independent life but not sufficiently to be able to carry on that life without a good deal of help from adults, the chief reason probably for the development of family life not only among humans but among those forms of animal life where there is any period of infancy in the offspring.

Let us consider some other aspects of the infant than the body proportions. The sense organs and central nervous system are fairly well developed at birth, "the sense of touch probably being the most nearly perfect in function at birth"—a very fortunate thing for the baby, as the sucking reflex is stimulated by a touch on the lips and the baby is thereby equipped to make the effort to take food. Babies, therefore, begin to react to outside stimuli as soon as they are born and therefore they are immediately beginning to be affected by their environment. However, probably for a month at least the baby's sensory equipment is sufficiently imperfect to give him some protection from the constant impact of his environment upon him. Fortunately, indeed, is it for him that he is not immediately stimulated by all the experiences in sight, sound, smell, taste, and touch that surround him. The world would certainly be "too much with him" if he did not have some protection from it, for a little time, at least. But by the time he is three years of age his sense organs will probably be as sensitive to stimuli as an adult's and he will have learned many responses to those stimuli, and he will have many associations connected with them—some satisfying, some dissatisfying, some fearsome, some inhibiting in their effect, some challenging, and his behavior will be affected thereby.

Although the very young infant will sleep by far the greater part of the 24 hours, he will make many random movements in his waking hours with head, arms, and legs but he will not lift his head, reach out for anything or use his legs for locomotion. All these types of behavior will come later, some fairly soon, some not for months. There will be a whole pattern of growth in motor control. He will learn to reach out for things. He will learn to bring thumb and forefinger in juxtaposition. He will learn to stand upright, giving up the use of his arms to assist him in moving from place to place. He will learn to go upstairs, putting up first one foot and then the other. And this learning may be helped or hindered. There may be pleasant experiences which challenge him to further exploration or his eagerness
for effort and exploration may be discouraged because he is not allowed to experiment. Fearful adults, adults too anxious to do things for him, adults who consider his explorations a bother may have hindered and discouraged his learning and affected his behavior in regard to learning.

Emotionally the newborn infant’s reactions are apparently limited. Some studies and recorded observations report the response of fear, love, and anger to a small number of stimuli. Certain loud noises and loss of support call forth what seems to be a reaction of fear; restraint of motion of the frequently moving arms, legs, or head calls forth a creditable exhibition of anger; and certainly it is an early expression of satisfaction which we see when attention is given. As time goes on he should grow in his affectional life through the period of satisfaction in self to love for his mother, his parents, then of his own sex, until as a mature adult he is ready to find satisfying love for one of the opposite sex—but here again the adult may be a help or, alas, a hindrance to satisfactory emotional development.

The newborn baby, then, can not do much, does not know much, can not feel much, but in the months following his birth he will learn to do a great deal, he will learn about a great many things, he will come to know the people about him and communicate with them, and there will be no question in our minds that he will react emotionally to many things, situations, and people. In other words, he will grow rapidly and develop rapidly physically, mentally, socially, and emotionally, and adults will necessarily have much to do with fostering his growth.

He will never for one moment cease to be a whole and growing organism. Each and every experience will mean something in his development, and how much it must be meaning in those early months and years when the rate of growth and development are so rapid! As one goes through the daily routine of caring for him in his home, in the nursery school, in the hospital, one is not just scrubbing grubby little knees or helping a reluctant one to learn to eat spinach or doing a mastoid dressing; one is having a contact with a child, a whole child, helping him in his learning about life, himself, and his fellow beings, influencing him in his attitudes toward life in possibly a very profound way. Every treatment given to a sick child should perhaps have just as much in it which will be worth while to his mind and soul as to his body. Certainly we should not be doing things which harm those important aspects of his organism as we cure his body. Scars on the body are so easy to see! Scars on the mind perhaps so slow to manifest themselves and so difficult to interpret! He is not clay which we mould into shape; we can not smooth out or change a curve with our thumb, as we can with clay. We can only give him the best possible environment for satisfactory growth. He himself will do the growing, but his environment is our responsibility.

Of what significance is all this to the nurse? In the first place the child comes into the world and begins immediately to react to some of the stimuli in his environment. Patterns of behavior are in the making with every reaction. Just how deeply significant these first reactions are in estab-
lishing behavior patterns we do not know, but on that sensitive plate of
the child's mind, sensitive, perhaps, as no photographic plate is sensitive,
they come as the first impressions among but few impressions. As time goes
on and the child reacts to more stimuli as the world presses in upon him
with a constant bombardment of impressions, is it not possible that one
stimulus among countless may have less significance than the one stimulus
among a comparative few in the earliest days of life? In these early and
assuredly important days of the child's life the nurse in many and many an
instance is playing an important rôle. Is she playing it well? Is she recog-
nizing that the child's emotional life is beginning as well as the physical?
Is she handling the baby in such a way that the reactions to fear and anger
are avoided, or is she possibly laughing when she sees the baby stiffen and
seem to grow angry when she holds his arms and legs? Is she giving him a
sense of security about life by the way she cares for him and treats him or
is life to seem an insecure thing from the first? Is there a difference between
hospital babies cared for somewhat impersonally in the nursery of a hospital
by several nurses in the course of 24 hours and the baby who gets the some-
what more personal care of a nurse or a relative in the home? We do not
know the answer to that question, but it offers interesting possibilities for
study. But we do know that nurses perhaps as much as mothers, possibly
more, especially if the babies are bottle-fed, are going to be the important
adults in the first days of a baby's life, when he is receiving his first impres-
sions of life. Through her he is going to receive many stimuli. His first
experiences of people and his reactions to them are going to be influenced
by her. As time goes on if he becomes ill she is again going to play a very
important part in his life. Who knows how greatly a child's sensitivity
may be increased at this time, how great may be the emotional upheaval at
such a time! Until he is five, or whatever his age when the teacher comes
into the picture, she is probably going to be one of the very important adults
in his life. True, he is going to become acquainted with many other adults,
and his affectional life is going to expand. Grandparents, aunts, and uncles
are possibly going to "take a hand" in his bringing up. How many people
like to do that—"take a hand"—a type of behavior on the part of individuals
which so often does not seem closely related to knowledge of the subject!
But the persons toward whom his parents are very probably going to look
as authoritative persons are the doctor and the nurse. It is practically always
so in the sickness situation and it is becoming more and more so in the gen-
eral growth and development situation, especially in those homes into which
the public health nurse goes. But in the homes where the private duty nurse
goes as well, in the hospitals where the sick children are brought (and there
are still so many of them) in fact wherever she is met the nurse is looked
upon as one who is qualified to give advice because she is believed to know.

Therefore knowledge about that whole organism, the child, is important
for the nurse because she is one of the first and one of the important influ-
ences in the child's life, and it behooves her to know what she is doing.
She influences him directly because she gives him so much and such early care. She influences him indirectly because she is looked upon as an authoritative source of information by the parents.

Second, all these matters are of significance to us today because so much of this knowledge about children is comparatively new. Much that was even discovered and written about by early scientists, educators, and philosophers is more widely known today and more definitely proven. What was doubtless an adequate or even very good curriculum for a normal school years ago would be considered hopelessly inadequate today. What was considered a good medical school years ago, and not so many years ago at that, didn't even have a chair of pediatrics. What was considered a good curriculum for a school of nursing years ago would call forth ejaculations of astonishment today because our body of available knowledge has increased so vastly. Therefore our teaching must necessarily change and expand to include this new body of knowledge. Can we think of a curriculum today which took no account in its teaching of gland therapy, vitamins, and other examples of newer scientific knowledge? Can we think, then, of a curriculum which does not take account of the knowledge of the whole child which we have today?

As an illustration of the progress in our thinking along the line of nursing education, for example, let me quote the first sentence from an article in the first number of the American Journal of Nursing, issued in October, 1900. The title of the article is "Work for Nurses in Play Schools." It was a delightful surprise to see such a subject discussed in the first number of the Journal, even though when reading it I discovered that it told about a project for teaching little girls "about compresses, fomentations, poultices, pastes, bandages, bathing, food, and temperature," the object of the play school being to keep "the little pupils from the demoralizing influences of the streets." But let me quote the first sentence of this article: "The story of district nursing has been told so often and so well that practically nothing remains to be said on the subject." And yet since that time we have brought schools of public health nursing into being, we have a magazine called Public Health Nursing, and, in fact, in May, 1935, we are still talking on the subject in the Journal, as witness Miss Titus' article in the May number in which she says, "because nursing education took firm root in the hospital before preventive medicine had developed in this country, we have simply gone on assuming that the basic preparation of the nurse should be entirely curative in nature.

It would appear that the findings of the recent Survey of Public Health Nursing suggest that the basic course must be reorganized so that the student must be instructed in health nursing as well as curative nursing if the quality of public health nursing is to be improved."

The Journal could not possibly publish an article today which would begin with that final sort of statement of that article of 35 years ago—"Practically nothing more to be said about district nursing."

We know, or can, if we will, know so much more about children than
we did years ago. For nurses, as part of health nursing, so-called, or as part of sick nursing, that body of knowledge about children which is available is in fact essential. Mind, body, and soul are too closely bound together to ignore one as we treat the other. Should we cure a disease and injure a personality as we do so? If we care for one who is mentally ill, we are responsible for the physical welfare. If we care for one who is physically ill, we must take care that mentally he receives no injuries. But as the nurse concerned with children you or I have an even greater responsibility for we have a growing organism in our care who must be nurtured in sickness and in health in such a way that the daily increment of growth which is added to his mental, physical, and social stature is satisfactory growth.

I have not been fortunate enough to be here this week to attend the meetings, and I do not know how often the woman has been referred to whose picture appears on the cover of our program, nor how often the fact that we are celebrating the 75th Anniversary of the founding of the Nightingale School has been mentioned, but I can not but say that the heritage from Florence Nightingale, in which you and I and all of us share, is not a material thing, a school, a book, a curriculum—it is something of the spirit, a vision of things yet to be done; and who can say that there are not yet myriads of things to be done by us for children if we are to give them a goodly world in which to grow?

**General Session**

*Friday, June 7, 9:00 a.m.*

Presiding: Carolyn Gray, R.N., New York City

General Topic: What Changes Do We Need in the Nursing School Curriculum? *(Continued)*

E. What Changes in Curriculum Content?

1. What Should the Contribution of the Biological and Physical Sciences Be to the Nursing School Curriculum?

Edna S. Newman, R.N., Director, School of Nursing, Cook County Hospital, Chicago, Illinois

A study of the early beginnings of nursing as a vocation for women reveals in the first groping for some plan of formal education the recognition of the place therein of the biological and physical sciences. In the educational program of the Florence Nightingale School in St. Thomas' Hospital the theoretical training consisted of a very few lectures, prescribed readings, and examinations given to the probationers in principles of medicine, surgery, chemistry, and very elementary physics, namely, the properties of light and air.
At the first annual meeting of the Board of Directors of the Illinois Training School for Nurses, October 1, 1881, there was a report of the organization of courses of lectures for nurses to include eight lectures in each of the following subjects: anatomy, physiology, materia medica, and therapeutics. Chemistry, the chief representative of the physical sciences, made its entrance later, and even now has not yet obtained undisputed recognition of its position in the curriculum, as is indicated by its omission from lists of examinations conducted by boards of nurse examiners for state registration.

That the early leaders in nursing education championed, from the first, the cause of the biological and physical sciences is evidenced by the topics of their discussions in the meetings of the American Society of Superintendents of Training Schools for Nurses. One of the early plans for a uniform curriculum provided for thirty-six hours of anatomy and physiology, and two hours of hygiene. Almost twenty years ago when the first so-called “Standard Curriculum” made its appearance 60 hours were allocated to anatomy and physiology, 20 hours to applied chemistry, 40 hours to nutrition and cookery, 20 hours to bacteriology, and 20 hours to hygiene and sanitation. Truly, a very modest portion of the curriculum to be devoted to these subjects for a system of education purporting to be professional in character, with a background and foundation of science.

It is hardly necessary to recall the deluge of well-deserved criticism by which the so-called "science teaching" in schools of nursing has been flooded by the classical studies of the Rockefeller Committee and the more recent studies of the Grading Committee. In 1933 a committee of the Association of American Medical Colleges appointed to study nursing education in colleges and universities reported that "basic sciences are obviously unduly condensed" that "in the most of these schools the credit value given is entirely too low to meet demands of a sound educational quantitative standard," and "the basic science courses are given in some university schools without reference to fundamental collegiate requirements."²

Our own leaders and educators have always appreciated the importance and value of the biological and physical sciences. They have striven to correct the lack of correlation and integration and the inadequacies in content and methods of teaching. Whatever slow progress has been possible has been made against criticisms of too much science, over-education of nurses, too many "frills" in nursing education. These discordant notes have been somewhat less insistent and discernible within late years.

It is not surprising that in our present program of curriculum reconstruction the problems of its science content, the aims, functions, and current practices in the teaching of the sciences should be some of the major considerations. If we study the field of general education throughout its entire

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² Journal of the Association of the American Medical Colleges, Vol. 8, Number 1.
course, from the primary school level to that of college and university, we find that much time, thought, and effort have gone into study and research, into discussions on platform and in committee, into written and published reports on these same subjects. Nursing education should be more generally and more closely integrated with other educational fields, and would profit by careful evaluation of contemporary literature throwing light on its problems.

Trends in nursing education are influenced and determined by those of general education. Today, as never before, the emphasis in nursing is on supplying community needs and on the importance of keeping pace with the changes which are the order of the day in the economic, political, social, and educational world. Fortunately the Central Curriculum Committee has included in its plans of organization, work, and study, the collaboration and opinion of experts in the fields of general as well as special education.

Therefore a restatement of the aims in education seems indicated and an understanding of what place scientific principles occupy in the program. A generally acceptable principle is that education should be a continuous process beginning with learning experiences of early childhood and extending throughout life with the schools or other educational institutions having as their aim the provision of elements of enrichment to this process. "The school will contribute to life's enrichment if its activities are of the kind from which ideas may be developed, and if the ideas may in turn be associated with principles and generalizations that are interwoven into human experience. The principles that ramify most widely into human affairs may be stated as objectives of science education. The findings from science have contributed enormously to thinking, to methods of study, and to the development of scientific attitudes that affect behavior. The principles and generalizations of science must, therefore, occupy considerable place in a program of general education, the aim of which is life enrichment through participation in a democratic social order." ¹

The program of nursing education must be consistent with the plan of general education to be successful. In the discussions preliminary to reconstructing the curriculum of the nursing school the question has arisen of definitions and philosophy of education as the central point around which to build.

Isabel M. Stewart, in the discussion of "What Educational Philosophy Shall We Accept for the New Curriculum?" says "Using such criteria and considering a wide range of aims, the Curriculum Committee has come to the conclusion that the conception of education as adjustment comes nearest to meeting all the requirements and is best adapted for use in the construction of a nursing curriculum."

By way of interpretation, nursing education should provide or supplement the background of scientific, cultural, and practical training which will prepare the nurse for the responsibilities she must face in the practice of her

¹ A Program for Teaching Science; Thirty-First Year Book, Part I, p. 27.
profession and which society demands of her on higher levels than heretofore.

What has science to contribute toward achieving the aims in nursing education? "The attitudes of science are those of respect for tested truth and the methods by which it is revealed. Enriched living is the goal toward which science is striving, and it is the hope of science that, through tested truth, it may help to neutralize prejudice and animosity, and reduce the friction between individuals who are the entities of our human social order."

"The achievements of science are the products of the recent period and yet its tested truths have influenced and are influencing in enormous measure the present social order. Tested truths should be the units with which we think. In a program of general (or liberal) education those truths which are the foundation of our social order and those methods which may be effectively used to reveal truth must be given prominence in the curriculum." 1

The progressive teacher of science will find in the results of educational research already available and applied to the problems of teaching sciences in classroom and laboratory the means for professional growth and improvement. There is, for example, a trend toward simplification of scientific terms which is of considerable importance. One investigator has established the values derived by pupils from voluntary reading of scientific books or articles, and furnished evidence that a well-equipped science library in the school with directed study, conferences, and reports on readings, should function in increasing the students' command of scientific material. General science textbooks and laboratory manuals present many distinct types of problems and questions with which teachers should be familiar. They should know also how to train their students by abundant practice in the solving of each type. Methods of using visual aids, the motion picture, microprojection, or the film slide, are being constantly investigated and improved. Here it is important that the teacher plan her lessons carefully to insure the focusing of attention on specific aims and results to be achieved. Otherwise these visual aids are likely to serve chiefly as "effortless entertainment."

A number of investigations into the relative values of various teaching techniques—for example, project teaching, the topical method, the unit plan, as compared with the effectiveness of the more conventional textbook, recitation, and recitation-study methods—present justification for the use of various methods and mastery of newer techniques, which will improve the teaching of general science and which the progressive teacher will welcome.

Equally helpful for instruction in sciences in the school of nursing are the results of research applicable to laboratory methods of teaching. In the report of a committee of the National Society for the Study of Education, from which this material has been obtained, there is emphasized the conclusion that students with laboratory experience show resourcefulness. "If

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1 A Program for Teaching Science; Thirty-First Year Book, Part I, p. 27.
resourcefulness is really one of the qualities upon which success in life is founded then we should present more problems involving resourceful activity in our classroom teaching, our quizzes, examinations, and tests. Some of the emphasis placed upon memoriter methods and achievements may well be redirected toward the development of practical resourcefulness in meeting daily problems. If experience is one of the foundations of resourcefulness, then good training in the schools should include many experiences with actual objects, in varied fields of activity, related as frequently as possible to actual situations of practical living. The solution of simple perplexities gives training for more complex dilemmas."

There is evidence which indicates that "briefer methods of reporting laboratory exercises may be substituted for the formalized essay type of report with equal effectiveness in certain respects and with considerable saving of time." The skillful teacher will provide opportunities for reporting by the conventional method, along with opportunities for reporting by the diagram method and by various other short-answer methods.

It is recommended that simple diagrams, clearly labelled, replace those copied by students or embellished in purely artistic ways. Teachers should perfect their own skill in making diagrammatic drawings and train their students to make and interpret diagrams. In a study to establish the relative merits of individual laboratory work by students versus demonstration by teacher or student it was found that (1) each method offers training in certain knowledges, skills, and habits not offered by the other; (2) the demonstration method is more economical in time, effort, and money; (3) time thus saved can be used for additional laboratory exercises, reading projects, individual investigations, observations, and drill upon essentials; (4) the demonstration method should be combined with individual student exercises in order that they may acquire desirable manipulatory skills, resourcefulness, laboratory techniques and habits.

It is important before we revise our program of biological and physical sciences that we consider modern trends in planning of teaching rooms and their equipment and realize the existence of problems which need research and study for their solution. Science departments, teaching rooms, and equipment are costly. Partly for the sake of economy and partly from the point of view of certain educational advantages there is a growing tendency to combine classroom and laboratory. The equipment and furnishing of science teaching rooms should be evaluated in terms of the learning situation which they create. Rooms, equipment, demonstrations, exercises, and experiments should be so developed and organized as to contribute to the objectives of science teaching, to the aims of education to which the study of science contributes, and to results in learning secured by the students.

We arrive now at the consideration of content of the courses in biological and physical sciences. The determination of the content which is likely to serve best the needs of students of nursing is one of the major problems confronting the curriculum specialist. In solving this problem in our own field it would seem advisable to follow the well-known path of reasoning,
that of proceeding from the known to the unknown, taking cognizance of
certain well-established truths and principles founded on the results of
scientific investigation and psychological theories. Some of these are
(1) aims in general education and objectives in science teaching, (2) out-
comes in terms of measurable results, (3) guiding principles based on the
psychology of learning.

We have already discussed the first point, but it is somewhat more difficult
to make an all-inclusive or general statement of the aims and objectives of
science teaching on the college level—and we are agreed that our teaching
in nursing schools should be on that level. Broadly stated, their function is
that of preparing the nurse for her life and work. Whether our courses
should be chiefly of the survey or the preparatory type is also a controversial
point. The aims of the survey type of course should probably include:
(1) information, (2) development of interest in science, (3) understanding
of relationships between sciences, (4) development of scientific attitudes
of mind, (5) applications to environment and everyday life of scientific prin-
ciples, (6) culture. For the preparatory course, to the aims just listed should
be added the primary function of preparation for further study and special-
ization. For courses in nursing education some combination of these aims
or all of them should probably function in the planning and teaching of
science courses.

The natural sciences lend themselves readily to scientific study of their
methods, subject matter, and outcomes, and there has been a general tendency
to submit the elements of the program to critical study and evaluation. Cur-
riculum workers may secure data made available by authorities who have
assembled them. In the article by C. Mabel Smith in the May number of the
American Journal of Nursing a number of examples are listed, and avail-
able sources of materials as well as methods whereby data have been derived
are described.

From the field of psychology there are generalizations and principles with
direct application to the problems of the curriculum-worker as well as those
of the teacher. Proceeding from this point to that of considering changes in
the nursing school science curriculum is a step into a somewhat less clearly
defined realm. Proposals must necessarily be tentative, pending definite rec-
ommendations from the various divisions of the Curriculum Committee after
further conference and study. We shall deal briefly with various factors
that will doubtless influence these.

The existing aims in science teaching will probably undergo no radical
change but knowledge and experience in more effective methods of correla-
tion and integration may result in modifications and changing emphasis.
Content, length, arrangement, and sequence of individual courses will be
influenced by entrance requirements, science subject prerequisites, and the
level of instruction in the nursing school itself. If, as seems probable, there
be a prerequisite of certain sciences, namely, introductory general science,
biology, and inorganic chemistry in the senior high school or junior college,
it will result in changes in level and content of courses in at least anatomy,
physiology, and chemistry. There is ample justification for lengthening and strengthening our science courses generally, whether instruction be on the senior or junior college level. One of the most difficult problems of all is to determine what content meets our needs, and ways of discovering objectively and quantitatively how much and what kinds of chemistry, bacteriology, hygiene, etc., a nurse should know in the practice of her profession.

As with the content so with methods and devices of instruction. We have imputed to particular methods of instruction certain values which have not yet been subjected to experimental verification. Studies need to be made to test the effectiveness of our variety of methods of instruction, and to construct reliable and valid measures of achievement. What combination of methods yield best results? How much of the total time in a course in science should be devoted to each? In view of the fact that laboratory teaching is expensive, can we deny the importance of experimental investigation to present evidence on the relative efficiency of different types of laboratory teaching? An existing need is for critical analysis applied to our sources of materials for courses in science, such as reports of curriculum committees, textbooks, courses of study, outlines, syllabi, laboratory manuals, and work books. The recent findings of the Grading Committee in their study of nursing school libraries have revealed the shortcomings in technical nursing text materials. Textbooks should represent the cooperation and viewpoint of three groups: (1) subject matter specialists to insure accuracy and recency of materials, (2) instructors in sciences, in nursing principles and practice who refine the materials in the light of their appropriateness of content and difficulty, (3) specialists in the teaching of science who contribute a knowledge of developments in the field with respect to educational research.

To summarize briefly: The discussion has been directed toward the contribution of the biological and physical sciences in the new curriculum. Aims in general education and objectives in science teaching have been considered with a view to their application to aims and objectives in science teaching in schools of nursing. The curriculum worker and teacher may receive guidance for the solution of their particular problems from the results of scientific research in the fields of general education. In reconstructing the science curriculum, subject matter and content, length, and arrangement of courses, teaching methods, materials, and facilities will be determined by our philosophy of education, its interpretation and expression in nursing education, and the effect of these on standards generally.

2. What Should the Contribution of the Social Sciences Be to the Nursing School Curriculum?

Anne L. Austin, R.N., Assistant Professor, School of Nursing,
Western Reserve University, Cleveland, Ohio

The increased complexity of modern life, the rapidity of social change, and the resulting tensions, all demand changing emphases in education.
Great concern is felt at the present time in all fields of education, as to how teaching can best prepare the youth of today for life in a changing social world. The responsibility of all individuals to contribute their best effort to social life is also being stressed.

Whatever the character of the emerging social order, it is certain to be different from the life of the past. This fact calls for adjustment in all phases of activity, and therefore in the field of education. Adjustment in education for the professions is of crucial importance in view of this new trend in social life, because of the part played by the professions in community living. Nursing as a needed activity in the group shares this concern for a type of education which will fit the individual for adjustment.

What does the participation of the nurse in group life consist of, and how may those who are responsible for the education of nurses, best plan this education so that the nurse may contribute most in the process? One way to find an answer to this question is to analyze the duties and responsibilities of modern nurses to see in what ways nursing functions in community life. The most recent analyses of nursing activities are those made by the Committee on the Grading of Nursing Schools and by the National Organization for Public Health Nursing. These surveys record a broadening of the duties of nurses to include not only the therapeutic care of the patient, which has always been their function, but to include also the mental and social care of the individual and his family. The emphasis with relation to the object of nursing care is thus seen to be changing. This is particularly true as the nurse understands more thoroughly her part in the plan of community living. Her tasks take her not only to the bedside of the sick patient in the hospital and in the home, but to the family life of all the members of the group, to the school, to the day nursery, to the factory, and to the clinic.

Nursing education, more than ever before, is now compelled, if it is to fulfill its social obligation, to adjust its objectives, its curricula, and its methods to the requirements of an emerging social order. Education always expresses some social philosophy. In a very real sense the curriculum of the school of nursing expresses the philosophy of nurse educators about the part which the nurse plays and should play in the social life of her time. This point of view concerning the educational philosophy of nursing has been well expressed by Miss Isabel Stewart in her articles in the *American Journal of Nursing*, with relation to the present revision of the Curriculum for Schools of Nursing being conducted by the National League of Nursing Education. A scrutiny of educational practices in the field is necessary in order to bring about those modifications which are suitable for producing nurses who shall be at home in situations demanding insight, intelligence, and skill in solving problems of sickness and health.

The Committee on Curriculum Revision has accepted as its major aim for the entire curriculum the ability to adjust. This seems to be the best aim which nursing education could possibly have at this time. It expresses in a word the one thing which is demanded of nurses in all phases of their work
in a rapidly changing social order. The makers of programs of study in the curriculum will need to keep this aim in mind at all times. And in no other group of activities is this more true than in the study of the social sciences in nursing, both in the classrooms of the schools and in the practice fields, the hospital wards, and the homes of patients.

This group of subjects, variously described as including a study of history and sociology (both the principles and their application to the family and community life), economics, and relations with human beings, has in recent years received much more emphasis than formerly. When the last revision of the curriculum took place, these disciplines were just beginning to be recognized as important to an understanding of the work of nursing. Indeed, in the general field of education, they were not recognized fully as having a place. Changing trends in group life have brought to the very fore of educational philosophy, the importance of an understanding of group life as essential to all students, and particularly to professional students.

In the present discussion, the following fields of study are being considered: history of nursing; underlying principles of sociology, as they relate to nursing; the family; the community; and professional relationships of all kinds which may be of importance to the nurse. In the field of professional relations are included the ethics and professional problems of the earlier curriculum. The reconstruction of the curriculum in these so-called social sciences in the light of changing functions of nurses requires consideration of many questions. It is essential to recognize, as Miss Stewart has pointed out, that before any curriculum can be set up in any subject, it is necessary to clear the way by stating aims and objectives and the stand to be taken on the main issues and problems involved, by deciding many matters, such as the kind of system in which the curriculum is to operate, the resources which will be available for use, the type of student using the curriculum, the length and breadth of the total program, the level on which the plan is to be constructed, and the educational philosophy and standards which are to be accepted for the teaching. Every one of these considerations will come up for decision before a program of study in the social sciences can be set up.

In changing the curriculum with reference to these subjects it means in most schools the addition of much new subject matter and also a different spirit and approach all the way through the nursing course. The content of the social sciences can not be taught entirely in the classroom any more than public health nursing can be taught in a specified number of hours in the classroom without field work application. The teacher of social science and the clinical teachers need to help the student to integrate the theory with the practice on the wards and in the homes of the patients if the content of the classroom teaching is to be used to its maximum possibility in life situations. Good nursing care in any situation requires the coördination of all the teaching in nursing, and the social sciences should occupy an important place in the materials available for an understanding of the patient, and should function in the actual care of the patient.
What aims and objectives may be accomplished by the teaching of the social sciences in the school of nursing? Can curriculum makers, for example, look to these subjects for underlying principles for the practice of nursing? In answer it may be stated that this may probably be their most significant contribution to nursing. Dr. Bagley has said recently that one value of the social sciences lies in the perspectives and backgrounds which they may supply. The Report of the Commission on the Social Studies of the American Historical Association stresses the point that the main function of the social sciences is to give accurate knowledge of and insight into the lives of men in social groups; and of social science instruction, to teach this knowledge and insight with all its attendant skills and loyalties. In this day of great need for understanding on the part of nurses, of patients as individuals, as a means of helpfulness, this becomes of moment in the planning of curricula. The social sciences are needed to introduce the nurse to the more pertinent plans, programs, and philosophies which are being called upon to solve the needs of human beings, particularly as they relate to health. The social sciences should provide nursing students with the materials for a critical study of the factors underlying the relations between nurses and their patients, and organizations with which nurses work, and relations with workers in other professional fields concerned with the welfare of patients. Through the social sciences the student becomes aware of her place in the group and of the value of group action. These subjects should also give knowledge of the historical traditions and usages which have contributed and continue to contribute to the practice of nursing, and should be used to illuminate the development through evolution of the art and profession of nursing. They can point out the strong and weak points in the social planning of the past in nursing. They should supply the principles for use in contacts with agencies contributing to social welfare. The social sciences should be called upon to prepare the nurse for entrance into some field of nursing endeavor by giving an accurate account of the pathways by which nurses enter these fields and of what preparation is necessary before this can be done. They should contribute much to the development of the personality of the student by enabling her to better understand herself as a member of many groups.

In addition to the underlying principles of social life, the study of social science in the school of nursing can also furnish techniques and methods to be used for direct application in the solution of problems. They can indicate, for example, the best methods of approach to various groups, and the techniques of reference to social agencies as a basis for the work of the nurse in the hospital and in the homes of the community. In the activity analysis made by the Grading Committee and in the Survey of Public Health Nursing, it is interesting and significant to note the large portion of the nurse's work which consists of working with other agencies, in developing a social plan for the best interest of the patient. Methods of cooperation with closely allied professional groups, such as the medical group and others, may be
learned here also. In addition to knowing why certain relations exist, the nurse needs to know how to go about sharing the group activities of her own profession and how to cooperate with the organized plans of her own profession. These techniques are as important as the underlying principles and are to be included in the aims and objectives of the teaching of this group of subjects.

In the choice of subject matter and methods of teaching, among the outstanding considerations will be the life experiences of the students. The materials chosen must be within the range of the capacity and experience of the learners to be of value to them. The material should be organized as a closely integrated unit of the total instruction of the school and be a part of the activity of the students in their school life, their life in the community, and the culture in which the students live and work. The students should be impressed through the very nature of the teaching, by the continuity of social life, and their part in this life, as members of a professional group in the community. This can partly be brought about by avoiding a series of short courses, and having one well-planned course running throughout the nursing program.

On the basis of the life experiences of the students and the other considerations mentioned, what building materials shall be used for a course of study in the social sciences in the nursing school? The arrangement of the parts of this structure will depend upon all the circumstances, and will have to be worked out in each case. One of the important divisions will be the history of nursing. Teachers of this subject have a fairly clear idea of the events which have made up the background of the present practice of nursing. An emphasis in accordance with a social scientific point of view will be accomplished by teaching the history as the development of an art and a profession. This may be especially well worked out if this course is taught parallel or in connection with the part of the study having to do with the family and the community. One can, for example, point to developments in the primitive family, and at the same time, refer to the possible origin of nursing as a folkway in this early preliterate period of the family. The function of the medicine man as part of community life in early times can also be studied. In the division of the study devoted to professional relations, the development of the mores from simple folkways and customs, helps to explain how relations to certain groups have come about, and how it became right or wrong to do certain things.

There are some basic sociological concepts which the nurse needs to understand because of their direct relation to her care of patients. For example, the importance of the social derivation of human nature and personality and how this may alter the patient’s reaction to nursing care, needs to be understood by the nurse. The nature of the social heritage of each individual, through which are acquired attitudes, ideals, and motives, all of which influence behavior in various situations, needs to be taught. These nonmaterial culture traits play such a large part in all the relationships in which the
nurse is involved that they can not be neglected in the teaching. A knowledge of the folkways, customs, and mores of various groups lends itself later to an understanding of nursing traditions and of patients' behavior in any situation. The nature and functioning of social groups, such as the family, the neighborhood, the community, racial and nationality groups, and interest groups, such as professional groups, are important in the education of the nurse. The concept of race, the factors involved in racial and other forms of prejudice, help in an understanding of nursing problems, and the way in which nurses may assist with these problems when they are encountered. A lack of insight into these factors often limits the influence of the nurse in the field of health work.

Another sociological concept which functions in nursing is that of social control. Around this concept revolve organization in nursing, legislative, educational, and ethical standards, and the rôle of the leader. Particular emphasis may be placed in this connection on the work of some of the outstanding leaders in nursing. As an aid to the understanding of what is happening in the modern world of change a discussion of the concepts of social change and cultural lag may be included. Many of the more serious problems in nursing may be better understood in the light of these two social processes. The recognition of the necessity for adjustment of these problems emphasizes the main aim of the nursing curriculum.

It can not be too strongly stressed with relation to this introductory discussion of sociological principles, that only those concepts should be included which will find a definite use in the life and work of the nurse, and which will give the nurse some insight into and understanding of her function as a professional worker.

Some study of the family group and of community living are desirable in the curriculum of the nursing school, particularly as the emphasis of nursing care changes from the individual patient to the family group. A knowledge of some of the changes taking place in family life, and of their possible relation to the attitudes of the patient to his illness, may be of help. The relation of family life to the development of human nature and personality needs to be stressed, also the family as an institution in the social group, and how its status may affect the patient and his health. Other important considerations are the economic aspects of family life, such as the question of incomes, particularly as these are affected by illness and hospitalization, and the problems created in the family in buying food for the sick person and in paying for medical care. The relation of income to illness has been brought to our attention again by the United States Public Health Service study which shows that families dropping from the "comfortable" to the "poor" class suffered the greatest illness rate in 1932. The nurse needs to be able to recognize and know the meaning of family tensions and conflicts incident to illness. Some study of the rural family is useful to help in an understanding of the problems of the rural person in the urban hospital, for example. The aged member of the family, the child in the family, and the
nurse's relation to these need to be discussed in any study of family life in the school of nursing curriculum. An appreciation of the nurse's part in existing efforts to adjust family problems, such as proposed plans for economic security, socialized medicine, and health insurance, family clinics, birth control advice, medical and psychiatric examinations, social work, and nursing is of great value to the nurse to help her to assist families under her care.

The nurse, more and more, needs to know how to adjust to community life and participate in it, not only on behalf of her patients, but also as a woman and as a member of a professional group. This involves a knowledge of community life as it has developed for complete living, into activities for getting a living, making a home, training the young, the best use of leisure time, activities for communication and transportation, and particularly activities for social welfare, such as activities for the promotion of health and social betterment. The ways in which the rural community differs from the urban community and how these factors affect patients in the hospital may become important to the nurse, also.

One of the important phases of the social sciences in the school of nursing is the study of the relations of the nurse to other individuals and groups, and how these relations may best be utilized and organized for the most satisfactory functioning of the nurse. In this connection, a knowledge of the factors of isolation and contact and their rôle in various relationships is essential. An appreciation of the part played by conflict and accommodation and how relationships may be improved is indispensable also. The sociological basis of these relationships may be taught in the early part of the course and then put into practice in life situations throughout the nurse's life. If the level of instruction is raised, it should be possible to consider the relationships in the light of the basic factors which enter into them. For example, as was indicated in discussing the aims and objectives of the social sciences in the school of nursing curriculum, a study needs to be made of the relation of the nurse to the patient, what enters into this relationship, and how it may be improved for the welfare of the patient; the relation of the nurse and the doctor, the attitudes which may exist between these two groups and what may be the basis of these attitudes; the nurse and the hospital, including a discussion of the function of the hospital, and the responsibility of the nurse to aid in the fulfillment of this function; the relation of the nurse and the school of nursing, stressing the responsibility of the school to the nurse, of the nurse to the school, some of the problems which arise in life in a dormitory, and in the use of leisure time; the relation of the nurse to other professions which are also concerned with the welfare of the patient, such as social workers and dietitians, what factors enter into these relationships and how the relations of these groups may be improved. This course may very well be a clearing house for problems arising out of the experience of the nurse in all the phases of her education and life.

The study of relationships of nurses with others may be continued in a later period of the course, when the student has become more mature and
ready for a presentation of the various forms of nursing in the community, in which she will probably participate as a graduate nurse. In addition to these considerations, it becomes essential to include the part of the nurse in professional organizations, and some of the newer trends and findings in nursing practice. This study of professional relations forms one aspect of the guidance program of the school of nursing and is of great importance for this reason also.

One of the considerations of consequence in planning the curriculum in the social sciences in the school of nursing is substance-content. Nothing which can be done in the way of techniques can make up for lack of scholarly competence in the subject, and no device which can be used, can in any way make up for a lack of knowledge, understanding, and vision on the part of the teacher in this field. The good teacher will do everything possible to see to it that the knowledge, skills, and attitudes acquired by the student through the learnings in these courses will be those which will be useful in the world in which the students are living, working, and thinking as professional women. The competent teacher will seek always to improve her teaching, so that it will be well integrated with the other teaching being done in the school.

In the final analysis, the real test of the teaching in the social sciences in the school of nursing will not be the results of tests set up by the teacher of the course, but will be the way in which the nurse meets situations in the community in which she works. By their fruits shall you know them and your teaching. Today, more than ever before, there is needed in schools of nursing, teaching in the social sciences which is marked by scholarship, courage, and vision.

3. WHAT SHOULD THE CONTRIBUTION OF THE MEDICAL SCIENCES BE TO THE NURSING SCHOOL CURRICULUM?

DAVID SEEGAL, M.D., Instructor in Medicine, College of Physicians and Surgeons, Columbia University, New York City

I should like to speak to you concerning certain aspects of our responsibilities as physicians in the education of the student nurse. During some years of such teaching I have heard a few of my medical colleagues make such remarks as these: “We are overteaching our nurses,” “Instruction should be limited to practical methods of treatment,” “In teaching nurses, a little knowledge may be dangerous and we might turn out half-baked doctors.”

If I may be permitted to lay my cards on the table at once, I should say that I emphatically disagree with this point of view. I recognize that the line of direction for the education of the student nurse may be different from that of the student physician, but for me the pedagogical principles are the same.

It is of more than passing interest that many physicians who maintain the attitude that nursing instruction should be limited to teaching the student a
series of therapeutic procedures, are the first to seek out a nurse of a different training when they have illness in their own families. Such a physician whose child has typhoid fever is quick to advise the supervisor of nurses that he desires a nurse who knows the natural history of typhoid fever, who is alert to the disease complications, whose understanding of the therapeutic armamentarium is not limited to cookbook and rote applications, but whose education has been such as to insure that the nurse knows why each move is made.

In order that our instruction should meet these needs, there are some teaching principles which may be of value in the development of what has been well termed "the prepared mind." It is with these points which I should like to deal just now.

We consider it advantageous to give our students an appreciation of the difficulties in establishing the simplest fact concerning the natural history of disease and the treatment of it. It is important that they realize the enormous amount of time, effort, and ingenuity required to cultivate the final fruit on the tree of medical knowledge. We are all too ready to accept such an advance as insulin in the treatment of diabetes without realizing that this advance was made possible only by much previous painstaking spade work.

The soil from which this fruit was finally to spring received a significant cultivation in 1889 when von Mering and Minkowski found that the extirpation of the dog's pancreas lead to a condition strikingly similar to diabetes in man. From this soil a sturdy trunk developed in 1893 when Laguësse published experiments suggesting that diabetes was due to a suppression of an internal secretion of the Islands of Langerhans in the pancreas. Foliage appeared on this tree at the turn of the century when Ssobolew showed that atrophy of the pancreas exclusive of the islet tissue did not result in diabetes. In the same year Opie found that in patients with pancreatitis involvement of the islet tissue resulted in diabetes. In the next 20 years a number of green fruit appeared on this tree in the form of pancreatic extracts which were believed to produce a depression of the abnormally high blood sugar levels in diabetes, but these results were not convincing and it remained for Banting, a surgeon, and Best, a medical student, to cultivate the final ripe fruit in 1921. Their extract of the pancreatic islet tissue was called insulin. This was another milestone in a most gratifying chapter in the History of Medical Science.

In the light of this historical emphasis the interest of the student nurse is stimulated, and she is quick to develop a humility for the tedious methods of elaborating facts and it is this quality which we consider pedagogically desirable.

We believe that it is valuable to initiate in the student mind an understanding of the necessity for the proper evaluation of data. One of the commonest fallacies which serve to plague the lay and professional mind is the habit of believing that since one event follows another, the second event
has been caused by the first. In the days before we had a specific for the
treatment of pernicious anemia, some of our patients with this disease would
leave the hospital in a period of relapse and would consult a non-medical
source, and in the natural course of the disease a remission or temporary
cure would ensue. In one such instance the patient returned to the hos-
pital and berated us for not knowing so much as the chiropractor. It was
rather painful for us to realize that another relapse would soon appear.

This type of loose reasoning is not limited to the layman for we see evi-
dence of it in many of our medical journals. It has been the cause of an
enormous waste of time, energy, hope, and money. It can only be com-
battled by emphasizing those methods of intellectual honesty by which evi-
dence is proven to point to the truth.

In teaching materia medica we have repeatedly emphasized that any drug
can be proven of merit in the treatment of a given disease only after it has
been shown to be effective when subjected to such criteria as:

1. Have the cases presented been proven to be examples of the disease described?
2. Would the patient have been cured, irrespective of the treatment, due to the
   natural course of the disease?
3. Were there enough cases in the series to justify the conclusion?

These criteria afford the example which we utilize in pointing out to our
student nurses the necessity for the type of mental discipline required to
evaluate facts. In addition to helping the student during her formative
period, this point of view should be effective for the nurse in her graduate
period when she is so frequently called upon to make independent decisions.

In addition to instilling a humility in our students through the realization
of the difficulty of proving a single point, and teaching our students the im-
portance of properly evaluating these facts, we feel that it is incumbent upon
us to give the student an understanding of the mechanism of disease and its
care.

It is not enough to teach the student that glucose is part of the treatment
of diabetic coma. She must also understand why glucose is used. It is not
enough to teach a student that sodium chloride is important in the treat-
ment of Addison’s disease. She ought to know why. It is not enough to
teach a student too much digitalis is harmful. She ought to know why these
effects occur. I should like to tell two stories which illustrate this point.

Wenkebach, an eminent Austrian cardiologist, was consulted by a Viennese
artist because of troublesome extrasystoles. Now, some maladies cause more
discomfort in certain nationalities than in others. To many of us the sen-
sation of extrasystoles or premature ventricular contractions are simply annoy-
ing, but in Vienna this minor cardiac irregularity might be the spark which
inspires such a melody as Two Hearts in Three-quarters Time.

Wenkebach had little to offer his patient and did not see him again until
he was consulted by this artist one year later. On this occasion Wenkebach
learned that his patient had been to the Dutch East Indies. During that
time he had been completely free of his cardiac disturbance but on returning
to Vienna all his old symptoms had recurred. The story might well have stopped here and if it had, we probably would have lost the use of an important drug in the treatment of cardiac disease. But Wenkebach had an inquiring, alert mind. By careful investigation he found that his patient had been taking quinine during his sojourn in the East Indies as a prophylactic against malaria. With this fact in mind, Wenkebach advised his patient to take quinine again. The cardiac disturbance was quickly controlled. Since that time, the quinine derivative, quinidine, has been found most useful in the treatment of this cardiac irregularity.

I have been agreeably surprised to observe how promptly the student mind catches the point in this story. With this type of teaching the student becomes interested, alert, and fits into an important rôle in the coöperative effort we term medical care.

Many of the discoveries in medicine appear to be due to chance but as Pasteur has put it: "Discoveries do not depend on chance alone but on change plus the prepared mind."

In another instance one of our eminent surgeons was treating children who had lye burn obstructions of the esophagus. He performed the preliminary gastrostomy and tried to build up the patient's resistance by high caloric feeding through the gastrostomy wound. Both he and his staff were very disappointed in the failure of the children to gain weight and strength, despite the fact that what seemed to be an adequate diet was being administered through the gastrostomy tube. In the midst of these difficulties, one of the nurses made the observation that preliminary digestion in the mouth was absent in these cases and that this might be the cause of the difficulty. Following her suggestion, saliva from the individual patient was added to the gastrostomy feeding and the resulting improvement of the children was striking.

It is this type of alertness that we are striving to develop. It is quite obvious that we can not teach our students how to meet more than a few of the complex problems which will await them, but what we can do is to teach them how to tell a real fact from a gold brick or at least to develop in them a humility with regard to the difficulty of this evaluation, and to gain a comprehension of medical practice and therapeutics as a dynamic rather than a static problem. Once this interest is established, enough momentum will have been developed so that we may feel that we have done our part toward developing the prepared mind which is our goal.

If I should be asked how much medicine a nurse ought to know, I would answer by trying to visualize the criteria I should utilize in advising my daughter which nursing school to attend.

First, I think she ought to know enough medicine so that she gets fun out of the work.

Second, I think she ought to know enough medicine so that she can really be of service to the patient.

Third, I think she ought to know enough medicine so that when occasion arises she may be in a position to make a contribution to medical progress.
4. WHAT SHOULD THE CONTRIBUTION OF THE NURSING ARTS AND ALLIED SUBJECTS BE TO THE NURSING SCHOOL CURRICULUM?

MARTHA RUTH SMITH, R.N., BOSTON, MASSACHUSETTS

I wonder if my whole contribution to this discussion might not be just as effectively made if I were to make about three summarizing statements to the effect that the nursing arts area should provide an opportunity to do the kind of nursing that all the other speakers of this convention have pointed out it was incumbent on the nurse to do in order to carry her share of the care and prevention-of-illness program. Practice of the right kind of nursing is the keystone of the whole nursing curriculum. The main factors involved in achieving this right practice of nursing are a realization of what good nursing is and an opportunity and capacity for doing it.

There is much that has been given during these meetings that is content in the nursing practice area. My problem becomes one of organizing these things within the area itself.

There is much that has been said that is basic to any content in the nursing area.

The factors fundamental to this discussion which have been discussed with you by others and which bear upon my topic are:

1. The admission of a student with some foundation in the biological, physical, or social science—which means a student oriented, in some degree at least—to the field of personal and public health preservation.
2. Emphasis on the educational approach which is more concerned with ends, understanding, and intellectual control on method than is the older training approach with emphasis on tools, devices, and techniques.
3. Learning through active participation in situations that the student realizes the significance of and finds satisfying in achieving—a process basic to the relation of theory and practice and to the arrangement of courses in the other areas in relation to the nursing practice area.
4. A concept of what good nursing is, which, broken down into its component parts, seems to be: having a knowledge of patient's condition or any of the principles of any part of his care in which the nurse functions; a knowledge of how environmental factors affect his condition, and the ability to use this knowledge effectively in carrying out specific nursing duties, such as observing and interpreting significant symptoms (both physical and mental), recognizing and considering patient's reactions, helping him adjust to them in a way that brings to him a satisfying response and a warranted sense of security, and to utilize all resources well whether these resources be the patient's or the nurse's, personal or professional, hospital or community.

The problem of this paper then is to bring before you without getting lost in details the changes needed in the nursing arts area to make it contribute what it should contribute.

When it comes to the actual introduction of the student to nursing practice our primary concern is to have her learn at the very outset a concept of nursing that is adequate and to practice it, for it is only through practicing it that one can learn it.

In order to build up the concept of an adequate professional foundation it
would seem necessary to have two units of instruction running concurrently—one mainly active participation in nursing, the other carefully planned observation of nursing with ensuing discussion. These two factors would show what nursing consisted of, whether practiced in the hospital, home, health center, or treatment clinic. In this way is built up a forceful realization of what nursing is, what its demands are, and what it behooves the student to learn during her professional preparation.

The unit of active participation would be nursing in the hospital proper. It would begin with the student caring for a type of patient who needed a sort of nursing care for his personal hygiene needs because he was so ill that he was unable to care for them himself either wholly or in part. In his personal hygiene needs are included: nutrition, elimination, rest, exercise, adjustment, and diversion, etc. Nursing techniques included here would approximate those taught in a home nursing course.

Accompanying and preceding such nursing activities would be discussion of not only the techniques involved but also those elements entering into intellectual control of method:

a. What nursing is, what its objectives are, by what methods it carries out its function of conserving strength, building up strength, aiding the patient to adjust, helping in the curative process by carrying out nursing treatments which are remedial in type and given under the prescription of the doctor

b. A method of planning nursing care so that it is individualized for each patient on a basis of:
   - Considering each patient’s individual physical and psychic needs
   - Considering how the immediate environment helps or hinders his recovery
   - Understanding how the prescribed nursing measures remedial in nature contribute to recovery
   - Understanding what the patient or his family need to be taught to re-assume the major responsibility for his care and prevent a recurrence

c. Standards for evaluating nursing care

In thus introducing the elements that enter into a nursing care plan, the integration of units of instruction dealing with setting up and maintaining the proper physical environment, nutrition, observing human reactions, and teaching functions of the nurse is provided for.

The unit of observation of extra-hospital nursing would dovetail with this unit. Building on what background the student brings in the organization of public health she should be led by observation and discussion to see how the nurse functions in relation to this field and become aware of what such a place demands of her in the way of knowledge and skills. This observation does not aim to teach her public health nursing. It aims to make more vivid certain of the elements that enter into planning and carrying out nursing care in a way in which hospital nursing never can. For example, the availability of care for illness and disease prevention, the types of problems entering into the patient’s care—his physical environment, his relation to his family group and its customs, his standards of living—and the type of problem involved in interpreting to patient what needs to be done and
the importance of motivating him to want to do it. Perhaps above all it should give the students a glimpse of how worth while nursing is and thus help to motivate the learning opportunities provided her in the program of professional preparation.

After the introduction to the elements of nursing care of patients whose needs are simpler and more general and satisfactory achievement of this type of nursing practice, the student is ready to proceed to those nursing measures which are definitely therapeutic and remedial in nature, which are prescribed by the physician and carried out by the nurse acting either as the doctor's agent or his assistant.

The principles basic to these nursing procedures are, of course, the meanings derived from the group of related facts brought together from the biological, physical, social, and medical sciences. More emphasis is needed in formulation of these principles than insistence that every step of the technique taught be followed exactly from first to last, forever and ever. I refer to emphasis on points of procedure which must be adhered to in order to get maximum therapeutic effect and safety; ways of securing comfort for the patient; what his reaction to the treatment is likely to be and how his adjustment to it may be made as easy as possible; what the problems of the nurse are likely to be in giving the treatment; what types of teaching opportunities may offer themselves in situations in which this treatment may be given.

There is, to be sure, the moral responsibility of teaching the students the best way we know to do a procedure and to provide opportunities for them to do these procedures in a situation where the procedure as presented can be carried out. Not to recognize that certain patients' needs and certain situations demand adjustment of procedure, not to plan for such adaptation, and not to encourage and stimulate initiative and resourcefulness by adapting procedures in necessary situations, is to cut off the full development of needed personal qualities in the student and the intellectual control of method sought for.

This point of adaptation of procedures to needs of types of patients leads to the consideration of the teaching of nursing care in relation to disease.

The discussion of the organization of the content of the clinical nursing area is again a general method of approach to every clinical field without a detailed discussion of content of any particular field.

Just as the classroom discussion during the introductory period unifies all factors into a complete picture of what the patient needs for adequate care, just so the classroom teaching of nursing on the clinical level does this. The factors with which it deals are more complex, however. It is in the classroom teaching at this level that the general principles of nursing care in relation to disease are learned. Nursing classes are the focal point for development of nursing principles through the integration of the pertinent facts about the disease, prescribed therapy, diet, typical reactions of patient to this
disease, what the content of teaching is in relation to this disease, how the hospital and community are organized to care for his needs.

All formal ward teaching of nursing is for the purpose of relating concrete nursing situations to the nursing principles developed in the classroom and to show as no classroom teaching can ever do the human and personal elements, to show the patient's reaction to his care and to integrate all factors contributing to comfort, discomfort, and adequate care of the patient. The content then is determined in relation to the classroom and on the basis of some particular type of nursing skills which the care of such a patient or such a disease demands.

I approach the subject of content of nursing practice with a great deal of hesitation. This is the part of this paper that should be most clear and most complete. It should point out what the graded levels of experience are within a nursing school. It should present an analysis of what are those nursing skills and personal qualities to be learned through practice, the keystone of the nursing curriculum. No one and no group has yet contributed, that I know of, an accepted basis for graded levels of experience, nor an adequate list of nursing skills. Surely I can not. There are, however, two separate studies being carried on now which seek in one instance to determine degree and types of nursing skills demanded with certain patients and certain types of conditions; in the other instance to analyze what makes for success and failure in nursing situations.

When findings from adequate studies of skills are available, then, and then only can we use such criteria as the basis for determining content of nursing practice more satisfactorily than it can now be done. Until then the usual means of determination on a basis of the care of types of patients with such conditions as are likely to demand nursing care from the graduate nurse, and learning the nursing techniques and nursing practice most commonly required in each of the clinical branches will be used.

The gradation of levels of experience seems logically to be from the supportive, non-technical care of the introductory period to the early clinical period when command of skills in curative nursing procedures is being developed in a situation and with a patient where the nurse may carry out a pretty complete plan of care. It then reaches the level where much adaptation is necessary, and finally comes to patients who demand maximum skill in physical handling, nursing the mind, overcoming resistance to treatment, meeting emergencies, etc., until the student nurse is able to function safely in a situation where her nursing care is quite independently carried out. An example of this type of care is found in the public health field.

Though I have said I could not contribute details to special fields I have had a little experience the last four months as a nursing student myself that makes me wish to append a few of my own reactions to this discussion of content of practice in the nursing school curriculum.

It is not an uncommon practice for a school of nursing to have two months of mental nursing experience and two months of public health nursing, so
I thought perhaps I could learn some of each field in two months each. Probably the chief impressions I got out of each experience was how much a nurse had to know to do each type of nursing, what a worth while person she had to be, and how infinitely important is the time element in these fields because the patients have to know the nurse before they will accept her and she can function well.

It is still a mystery to me why we can not teach the understanding and observation of behavior just as well without caring for the frankly psychotic patient but we can not. From this type of patient whose reaction to his handling, psychological and physical, is the all-important factor in his treatment and progress, there is something very fundamental to transfer to those patients who are not psychotic in order to avoid tensions and to give needed sense of security. And when it comes to learning the indirect suggestion technique—the teaching technique by which most of the nurse’s teaching is done—the training field of the mental hospital is unexcelled. The two months’ experience in mental nursing is decidedly for purpose of the learning of good general nursing. Mental nursing could never be learned in two months,—or four months, for that matter.

Neither can public health nursing be learned in two months. It does bring home forcibly a realization of the varied elements that have to be considered in nursing all patients, a realization of what the community depends on the nurse for, and a feeling that is rarely equalled of how worth while nursing is. What the actual practice in the public health field provides is a tangible and visual basis to motivate the student’s learning of the subject matter in the courses which have to do with the elements of public health.

My experience in public health nursing has made me question again why we refer to pediatrics, obstetrics, communicable nursing, etc., as “specialties.” The major part of the work was with children or new mothers and new babies. The organization of these phases of care is so well developed and those of us who have not actively participated in the field know so little. I question, too, in my mind whether any position of supervisor of pediatrics or obstetrics can be justifiably held in a nursing school if these people have not had or do not have active contact with the public health program relating to their clinical branch.

If only the majority, rather than an isolated few, of my patients had needed me to irrigate a wound or care for lobar pneumonia I would have been quite comfortable in my public health nursing experience. I would have been much more comfortable, too, if mothers had not asked me so many good questions I could not answer, or even if I myself had not seen so many chances where pertinent facts would have been gratefully received if only I had had those pertinent facts in a nutshell.

It is not a mystery to me now why the nurses rated lowest on the teaching aspect of the visit in the recent survey of public health nursing. If the ex-
experience of those nurses was like mine, they do not know what they would have liked to teach.

**Changes in the Content of Subjects Allied to the Nursing Arts**

I met my most ignominious defeat on the questions and needs in relation to the field of nutrition. Thus I feel somewhat prepared to offer some suggestions for necessary content in relation to one aspect of this field.

There are three types of problems involved within this area of nutrition and dietetics. The first problem arises because in the hospital a specialized group of workers—dietitians—carry this service, planning and serving all food. In the field the nurse, whether with one private patient or with a case load of forty families, has actually to do the planning and supervising, and she is a lone worker, most of the time. If she has access to a nutritionist for consultation once a day to meet emergency problems of diet and nutrition, she is fortunate.

To the second problem in relation to dietotherapy I can contribute little, but I reiterate the fact that experience in the basic essentials of planning, preparing, and serving the actual patient for whom the diet was prepared, is needed to a sufficient degree to have the nurse aware of problems of procedures involved. Perhaps this is a change only in that the right amount of the right kind of experience is not yet planned for.

As far as the third problem relating to normal nutritional problems rather than specific dietotherapy goes, there is a continual weakening of a skill never well enough developed in planning, supervising, and preparing the patients' meals. There seems to be an increasing tendency for dietitians to serve all meals.

When problems of feeding and nutrition are considered in the light of restoring and building strength, this is an all-important element in planning and carrying out nursing care.

Is there not an area of this nutrition field that perhaps will fall under the heading of social dietetics which will help the nurse act more efficiently in her capacity of nurse as well as in her capacity as nurse-citizen helping to conserve society's resources, which will provide her with many of those pertinent facts in a nutshell that she needs such as:

- low cost diets—adequate or emergency in nature;
- preparing weekly grocery orders;
- helping in planning palatable menus that fit into these requirements;
- racial diets;
- ways of getting people to take milk, for milk is decidedly not popular;
- suitable diets for the early age groups as well as prenatal and lactation periods;
- adapting special diets to family diets and vice versa;
- ways of overcoming finicky food habits;
- budgeting.

Hygiene also falls within the field of the allied arts. The preparation of the student here is concerned with her as an individual, as a nurse, as a teacher of health.
Health education specialists have provided us with a definite guide in the principles enunciated of using all activities which involve healthful practices as basis for motivating and acquiring specific health knowledge and integrating in all science courses in the program of study those facts relative to health maintenance and promotion from which the facts issue and in which they belong. Thus, a course in personal hygiene would be deleted from the program of courses and the health program of schools would be basis for establishing of habits, attitudes, and acquiring knowledge.

The preparation of the student as a health nurse had been indicated in the organization of content and type of approach in the introductory and clinical period. The preparation of the student as a teacher of health has also been suggested in the set-up of class and activities in the clinical program. If there is a course in method of health teaching other than here and in psychology, it would, I assume, be included in the social science area.

At the beginning the points were made that the main factors in the practice of good nursing were a realization of what good nursing is and an opportunity and capacity for practice. It is hoped that sufficient changes in content or changes in emphasis perhaps have been shown so that there appears a wider conception of nursing, its means and relationships, better integration of materials around the getting well and keeping well idea, more consistent attention to consideration of patients' adjustment needs, gradation of practice in situations which have significance for students, in which they can achieve the adequate practice of nursing.

**General Session**

**Friday, June 7, 9:00 a.m.**

Presiding: Elizabeth C. Burgess, R.N., *Professor of Nursing Education, Teachers' College, Columbia University, New York City*

**General Topic:** CONTROL AND SUPPORT OF NURSING SCHOOLS

**A. Hospital Control**

**Joseph C. Doane, M.D., Medical Director, Jewish Hospital, Philadelphia, Pennsylvania**

For a physician, even though he may have for many years been interested in administrative medicine and the education of the nurse, to endeavor to throw any real light on this much discussed question appears an almost impossible task. It is an assignment requiring the tact of an international diplomat, the vision of a prophet, and the wisdom of at least an educational Solomon if not more. I am reminded, however, that a mild conflict of opinion sharpens wits and makes more keen the perception of right and the detection of wrong.

The control of nursing schools by hospitals apparently appears to some as a plan of questionable respectability. To these the assignment of such a subject to a person who has been interested in hospitals might appear as a
request to justify or to acknowledge a wholly evident wrong, as an attempt at a futile explanation of an arrangement suggestive of a plan oppressive in its tendencies and destructive of nursing school initiative. This, to the writer, does not appear to be the case. He has no apology to offer for the arrangement whereby schools for nurses (I detest the circus suggestion in the word training) represent integral departments of the hospital organization. Nor do I asserting at the outset that this is the best plan. It is simply the scheme most frequently observed throughout the field and the one which in the light of our present economic difficulties seems likely to persist for not a short period of time. The reasons underlying this arrangement are not difficult to discover. The medical school is constructed usually in a congested section of a city because there is to be found ample clinical material from which to teach. The origin of the connection between hospitals and nursing schools, however, probably can not be explained by an attempt to meet such a wholly educational need. Early hospitals and nursing authorities apparently sense both an economic and educational aim in this arrangement. Because hospitals, some by necessity and others through sheer blindness, have profiteered on this arrangement, their motives generally should not be impugned in any wholesale fashion. The attention of hospital boards and superintendents, however, should be continually directed to the ever-binding moral obligation which exists when students, whether they be nurses, laboratory technicians, or pupil anesthetists are accepted. To promise education and to procure the services of persons of any type without fulfilling such promises are unethical and wholly unrighteous. There are those that believe that the nurse can not be properly educated and patients effectively served at the same time. To leaders in the nursing profession this statement has come to represent almost an educational axiom. It must be granted that too often one or the other of these objectives seems to fail of accomplishment.

Attention is now directed to the scope of this problem. During the past five years the number of schools for nurses operated in conjunction with hospitals on a departmental basis in the institutions approved by the American Medical Association has dropped 283 or about 15%. Those schools only approved by their respective state boards are included in this figure. Of the 264 unaccredited schools existing in 1927 but 18 were in operation five years later. What has become of the remainder? Some have succumbed with the hospitals of which they were a part. Others have been replaced by graduate nursing. Most of those which now languish will eventually expire. In the past few years there has arisen a general belief that there is no place in the professional field for the approximately 16,000 nurses being graduated annually. It has been stated that there should be fewer schools for nurses and that it is wholly unfair to accept probationers who in their lack of information do not realize that there will be no work for them when they have graduated. The writer of this paper has continually and consistently contended that perhaps there are too many schools for nurses but that of a certainty there are too many poor schools. What the field needs is not so
much fewer nurses but rather fewer poor nurses. The corollary of this statement is surely this: There is still a demand for a greater number of young women with high professional and personal background, and possessed of an education and an understanding of human nature which would enable them always to appear as worthy representatives of your splendid profession. There should be an open season for lame ducks in your as well as in my profession.

What is the general hospital set-up in regard to its school for nurses? I have seen some instances in which I felt that the school for nurses controlled the hospital rather than the reverse being true. Here a strong, aggressive superintendent of nurses dominated the scene. Usually the superintendent of nurses answers directly to a hospital administrator. Often the latter is not an educationalist and sometimes the former is not truly so. Such a combination is a bad one. If even one of these directing heads be educationally minded, the pupil nurse might be fairly well served. When both have seen the vision of educational possibilities, a good school is usually to be found. The objection expressed in the 1923 volume on Nursing and Nursing Education in the United States that “the compliance with hospitals needs continues to be a genuine obstacle to the educational advance of the nurse” is to my mind not an explanation but an excuse for the presence of an unneeded hospital, a poorly-equipped superintendent or superintendent of nurses, or all three. This conflict between the care of the patient and the need of the nurse does exist, however, too often and it is the nurse and her education which usually suffer. Granted that the ideal situation would be some other arrangement than the one which now exists, I am not willing to concede as a general rule that the system is wholly to blame but believe that its human factors are likewise harmfully indifferent or ignorant of the educational requirements of the nurse. Much ground remains to be plowed in convincing the doctor that the curriculum as planned today is one peculiarly fitted to educating a professional nurse. His yearning for the old-time nurse is gradually growing less acute. The nurse herself led by her elders has come to demand recognition as a representative of a dignified profession. Often she presses her claims mainly, sometimes because of her own lack of qualifications and often because the hospital has failed to keep faith with her. In some cases, schools for nurses fail not so much in their teaching procedures as in displaying discretion in selecting the human material from which they promise to fabricate a skilled graduate nurse. A certain medical college in the East is said to graduate splendid young physicians not because of the brilliance of its teaching staff but because of its skill in choosing candidates for the freshman class. Here again the hospital superintendent or the superintendent of nurses should be reproached rather than a wholesale condemnation of nursing schools and hospital relationships. I am fearful lest I am falling into the error of attempting to justify a system which has in many instances proven ineffective and yet I must protest any implication that a deliberate wrong is being done. No true superintendent of a hospital
will oppress his directress of nurses. All directresses of nurses are not better qualified than all hospital superintendents but an institution administrator who has not learned the lesson of selecting a highly trained nursing specialist to head his school and, after so doing, the wisdom of supporting her, should vacate his executive chair to one better qualified. A search, however, of hospital shrubbery has failed to reveal an abundant crop of dollars which may be harvested to maintain the institution which is proverbially poor. If routinely money can not be secured to properly care for patients and at the same time educate nurses, then and only then can a wholesale condemnation of hospitals and schools for nurses’ relationship be made.

A few specific remarks may here apply. The training school committee should be a helpful group. It is usually devoid of educationally-minded persons. It consists often of those well intentioned but wholly without pedagogic information. It too often is employed as a sort of by-pass around the superintendent. It sometimes is a punitive weapon used to intimidate or coerce him into recognizing his duty toward the nurse. As such it has no reason for existence and is a disrupter of hospital morale of a most pernicious nature. From a personnel standpoint, therefore, no school for nurses can attain its highest aims unless both the hospital executive and the superintendent of the school are educationally minded, are co-operative, and are willing to concede a point when the welfare of sick people demands it. Personalities which arise in the name of education should be carefully inspected to learn whether some ulterior motive can not be detected therein.

The hospital school of today needs better physical facilities and better teaching. Physician lecturers often consider too casually an assignment to instruct nurses. They are often poorly prepared, tardy in attendance, and as a rule resent criticism. A most skillful surgeon may be a clumsy lecturer. Better co-ordination of classroom and ward teaching, ward classes for nurses, and the greater routine use of clinical material for instruction purposes are but a few of the urgent needs of the average school for nurses. A great hue and cry has been rightfully raised relative to the assignment of menial duties to the pupil nurse. But, unfortunately, in securing a great good, a doubt has been raised in the mind of the probationer as to the respectability of this type of work. Non-nursing duties are necessary to some degree and possess certain educational angles. To require the nurse to pay tuition and board and to spare her, therefore, bed-washing, lettuce-cleaning, and sponge-making would be a splendid thing educationally and perhaps economically. To secure more ward maids with the money thus obtained would probably be possible. At the same time, while the writer does not believe that prolonged assignment of nurses to such duties is a proper thing, yet he regrets the unhealthy reaction on the part of some young nurses that to cook a family meal or to wash a kitchen table is never a justified nor necessary service on the part of the graduate nurse. I am not condoning any of the wrongs which have taken place in the hospitals of this country nor am I urging their continuance. I am suggesting that unless the education
of the nurse can be placed on a high extramural basis with hospital internships for practice, the leaders in the medical and nursing profession must instead of condemning the present situation in a wholesale manner, constructively turn their faces toward working out a more equitable plan.

I would not conclude this paper without adding to it some more concrete suggestions and emphasizing some already made—a more careful selection of applicants from the standpoint of social background, intelligence, and other aptitude tests, these persons to be possessed, if possible, of one or two years at least of college preparation; hospitals to endeavor to establish a plan of charging tuition and other maintenance fees, thus placing the education of the nurse on a higher scholastic basis; having educators as advisors to or as active members of the nursing school committees; an endeavor to attain affiliations with mental, nervous, communicable, and public health hospitals when such experience is not available; an arrangement for ample study time for all students; more graduate personnel to relieve students when at class and to provide for ample supervision. These graduates should be able to assist in teaching and thus create a stronger liaison between classroom work and ward work; sparing the pupil nurse in so far as is economically possible of non-educational assignments; the adherence to the published curriculum, adequate recreational, living, and dining facilities; the stressing of good manners, courtesy, tact, and a scientific humility to prepare a nurse for contact with all social types of patients; lastly, an attempt to bring about greater state responsibility for the financial support of nursing schools.

To demand reform without suggesting a remedy is often futile. For a nursing profession to endeavor to change conditions as they exist without the help of those others who should be interested, namely, hospital trustees, superintendents, the public, the patient, is to my mind a hopeless task. Where ignorance and indifference exist, educational enlightenment may still be developed. The cause of the nurse may still be safe in the hands of that splendid army of trustees, many of whom need only to be shown the way. Economically today any widespread revolutionary alteration of our present plan for education for nurses seems most difficult.

B. COLLEGES AND UNIVERSITIES

MILTON CHARLES WINTERNITZ, M.D., Dean, Medical School, Yale University, New Haven, Connecticut

ALPHONSE M. SCHWITALLA, S.J., President, Catholic Hospital Association; Dean, St. Louis University School of Nursing, St. Louis, Missouri

(Since these talks were not presented from formal papers, we are giving herewith a digest reprinted from the American Journal of Nursing, July 1935, pp. 692-693)

COLLEGES AND UNIVERISTIES

Declining to discuss specifically "Control and Support of Nursing Schools," the topic assigned him, Dean Milton C. Winternitz warned his audience to
be not too impressed with the education now available in colleges and so, by brilliant indirection, reminded his hearers that nurses must themselves safeguard the content of courses and the educational methods by means of which nurses shall be taught. Making a sharp distinction between “nursing for education” and “education for nursing,” Dean Winternitz pleaded for a type of education in which well-prepared students would work and work hard for the knowledge needed to make them good nurses. He took a very advanced position on the subject of didactic work and required hours, believing that the student who is doing what he wants to do needs no coercion.

Of the future of nursing he believes that the great service will not be hospital care of patients but in the maintenance of health, although there must always be three facets to nursing—hospital, home, and public health. Because “continuous active care of the individual” is not yet “in the consciousness of the medical profession,” it would conceivably be possible for broadly educated nurses to usurp the rightful place of doctors as health advisers! However, being a nurse does not fit for specialization. That, as in medicine, must come later.

The problem of support and control of nursing education would be simpler if faced more honestly, Dean Winternitz believes. Student nurses should not be depended upon, any more than are medical students, for expert work. The argument for an internship, or residency, for the recent graduate, should be the same for both medicine and nursing. Facing the facts honestly requires a real analysis of finance and of service; and adjustments, Dean Winternitz believes, must be made on the basis of the cost of nursing care for patients. Obviously, subsidy of the institution which cares for patients and attempts also to give an education in nursing must be increased if neither is to suffer.

Dean Winternitz again warned against blind faith in educational institutions by saying that “Nurses should know what nurses should be taught by the various specialists.” They must also be able to evaluate teaching methods, since “the best teacher is the one who can present his subject in the shortest time.” Furthermore, the nurse executive in the university school must have the ability to serve in a liaison capacity between all those departments, such as medicine and sociology, from which the source material for nursing must be drawn.

COLLEGE AND UNIVERSITY AFFILIATIONS

The complex subject of university and college affiliations was discussed with clarity and precision by Father Alphonse Schwitalla, President of the Catholic Hospital Association. It was comforting to be reminded that our difficulties in evaluating affiliations are by no means limited to nursing, since Father Schwitalla cited examples of such difficulties occurring in the powerful North Central Association of Colleges and Secondary Schools. Specifically, Father Schwitalla warned of mechanisms which permit a university to grant a degree for work over which it has no control. “Affiliation” has been
used so loosely, according to Father Schwitalla, that it “may mean anything from a letter from a Dean, to a careful program” and is almost meaningless as used at present. Despite this, the move toward institutions of higher education must go on and Father Schwitalla urged the development of sound but individualistic rather than formally standardized programs. Father Schwitalla suggested a fourfold classification of the possible relationships between school and college or university:

1. University Integration. The school of nursing an integral part of the university.
2. Adoption of school by university. Here the school of nursing is put into the university without central control, the faculty is drawn largely from the university faculty, the university approves the curriculum, the university approves the nursing school faculty, but the university has no voice in financing the school.
3. Course affiliation. This might apply to schools which give certain courses, as in basic sciences, for which the university grants credit but which do not receive credit for clinical courses.
4. Accreditation. This term might be used when the university definitely steps down from its proper educational level by giving “blanket credit” covering a number of courses.

Closing Business Session

Friday, June 7, 3:45 p.m.

Presiding: Effie J. Taylor, R.N., President

Miss Taylor explained that there were some reports left over from the first business session.

REPORT OF THE COMMITTEE ON STATE BOARD PROBLEMS

The last meeting of this Committee was held in New York City on January 22, 1935. A report of this meeting was made to the Board, January 25, 1935. This is a report of the progress of the work of the Committee since that time. The data compiled by Miss Ella Taylor on present methods of inspection have been mailed to all state boards of nurse examiners. A subcommittee to study state board examinations has been appointed, consisting of Sister Domitilla, chairman; Miss Juliet George and Miss Helen Faddis. Their report will be given at the round table, Saturday morning, June 8, 1935. The chairman has not succeeded in finding subcommittees to study (1) Qualifications of State Board Members and (2) Better Methods of Inspection, as suggested at the January meeting.

Because of limited time and space, the suggestion that three round tables be conducted at the annual meeting has been changed. Two sessions will be held, one of these a closed session. At the other, state board examinations will be discussed.
The list of problems which concern members of state boards of nurse examiners compiled by this committee includes:

1. Better selection of students for nursing schools.
2. Programs of publicity to attract better applicants for schools of nursing. The Nursing Information Bureau is leading the way in this project.
3. Revision of the curriculum. The Central Curriculum Committee is doing this piece of work.
4. Higher standards for nursing schools. The Committee on Standards is studying and carrying on this program.
5. Better-prepared faculties, head nurses, general duty, and special nurses.
6. Staff education for nurses in all hospitals, whether or not there is a school.
7. Adequate basic experience for students in schools of nursing. A nationwide study of clinical services available to students, especially in the neglected fields of communicable diseases, tuberculosis, psychiatry, pediatrics, and community nursing.
8. Better cooperation between state boards and the state leagues and state nurses' associations. A letter has gone out to all state leagues, asking them to organize state committees on state board problems.
9. More uniform methods of examination and registration in the various states. This study is in process by Sister Domitilla and others. Her report at this meeting will be followed by a general discussion, which should pave the way for still further study and recommendations for improving present practice.
10. The essentials of a nursing law and state board requirements as they relate to the education of nurses. Miss Burgess is chairman of a subcommittee to study this phase of the subject and will give a report.

It would seem that problems 1, 2, 3, 4, 5, and 6 are or can best be initiated by others than this Committee, and that this Committee can help. Problems 7, 8, 9, and 10 would seem distinctly the responsibility of this Committee. Subjects related to these last four problems are to be discussed at the special sessions sponsored by our Committee and at the Committee meeting.

Respectfully submitted,

D. DEAN URCH, Chairman

REPORT OF THE COMMITTEE ON SUBSIDIARY WORKERS

Although the Committee has no real report, I do not want this group to go away with the matter of the subsidiary workers entirely overlooked. I wish to say that the Committee has no report to make not because the members feel it an unimportant matter, but that it is because of its importance and its complexity that nothing has been done.

I should like to have an expression of opinion as to whether the group here feel that the matter of subsidiary workers should at this time have our attention.

Last year we reported to you the sources which contribute at the present time to this group of workers. We made certain recommendations, which related primarily to the necessity for control, believing that control of nursing by this group should be actually in effect prior to our giving much thought or approval to the organization of schools for the preparation of subsidiary workers.
In January, 1935, the following recommendations were made to the Board of the National League of Nursing Education:

1. It requests that the National League of Nursing Education support the principle that all persons who nurse for hire should be licensed
2. That it disapprove the opening of schools for the training of subsidiary workers until control of nursing practice is secured
3. That it believes the term "nursing aide" more desirable than that of "practical nurse"

At that time the Committee was of the opinion that its work for the time was completed and asked that it be discharged. The Board, however, requested that it continue its study.

We are sure that you must have some opinion on this matter of subsidiary workers, particularly those who are closely connected with state boards of nurse examiners, or perhaps some of you who use subsidiary workers in your own hospitals.

Respectfully submitted,

ELIZABETH C. BURGESS, Chairman

The majority of those present felt that the work of the Committee on Subsidiary Workers should be continued.

REPORT OF ROUND TABLE ON HEALTH PROGRAMS IN SCHOOLS OF NURSING

JULIA MILLER, R.N., Chairman

The time allotted for so important a subject as student health was short, but we did have time to have a résumé of health programs in several types of schools.

Miss Mary Sullivan, Health Service Director of Bellevue School of Nursing, discussed health programs in public hospital schools. This paper gave to us new angles of approach in preventing illness among our nurses.

Miss Houston, Health Nurse at Yale University School of Nursing, gave a splendid survey of health programs in University Schools of Nursing. Her discussion of prevention of illness provoked, later in the meeting, much interest and informal discussion on immunization.

We realize that if this program of health is to be carried out, we must convince hospital superintendents, business managers, and those who hold the purse strings, that student illness is costly. Miss Murdoch, in her paper, gave evidence of its costliness.

The result of the Round Table discussion on health programs seemed to indicate that nursing as a whole is conscious of the part that positive health plays in general adjustment of our students. There is also a realization that health programs should be given definite thought as to organization, control, and student response. If the thought of this convention is to be brought to its greatest fulfillment, the student and graduate health programs must be given major consideration.
REPORT OF ROUND TABLE ON NEW CHALLENGES TO THE NURSE IN HER RELATION TO THE CHILD

DOROTHY ROOD, R.N., Chairman

At this Round Table Miss Winifred Rand presented a paper on Integration of Child Development Principles in Pediatric Nursing, in which she emphasized the problem of learning versus teacher's activities in instilling knowledge into the nurse. The attitude which the nurse has when she comes to a classroom in uniform under close observation of an instructor who is a monitor, which instills fear into the student nurse, that point of fear in the classroom has no place whatever.

Miss Margaret M. Adams spoke on The Practical Application of the Principles of Child Guidance on a Busy Hospital Ward. She really gave us some very definite child development laws and showed how they could be carried out in the procedures which have to go on without any more equipment or any more time being taken than if the wrong kind of care were being given.

Miss Winifred Kaltenbach spoke on Opportunities for Teaching Normal Development Through the Case Study Method. The case study has had a long and interesting history and has gone through a good deal of development and much improvement has taken place. The emphasis in the case study is on the normal development of the child at various age levels with emphasis on the wide range within the normal.

The subject on which Miss Elizabeth Pierce talked was Hospital Facilities as They Affect Parent Education Programs in Hospitals. We feel that parent education is a problem which requires all the vision and all the daring and initiative which nurses in child nursing and child development have at their disposal. I think that every nurse in contact with parents and with children feels the acute lack of information and ability and methods of attacking such problems.

Miss Pierce pointed out the hospital facilities which are available and the function of the hospital in carrying out parent education.

Miss Marcella Faye spoke on Parent Education in a Hospital, as it related to the student nurse. At the Children's Memorial Hospital in Chicago the student nurses take turns with the supervisor in putting up exhibits and in helping on visiting days to go over the toys which the parents bring to the children, and help in advising them regarding the kind of toys that are good for the children and in explaining to them why those are the right playthings to have.

They also have experience in going to the five and ten cent store and knowing what the five and ten cent stores have for children, and in getting acquainted with the community facilities in that way.
REPORT OF ROUND TABLE ON WHAT CONSTITUTES AN ADEQUATE LIBRARY

NINA D. GAGE, R.N., Chairman

The Round Table discussion on what constitutes an adequate library was attended by over one hundred members of the League. The first paper on the program was The Library as an Educational Tool. Miss Ann Doyle, of the Bellevue School of Nursing, discussed this paper and presented it in a very interesting way. She showed us the reason why the library facilities must be taken into consideration with our changing need in nursing. Our curriculum revision has been developed because of this change in nursing, but nursing has passed out of the hands of private endeavor and the nurses are going to have to meet changing conditions, as has been shown by Recent Social Trends, the report of a study of social institutions in the past thirty years which was published in 1931.

The second paper was on Principles of Organization and Administration for Special Libraries by Helen Bayne, Librarian of New York University Medical College.

The third paper was on Making the Resources of the Library Available by Ethel Wigmore, the Librarian of the Bellevue School of Nursing. This paper is printed in the American Journal of Nursing, August, 1935, pp. 728-732.

The meeting closed with a discussion on The Library of the Small School of Nursing by Mrs. Jean Martin White, from the Mount Vernon Hospital. This paper is also printed in the American Journal of Nursing, August, 1935, p. 733.

INSTRUCTORS’ SECTION

The Chairman of the Instructors’ Section reported that the Instructors’ Section had elected Miss Mina M. Booher, Chairman, and Miss Margaret E. Wyatt, Secretary, for the coming year.

COMMITTEE ON NOMINATIONS FOR 1936

Members of the Committee on Nominations appointed by the President, in accordance with the provisions of the By-laws\(^1\) were:

Hester Frederick, Baltimore, Maryland, Chairman
Irene English, Rochester, Minnesota

Nominations from the floor were:

Catherine Buckley, Cincinnati, Ohio
Edna Peterson, St. Louis, Missouri
Shirley C. Titus, Nashville, Tennessee

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\(^1\) By-laws—Article VII, Section 6. The Committee on Nominations. This committee shall consist of five members, two of whom shall be appointed by the Chair and three by the house.
On motion made, seconded, and carried, these nominees were elected.

**MISS LOUISE POWELL MADE AN HONORARY MEMBER**

Miss Louise Powell of Staunton, Virginia, was unanimously elected to Honorary Membership in the League.

**ACCRREDITING SCHOOLS OF NURSING**

A recommendation from the Board of Directors, "That a committee be appointed to study accrediting systems and plans, with the idea that the findings of this committee be taken to the Joint Boards with the proposal that consideration be given to the establishment by the three national organizations of some type of agency for the accreditation of all kinds of programs in nursing education" was discussed. A majority of these present felt that this recommendation should be carried out.

**RESOLUTION ON DECEASED MEMBERS**

Since the last meeting of the National League of Nursing Education we have received word of the death of the following members:

- Anna Aline Brown, Life member and charter member
- Mary Sands Littlefield, Charter member
- Ida Falconer
- Jean M. Cocheur
- Margaret E. Dorne
- Sarah C. Barry
- May S. Loomis
- Maude A. Wood
- Kathryn K. Schulken
- Evelyn Wood
- Bertha Harmer
- Leslie Wentzel
- Ida Venner Rogers
- Sister Caroline Braun
- Lucy Minnigerode
- Marie Louis
- Nellie F. W. Crossland
- Elsie Helmets
- Ursula Heileman
- Fanteen Pemberton
- Sister Margaret Laverty

**WHEREAS,** The ranks of this organization have been seriously depleted by the death of these members; and

**WHEREAS,** All of these women have served the organization and the profession of nursing long and faithfully, giving unstintingly of their interest, devotion, and counsel during their years of active service; and

**WHEREAS,** The National League of Nursing Education wishes to acknowledge their contributions and mourns the loss of their aid and support; therefore, be it

**Resolved,** That the National League of Nursing Education hereby expresses its sorrow at the death of these members, silently closes its ranks and carries on that their contributions and inspiration may not be lost; and be it further

**Resolved,** That these resolutions be spread on the minutes of this association at this, their annual meeting.

**DOROTHY ROGERS**
**EDNA NEWMAN**
**DAISY DEAN URCH, Chairman**

*Special Committee on Resolutions*
REPORT OF THE COMMITTEE ON RESOLUTIONS

It is significant that the National League of Nursing Education selected New York City as the place of meeting for the Forty-first Annual Convention. A quarter of a century has passed since it last met here.

In 1910, the New York Convention had as its central theme, the celebration of the Fiftieth Anniversary of the first school of nursing established by Miss Nightingale at St. Thomas' Hospital. Even though the program for the 1935 Convention has taken into account the fact that the Nightingale tradition has spread over the world, the theme has not been built around the past, but around a revelation of the challenge to the future.

The National League of Nursing Education wishes to thank the Committee most sincerely for a program which has proven so tremendous a stimulus to all attending.

The revision of the Curriculum in its various aspects, the discussion on Adjustment versus Discipline as a major aim in nursing education, the symposium on clinical instruction for new techniques in teaching, and the provision for lay participation in nursing education, the latter made for the first time by the League, indicate sound progress in nursing, which is, indeed, a tribute to the ideals of our Founder of Modern Nursing. Appreciation is expressed to all who have so ably contributed to this program.

For the arrangement of the convention, including the program, the gracious hospitality, the social diversions, the lovely music, and the most interesting historical and educational exhibits, we are indebted to our hostesses, the New York State League of Nursing Education, the New York City League of Nursing Education, the New York State Nurses' Association, the New Jersey State League of Nursing Education, and the New Jersey State Nurses' Association, to the Roosevelt Hotel, with its courteous and efficient management, to the Committee on Arrangements, to the Committee on Program, to the program monitors, to the exhibitors, to the press, and to the hospitals of New York and New Jersey who have arranged to receive visitors following the convention.

It is felt that special tribute should be paid to Miss Taylor, Miss Wheeler, Miss Young, Miss Watson, Miss Stewart, Dr. Winslow, Dr. Kilpatrick, Mrs. Belmont, Dr. Finley, and to Miss Nutting, whose absence was greatly regretted.

Respectfully submitted,

PEARL CASTILE
ELEANOR LEE
JUNE RAMSEY
FRANCES HELEN ZIEGLER, Chairman

Miss Taylor announced a registration of 1,223 for the Convention—the largest registration in the history of the organization.

Miss Pearl Castile, President of the California State League of Nursing
Education, extended a cordial invitation to those present to come to California for the 1936 Convention.

REPORT OF THE TELLERS

Total number of votes cast ........................................... 262
Votes discarded ..................................................... 20
Total cast for each nominee for each office:

**Vice President**
Nellie X. Hawkins .......................... 197
Harriott L. P. Friend ......................... 48

**Secretary**
Stella Goostay .......................... 169
Gladys Sellew .................................. 71

**Directors**
Isabel M. Stewart .......................... 208
Anna D. Wolf .................................. 176
Daisy Dean Urch .......................... 157
Phoebe M. Kandel .......................... 94
Helen L. Denne .................................. 89
Nellie M. Porter .......................... 82
Frances Helen Zeigler .......................... 80

Respectfully submitted,

ELLA HASENJAEGER
NELLIE S. PARKS
CHARLOTTE PFIEFFER, Chairman

The report was accepted, and the Chair declared the following officers and directors elected:

*Vice President:* Nellie X. Hawkins
*Secretary:* Stella Goostay
*Directors:* Isabel M. Stewart, Anna D. Wolf, Daisy Dean Urch, Phoebe M. Kandel

The Chair introduced the newly elected officers.
The Forty-first Annual Convention of the National League of Nursing Education was declared adjourned to meet in Los Angeles, California, the week of June 21-26, 1936.

SUMMARY OF SPECIAL CONFERENCE ON STATE BOARD PROBLEMS

DAISY DEAN URCH, R.N., Chairman

The work of this Committee during the past year has been directed toward gathering a list of problems which confront state boards of nurse examiners in the various states. Considerable data have been compiled and sent to all state boards. These data include methods of appointing members of state boards, requirement set-up for schools of nursing, methods of surveying schools, and holding examinations for certification.

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1 The Proceedings of the Conference on State Board Problems have been published separately and may be secured from League Headquarters. Price, seventy-five cents.
Two special studies have been made by subcommittees: one by Elizabeth Burgess on the Essentials of a Good Nurse Practice Act, and one by Sister M. Domitilla on State Board Examinations. The subcommittee of which Sister M. Domitilla was chairman offered the following recommendations:

1. That the state nursing organizations recommend for appointment to the state examining board only such nurses as would be qualified for their duties.

2. That the objectives to be emphasized by state board examinations be more clearly defined and that examinations be constructed which will more adequately attain these objectives.

3. That in addition to the usual objective or objectives, examinations be made instruments for promoting greater uniformity of standards in nursing education in the various states.

4. That steps be taken to promote greater uniformity in practice relative to the re-examination of applicants who fail.

5. That examinations in eight, ten, or twelve subjects be abandoned in favor of examinations along broader lines such as the areas suggested for the new curriculum. It might even be advisable to give an examination in the basic sciences to students who have completed a year of work in a school of nursing and reserve the final state board examination for the principles and practice of nursing, the medical sciences, therapeutics, the social sciences, and professional problems.

6. That each state organize a state committee on state board problems and that committee membership be extended to include experts on examinations from the field of general education.

7. That plans be made for a central council or committee which will be able to:
   a. Construct good examinations which can be secured by the various states
   b. Set standards relative to scoring and grading examinations
   c. Give advice and assistance relative to other matters which come under the jurisdiction of the examining board

8. That scientific studies be made to determine the advisability of giving examinations in nursing practice through practical demonstrations, and that acceptable methods of giving and scoring such examinations be determined.

Some of the problems discussed at the conference were:

Repeaters at state board examinations—what can we do to improve the situation; applicants who fail in one state, go to a neighboring state, pass the examination, then return and register in the home state by reciprocity; inadequately prepared faculty members; annual reregistration; selection of students; the closed school.
NATIONAL LEAGUE OF NURSING EDUCATION

CERTIFICATE OF INCORPORATION RECORDED IN THE OFFICE OF THE RECORDER OF DEEDS FOR THE DISTRICT OF COLUMBIA, APRIL 18, 1918. ACCEPTED AS THE CHARTER OF THE NATIONAL LEAGUE OF NURSING EDUCATION, APRIL 20, 1918

By-laws amended June 21, 1924; May 29, 1925; May 22, 1926; June 17, 1929; June 10, 1930; April 11, 1932; June 12, 1933; April 23, 1934; June 3, 1935.

CERTIFICATE OF INCORPORATION

KNOW ALL MEN BY THESE PRESENTS, that we, the undersigned, citizens of the United States, Jane Delano, Clara D. Noyes, and Georgia Nevins, citizens of the District of Columbia, and Lillian Clayton, a resident of Philadelphia, Pa., and Elizabeth A. Greener, a resident of the City of New York, desiring to avail ourselves of the provisions of Sec. 599, et sequitur, of the code of law of the District of Columbia, do hereby certify as follows:

1st. This organization shall be known as the National League of Nursing Education.
2d. The term for which it is organized shall be perpetual.
3d. The object of this association shall be to consider all questions relating to nursing education; to define and maintain in schools of nursing throughout the country minimum standards for admission and graduation; to assist in furthering all matters pertaining to public health; to aid in all measures for public good by cooperating with other bodies, educational, philanthropic, and social; to promote by meetings, papers, and discussions, cordial professional relations and fellowship and in all ways to develop and maintain the highest ideals in the nursing profession.
4th. The number of its trustees for the first year of its existence shall be thirteen.

IN WITNESS WHEREOF we have hereunto set our hands and seals on this 13th day of March, 1917.

James Picker, E. J. Morton as to ..........

Robert E. P. Kreiter as to ..........

{ Elizabeth Greener, R.N. (Seal)
{ Lillian Clayton, R.N. (Seal)
{ Jane A. Delano (Seal)
{ Georgia Nevins (Seal)
{ Clara D. Noyes (Seal)

BY-LAWS

ARTICLE I

Membership

Section 1. Membership in the National League of Nursing Education shall consist of three classes:

a. Active, including sustaining and junior active

b. Associate

c. Honorary

Sec. 2. An applicant for active membership shall qualify by:

a. Having graduated from a school of nursing accredited by the State Board of Nurse Examiners, the hospital with which the school is connected having a minimum daily average of 50 patients, the course in theory and practice covering a period of not less than two years;
b. Having become a registered nurse in one or more states;
c. Being a member of the American Nurses' Association;
d. Holding an advisory, executive, or teaching position in an educational, preventive, or government nursing organization;
e. Being recommended for active membership by the Committee on Eligibility.

Sec. 3. An applicant for junior active membership shall qualify by:
a. Having graduated from a school of nursing accredited by the State Board of Nurse Examiners, the hospital with which the school is connected having a minimum daily average of 30 patients, the course in theory and practice covering a period of not less than two years;
b. Having become a registered nurse in one or more states;
c. Being a member of the American Nurses' Association;
d. Holding the position of assistant supervisor, assistant instructor, head nurse, or assistant head nurse in an educational, preventive, or government nursing service;
e. Such membership shall be limited to a period of two years, after which one shall become a full active member.

Sec. 4. A sustaining member is an active member who has paid the dues required of such membership.

Sec. 5. An applicant for active or junior active membership in the National League of Nursing Education may be accepted in one of three ways:
a. As a member of a Local League of Nursing Education which gives automatic membership into State and National Leagues of Nursing Education;
b. As a member of a State League where there is no Local League and which gives automatic membership into the National League of Nursing Education;
c. As an individual member in states which have no State League of Nursing Education, or upon special action of the Board of Directors.

Sec. 6. An applicant for associate membership shall qualify by:
a. Having graduated from a school of nursing accredited by the State Board of Nurse Examiners, the hospital with which the school is connected having a minimum daily average of 30 patients, the course in theory and practice covering a period of not less than two years;
b. Having become a registered nurse in one or more states;
c. Being a member in good standing, resident, or nonresident, of her Alumnae Association;
d. Being enrolled as a student in university or college nursing courses, an executive or instructor in an accredited school of nursing, or in a hospital or school of nursing in a foreign country;
e. Being recommended for associate membership by the Committee on Eligibility or by special action by the Board of Directors.

Sec. 7. a. A State League of Nursing Education desiring to join the National League of Nursing Education shall make application on a blank form furnished by the Secretary or Executive Secretary. The form, after being properly filled in, meeting the requirements specified and to which is attached a card of approval of its Constitution and By-laws, signed by the Chairman of the Committee on Revision of the National League of Nursing Education, shall be sent with a copy of the Constitution and By-laws to the Executive Secretary.
b. Applicants for individual membership desiring to join the National League of Nursing Education shall make application on a blank form furnished by the Secretary or Executive Secretary. The form after being properly filled in shall be sent with the required dues to the Executive Secretary.

Sec. 8. An active or associate member in good standing in any State League who changes her residence to another state, may be admitted by transfer sent by the Secretary of the State League she is leaving to the Secretary of the State League to which she is going, entitling her to membership for the remainder of the fiscal year without
further payment of dues. At that time she may continue her membership only through the State League of the state in which she is a resident.

Sec. 9. An active or associate member having withdrawn from the National League of Nursing Education, or whose membership has lapsed on account of non-payment of dues, may be reinstated by paying the regular annual dues for the current year.

Sec. 10. Honorary membership may be conferred by a unanimous vote of the voting body at the annual convention on persons who have rendered distinguished service or valuable assistance to the nursing profession, the names having been recommended by the Board of Directors. Honorary membership shall not be conferred on more than two persons at any convention.

ARTICLE 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 shall be by ballot. A majority vote of active members present and voting shall constitute an election.

Sec. 3. The Secretary shall furnish to the chairman of the tellers a list of officers, Presidents of the State Leagues, and active members. The teller in charge of the register shall check the name of the member voting.

Sec. 4. The teller in charge of the ballot box shall place her initials upon the back of the ballot and voter shall then deposit the ballot.

Sec. 5. Polls shall be open for such a period of time as shall be specified by the Board of Directors.

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 any office, the Board of Directors shall fill the vacancy until her successor is elected.

ARTICLE IV

Duties of the Board of Directors and Officers

Section 1. The Board of Directors shall:

a. Hold a business meeting immediately preceding and immediately following each convention and shall meet at other times at the call of the President or at the request of five (5) or more members of the Board;

b. Transact the general business of the League in the interim between annual conventions;

c. Report to the League at each annual convention the business transacted by it during the preceding year;

d. Provide for the proper care of all books and papers of the League;
c. Select a place of deposit for funds and provide for their investment;
f. Provide for the auditing of accounts;
g. Provide for the maintenance of National Headquarters and for the making of this office the center of all activity of the League in connection with the American Nurses' Association and the National Organization for Public Health Nursing;
h. Appoint an Executive Secretary, define her duties and fix her compensation;
i. Appoint all committees not otherwise provided for;
j. Act upon applications for membership;
k. Determine the hours during which polls shall be open for election;
l. Supervise the affairs of the League, devise and mature measures for its growth and prosperity;

Sec. 2. The President shall preside at all meetings of the Board of Directors and Advisory Council and be a member, ex officio, of all committees.

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 meetings of the Board of Directors and of the Advisory Council;
   b. Preserve all papers, letters, and records of all transactions, and have custody of the corporate seal;
   c. Present to the Board of Directors all applications for membership together with the recommendations of the Committee on Eligibility;
   d. Report to the Board of Directors at each annual convention or upon request;
   e. Within one month after retiring, deliver to the new Secretary all books, papers, and reports of the League in her custody with a supplemental report covering all transactions from January 1 to the close of the annual convention;
   f. Send a notice of the annual convention to each member at least one month in advance;

Sec. 5. The Treasurer shall:
   a. Collect, receive, and have charge of all funds of the League, and shall deposit such funds in a bank designated by the Board of Directors;
   b. Pay only such bills as have been ordered by the President;
   c. Give a bond subject to the approval of the Board of Directors for the faithful performance of her duties;
   d. Report to the Board of Directors the financial standing of the League at each annual convention and upon request;
   e. Deliver, one month after retiring, to the new Treasurer all papers, books, records, money of the League in her custody, with a supplemental report covering all transactions from January 1 to the close of the annual convention;

Sec. 6. Necessary expenses incurred by officers or committees in the service of the League and such portion of the necessary traveling expenses of the Directors in attending meetings of the League shall be refunded from the general treasury by order of the Board of Directors, if previously approved by them.

Sec. 7. Nonattendance upon three consecutive meetings without sufficient reason will be considered a resignation. Notification for such nonattendance will be sent by the Secretary.

**ARTICLE V**

*Advisory Council*

Section 1. The officers of the National League and the Presidents of the State Leagues belonging to the National League shall constitute an Advisory Council.
Sec. 2. The duties of the Advisory Council shall be to keep the National League informed of the progress of nursing education in the states represented and to cooperate with the National League of Nursing Education.

Sec. 3. Meetings of the Advisory Council shall be held in connection with each annual convention, at such times as shall be designated in the program. The members shall be prepared to report on the work in their respective State Leagues.

Sec. 4. In the absence of the President a State League may be represented in the Advisory Council by an alternate appointed by the State League.

ARTICLE VI

Executive Secretary

Section 1. The duties of the Executive Secretary shall be outlined by the Board of Directors.

Sec. 2. She shall be responsible for the disbursements of all headquarters funds as assigned by the Board of Directors, and in this capacity shall be bonded.

Sec. 3. She shall attend the meetings of the Board of Directors and shall be a member ex officio of all committees.

ARTICLE VII

Standing Committees

Section 1. Standing Committees shall consist of at least three members, who shall be appointed by the Board of Directors, and shall be as follows:

a. Convention Arrangements
b. Curriculum
c. Eligibility
d. Finance
e. Nominations
f. Program
g. Publications
h. Headquarters
i. Revision

Sec. 2. The Committee on Convention Arrangements. This committee shall be responsible for the plans to be followed in carrying on the annual convention, by making arrangements for suitable places for general and committee meetings, hotel accommodations, exhibits, and general information.

Sec. 3. The Committee on Curriculum. The work of this committee shall include the study and presentation of the curriculum for schools of nursing and any other activity approved by the Board of Directors.

Sec. 4. The Committee on Eligibility. This committee shall check the qualifications of the applicants applying for individual membership according to the requirements of the By-laws, and if sufficient data are not furnished on the application form, shall secure such data by correspondence.

Sec. 5. The Committee on Finance. This committee shall carefully budget the finances of the League, advise concerning investments and approve other than routine expenditures.

Sec. 6. The Committee on Nominations. This committee shall consist of five members, two of whom shall be appointed by the chair and three by the house. On or before each September 1 preceding the annual convention, this committee shall issue to each State League a form on which the State League shall submit the name of one nominee for each office to be filled. These forms shall be signed by the President or Secretary of the State League and returned to the Committee on Nomi-
nations of the National League of Nursing Education before December 1 preceding the annual convention.

From the forms returned by the State Leagues, the Committee on Nominations shall prepare a ticket consisting of two names of the nominees receiving the highest number of votes for each office, and eight names for the office of Directors. If the list of names submitted is not sufficient to form a ticket, the Committee on Nominations shall have power to add names so that a full ticket may be made up. No name shall be presented to the Board of Directors or to the convention, either by the Committee on Nominations or from the floor, unless the nominee has consented and is free to serve if elected. This report shall be in the hands of the Secretary by January 1.

The list of nominations shall be published in the March issue of *The American Journal of Nursing*, shall be mailed to each State League at least two months previous to the annual convention, and shall be posted on the daily bulletin board on the first day of the annual convention.

Sec. 7. Committee on Program. The chairman of this committee shall request from the members of the Program Committee, the officers of the National League of Nursing Education, the State Leagues, and chairmen of all committees, suggestions for the program. This committee shall submit draft of this program to the President by December 1 of each year, who shall present it to the Board of Directors at the January meeting.

The committee shall be responsible for all correspondence unless otherwise instructed.

Sec. 8. The Committee on Publications. The committee shall keep informed concerning the contents of professional nursing magazines and pamphlets and other journals publishing material of interest to nursing and nursing education, recommend and decide upon reprints of articles contained in such periodicals, cooperate with the Committee on Curriculum in matters pertaining to its publications and prepare such other publicity material as may be indicated and approved by the Board of Directors and as allowed by the budget.

Sec. 9. The Committee on Headquarters. This committee shall have the power to act between Board meetings upon all matters which are referred by the President or Executive Secretary which do not require the formation of new policies, and to pass upon applications for membership which come from states where there are no State Leagues.

Sec. 10. The Committee on Revision. This committee shall investigate the eligibility of all State Leagues applying for membership in this organization. It shall devise ways and means for cooperation with states and territories for securing members and report its findings to the Board of Directors, whose decision as to the eligibility shall be final. It shall receive all proposed amendments to the By-laws of this association, and submit them for action at the annual convention. This committee shall also advise State Leagues concerning proposed amendments to their Constitution and By-laws for the purpose of keeping them in harmony with the Articles of Incorporation and By-laws of this organization.

Sec. 11. Each committee shall present a written report of its activities at the annual convention and at the January meeting, and keep the Executive Secretary informed of its work, as may be indicated, during the year.

**Article VIII**

**Dues**

Section 1. The annual dues for all active members of the National League of Nursing Education shall be $3.00.

a. In states where there is a State League, dues ($3.00) for all active members shall be paid through the State League on the basis of membership March 1 of each
year, except the first year of membership, when dues shall be paid at the time of application.

b. In states where there is no State League, dues ($3.00) shall be paid directly to the National League of Nursing Education. Dues shall accompany application.

Sec. 2. The annual dues for junior active and associate members shall be $2.00.

a. In states where there is a State League, dues ($2.00) shall be paid through the State League on the basis of membership March 1 of each year, except the first year of membership, when dues shall be paid at the time of application.

b. In states where there is no State League, dues ($2.00) shall be paid directly to the National League of Nursing Education. Dues shall accompany application.

Sec. 3. The annual dues for sustaining members shall be $8.00, which shall entitle the members to receive all pamphlets and reprints published by the League during the year.

a. In states where there is a State League, dues ($8.00) for all sustaining members shall be paid through the State League on the basis of membership March 1 of each year, except in the first year of membership, when dues shall be paid at the time of application.

b. In states where there is no State League, dues ($8.00) shall be paid directly to the National League of Nursing Education. Dues shall accompany application.

Sec. 4. Any State League or individual member failing to pay the annual dues by the first day of April shall receive a notice from the Treasurer, and if the dues are not paid within two months they shall have forfeited all privileges of membership. **Active individual members having forfeited their membership may be reinstated upon the payment of dues for the fiscal year.**

Associate members having forfeited their membership may be reinstated upon the payment of dues for the fiscal year.

**ARTICLE IX**

**Meetings**

Section 1. A convention of the National League of Nursing Education shall be held annually. In the even-numbered years it shall be held conjointly with the convention of the American Nurses’ Association, in the odd-numbered years it shall be held at such time and place as shall be determined by the Board of Directors and recommended to the League for its action at the convention next preceding.

Sec. 2. The order of business at each convention shall be in accordance with the program adopted at the beginning of the convention and shall include:

a. Annual reports of all officers
b. Annual reports of all Presidents of all State Leagues of Nursing Education
c. Annual reports of all Standing Committees
d. Report of Instructors’ Section
e. Address of President
f. Miscellaneous business
g. Election of officers
h. Reading of the minutes

Sec. 3. The Board of Directors shall hold a meeting each January and at the call of the President.

**ARTICLE X**

**Representation**

Section 1. The voting body at the Annual Convention of the National League of Nursing Education shall consist of active, junior active, and sustaining members of State Leagues in good standing, and individual active, junior active, and sustaining members in good standing.

Sec. 2. The associate members shall have no vote at State or National meetings.
BY-LAWS

ARTICLE XI

Quorum

Section 1. A quorum of the Board of Directors shall be seven (7) members.
Sec. 2. A quorum of the Advisory Council shall be ten (10) members other than the officers.
Sec. 3. Members from fifteen (15) states shall constitute a quorum for the transaction of business at any annual convention.

ARTICLE XII

Fiscal Year

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

ARTICLE XIII

Application of the Term "State League"

The term "State League" in these By-laws 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 XIV, By-laws, American Nurses' Association.)

ARTICLE XIV

Duties of State Leagues

It shall be the duty of each State League:

a. To know that all requirements for membership in the State and Local Leagues meet the requirements for membership in the National League of Nursing Education;

b. To know that the dues are paid by the first day of April of each year on the basis of membership the first day of March of each year;

c. To send to the President, Secretary, and Executive Secretary of the National League of Nursing Education and to the American Journal of Nursing, the names and addresses of all officers, immediately after their election or appointment, together with the date and place of their next annual meeting;

d. To report the activities of the State and Local Leagues at the annual convention, and at such other times as may be required;

e. To confer with the Committee on Revision of the National League of Nursing Education, regarding changes in their State Constitution and By-laws; all such changes to be made shall have attached to them a card of approval, signed by the Chairman of the Committee on Revision of the National League of Nursing Education, before being presented to the State League for action; upon the adoption of any changes by a State League, three copies of the changes adopted, accompanied by the card of approval, shall be sent to the Executive Secretary, one copy shall be retained at National Headquarters, one copy sent to the Secretary, and one to the Chairman of the Committee on Revision;

f. To help organize Local Leagues when desired;

g. To provide official representation as a member of the Advisory Council at each annual convention.

ARTICLE XV

Parliamentary Authority

Deliberations of all meetings of the National League shall be governed by Parliamentary Usage for Women's Clubs, by Mrs. Emma A. Fox.
ARTICLE XVI

The Official Organ

The American Journal of Nursing shall be the official organ of the National League of Nursing Education.

ARTICLE XVII

Amendments

Section 1. These By-laws may be amended at any annual convention by a two-thirds vote of the active members present and voting. All proposed amendments shall be in the possession of the Secretary at least two months before the date of the annual convention and be appended to the call of the meeting.

Sec. 2. These By-laws may be amended at any annual convention, by the unanimous vote of the active members present and voting, without previous notice.
LIST OF MEMBERS

HONORARY MEMBERS

BEARD, RICHARD, O., M.D. .......... University of Minnesota, Minneapolis, Minn.
BOARDMAN, MABEL T. ............... The American Red Cross, Washington, D. C.
BOLTON, MRS. CHESTER C. .......... Franchester Farm, Lyndhurst, Ohio
FENWICK, MRS. BEDFORD ............ 39 Portland Place, London W. 1, England
JONES, MRS. M. CADDWALADER ...... 21 East 11 Street, New York, N. Y.
LOCKWOOD, MRS. CHARLES .......... 295 Markham Place, Pasadena, Calif.
OSBORNE, MRS. W.M. CHURCH ....... 40 East 36 Street, New York, N. Y.
WINSLOW, C.-E. A., DR.P.H. ..... School of Public Health, Yale University, New
Haven, Conn.

RIDDLE, MARY M. .................. 17 North Washington Street, Muncy, Pa.
DeWITT, KATHARINE ................. 18 Worrall Avenue, Poughkeepsie, N. Y.
NUTTING, M. ADELAIDE ............. 500 West 121 Street, New York, N. Y.
Powell, M. LOUISE ................. 357 East Beverley Street, Staunton, Va.

LIFE MEMBERS

Dock, L. L. ....................... Fayetteville, Pa.

ACTIVE MEMBERS 1

SYMBOLS USED

(*) Indicates junior active member
(**) Indicates sustaining member
(†) Preceding state names indicates that state leagues have been organized

ALABAMA—16 Members

BAILEY, LAURA O. .................. St. Margaret's Hospital, Montgomery
Denny, Linna H. ................... 1320 N. 25 St., Birmingham
Golightly, Berta E.** .......... Garner Hospital, Anniston
Hood, Eloise ....................... St. Margaret's Hospital, Montgomery
McDonnell, Elizabeth T. .......... 2101 Highland Ave., Birmingham
Parker, Magiwa ................... St. Margaret's Hospital, Montgomery
Sister Alphonsa Auboin ........... St. Vincent's Hospital, Birmingham
Sister Helen Neuhoff ............ Spring Hill Ave., Mobile
Sister Laura Nicaise ............. 850 St. Anthony, Mobile
Sister Valeria** ................. St. Margaret's Hospital, Montgomery
Stuart, Lucile .................... 812 Forest Ave., Montgomery
Thrasher, Jewell W. .............. Frasier-Ellis Hospital, Dothan
Travis, Sue T.** ................. St. Vincent's Hospital, Birmingham
Vinson, Mary E. ................. St. Margaret's Hospital, Montgomery
Walter, Agnes M. ............... Employee's Hospital, Fairfield
Wortman, Jessie C.** .......... Baptist Hospital, Birmingham

1 This list includes only those members whose 1935 dues reached the National office by the time this Report went to press.
2 By-laws, Article I, Section 4. A sustaining member is an active member who has paid the dues required of such membership.
3 Article VIII, Section 3. The annual dues for sustaining members shall be $8.00, which shall entitle the members to receive all pamphlets and reprints published by the League during the year.
ARIZONA—10 Members

BALLMAN, CHRISTINE ........................................ St. Joseph's Hospital, Phoenix
BENSON, MINNIE C. .......................................... Room 210, S. Arizona Bank Building, Tucson
BRADDOCK, ESTHER ......................................... 121a E. Goodwin St., Prescott
HICKS, FLORENCE L. ......................................... 1637 N. 10 St., Phoenix
HOWARD, VIOLA ............................................. St. Joseph's Hospital, Phoenix
MCDONALD, EDNA M. ........................................... Good Samaritan Hospital, Phoenix
MINSON, MARGARET .......................................... 131 S. 2 St., Globe
POTTHOFF, LYDIA ............................................. Public Schools, Nogales
SWEENEY, FRANCES .......................................... St. Mary's Hospital, Tucson
WATTS, WILHEMINA H. ....................................... 1100 Monroe St., Globe

‡ ARKANSAS—8 Members

BUFFALO, RACHEL E.* ........................................ St. Joseph's Hospital, Hot Springs
MACNALLY, MARY A. ......................................... Ozark Sanatorium, Hot Springs
ROSE, DAISY** ................................................ Baptist Hospital, Little Rock
SISTER MARY ANGELA F.* ................................... St. Vincent's Infirmary, Little Rock
SISTER MARY FRANCIS ....................................... 503 Walnut St., Texarkana
SISTER M. HILDA ............................................. St. Bernard's Hospital, Jonesboro
SISTER M. PIA .................................................. St. Bernard's Hospital, Jonesboro
TETER, MARTHA A. B. ......................................... Trinity Hospital, Little Rock

‡ CALIFORNIA—223 Members

ALEXANDER, MABEL C. ......................................... Veterans' Administration Facility, Fort Miley, San Francisco
ALFORD, MARIAN ........................................... 479 37 St., Oakland
ALLEN, JOSEPHINE ......................................... St. Luke's Hospital, San Francisco
APPLEGREN, EMMA ......................................... Sutter Hospital, Sacramento
ASH, AGNES LARSON* ....................................... 350 Judah St., San Francisco
BAGLEY, ALICE ............................................... 600 Stockton St., San Francisco
BAKER, LOUISE .............................................. Stanford Hospital, San Francisco
BARATINI, AZALEA L. ......................................... 121 Hugo St., San Francisco
BARNES, SARAH B. .......................................... County Hospital, San Diego
BAXTER, MARGUERITE H. .................................. 2821 N. Griffin Ave., Los Angeles
BEATTY, EVANGELINE F. ................................... 3855 California St., San Francisco
BEHRENS, EDNA H. .......................................... Franklin Hospital, San Francisco
BELLI, ROSE M. ............................................... St. Luke's Hospital, San Francisco
BERTOLUCCI, EMMA M.* ..................................... Univ. of California Hospital, San Francisco
BIGHAM, JEAN L. ........................................... 1616 Huntington Dr., S. Pasadena
BLOOM, SARAH H. ........................................... 2282 Union St., Berkeley
BLUM, MILDRED E. ........................................... 2231 West 20 St., Los Angeles
BOEHME, STEPHANIA ......................................... 2200 Post St., San Francisco
BOND, SARA .................................................. French Hospital, San Francisco
BORG, MARTHA E. ........................................... White Memorial Hospital, Los Angeles
BOURNE, MARGARET G. ..................................... County Hospital, San Bernardino
BOWERS, MARIAN H. ......................................... Box 17, Loma Linda
BOYE, ADA M. ................................................ Children's Hospital, San Francisco
BROOKS, ESTHER ............................................ 1350 N. Yosemite St., Stockton
BROWN, ELIZABETH H. ...................................... Los Angeles General Hospital, Los Angeles
BROWN, MARY E. ............................................. 2413 Washington St., San Francisco
BRUCE, MARY D. ............................................. Children's Hospital, Los Angeles
BRYAN, EDITH S. ............................................ Univ. of California, Berkeley
<table>
<thead>
<tr>
<th>Name</th>
<th>Institution/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnett, Dorothy L</td>
<td>White Memorial Hospital, Los Angeles</td>
</tr>
<tr>
<td>Busche, Margaret J</td>
<td>2340 Clay St., San Francisco</td>
</tr>
<tr>
<td>Cameron, Claudia M</td>
<td>1212 Shatto St., Los Angeles</td>
</tr>
<tr>
<td>Campbell, Elizabeth F</td>
<td>Hospital of the Good Samaritan, Los Angeles</td>
</tr>
<tr>
<td>Castile, Pearl I</td>
<td>Univ. of California Hospital, San Francisco</td>
</tr>
<tr>
<td>Clarke, Eleanor S</td>
<td>2545 Sutter St., San Francisco</td>
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<td>Cobban, Franke F</td>
<td>St. Helena Sanitarium, St. Helena</td>
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<td>University Hospital, San Francisco</td>
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<tr>
<td>Conrad, Anna B</td>
<td>Seaside Hospital, Long Beach</td>
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<tr>
<td>Conzelmann, Ella B</td>
<td>Box 351, Stockton</td>
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<td>St. Helena Sanitarium, St. Helena</td>
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<td>Davis, Lina</td>
<td>San Bernardino General Hospital, San Bernardino</td>
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<tr>
<td>Davis, Mary E</td>
<td>306 State Building, San Francisco</td>
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<tr>
<td>Deutsch, Naomi</td>
<td>Dept. of Hygiene, Univ. of Calif., Berkeley</td>
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<td>Dobey, Elizabeth N</td>
<td>San Bernardino County Hospital, San Bernardino</td>
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<td>Doorley, Anne</td>
<td>150 Franklin St., San Francisco</td>
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<td>Downes, Opal C</td>
<td>5500 Louis Pl., Los Angeles</td>
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<td>DuBois, Emily</td>
<td>5032 You St., Sacramento</td>
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<td>Dunivian, Lulubel</td>
<td>206 Judah St., San Francisco</td>
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<td>Easley, Mary L</td>
<td>1200 State St., Los Angeles</td>
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<td>Estes, Lois B</td>
<td>Cottage Hospital, Santa Barbara</td>
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<tr>
<td>Farner, Caroline B</td>
<td>740 Parnassus, San Francisco</td>
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<tr>
<td>Ferguson, Carrie</td>
<td>Highland Hospital, Oakland</td>
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<td>Fisher, Louise*</td>
<td>1739 Oxford St., Berkeley</td>
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<td>Folendorf, Gertrude R</td>
<td>Shriners' Hospital, San Francisco</td>
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<td>Gillen, Rose M</td>
<td>214 Haight St., San Francisco</td>
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<td>Gillespie, Delia E</td>
<td>1804 N. San Joaquin, Stockton</td>
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<td>Goss, Ethel E</td>
<td>Children's Hospital, San Francisco</td>
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<td>Grant, Alice</td>
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<td>2812 Benvenue, Berkeley</td>
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<td>Civic Auditorium, San Francisco</td>
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<td>Hammond, Ethel</td>
<td>1368 Arguello Blvd., San Francisco</td>
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<tr>
<td>Hansen, Helen F**</td>
<td>Box 1157, Sacramento</td>
</tr>
<tr>
<td>Harris, Matilda</td>
<td>22247 Foothill Blvd., Hayward</td>
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<tr>
<td>Hartley, Helen S</td>
<td>130 S. America St., Stockton</td>
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<td>1013 S. Stanley Ave., Los Angeles</td>
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<td>Hertel, Hildegarde M</td>
<td>390 Central Ave., Oakland</td>
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<tr>
<td>Hicks, Maud A</td>
<td>390 Central Ave., Oakland</td>
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<tr>
<td>Hoeck, Elsie D</td>
<td>Highland Hospital, Oakland</td>
</tr>
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HUGHES, ANNA A. .......... Mater Misericordiae Hospital, Sacramento
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INGMIRE, ALICE E. .......... Santa Clara County Hospital, San Jose
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JAMME, ANNA C. .......... 609 Sutter St., San Francisco
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KELSEY, ETHEL M. .......... Univ. of California Hospital, San Francisco
KENNEDY, GRACE M. .......... St. Luke's Hospital, San Francisco
KESLING, NORA .......... 2826 S. Hope St., Los Angeles
KISZ, MARY V. .......... 312 N. Boyle Ave., Los Angeles
KRUMMERT, ILA J. .......... Queen of Angels Hospital, Los Angeles
Lafferty, Eleanor .......... Box 104, San Carlos
LAIRD, MAY .......... 2361 California St., San Francisco
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LINQUEST, ELIZABETH .......... 530 Webster St., Palo Alto
LOUR, MABEL I. .......... San Diego County Hospital, San Diego
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LYMAN, GRACE .......... Univ. of California Hospital, San Francisco
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MACLEAN, MARGUERITE L. .......... Highland Hospital, Oakland
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MAHAN, CARRIE V. .......... 642-A 6 Ave., San Francisco
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MARTIN, ANNA W. .......... Sacramento Hospital, Sacramento
MARTIN, ELIZABETH M. .......... Merritt Hospital, Oakland
MASON, RUBY B. .......... Mt. Zion Hospital, San Francisco
MASON, RUTH E. .......... 700 Parnassus Ave., San Francisco
McCLANAHAN, MARGARET H. .......... 2045 California St., San Francisco
McGREGOR, JEAN C.* .......... 301 Carl St., San Francisco
McKENZIE, ELIZABETH .......... Santa Clara County Hospital, San Jose
McLAREN, BEATRICE .......... Santa Clara County Hospital, San Jose
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MULVANE, GABRIELLE T. .......... County Hospital, San Bernardino
MULVANE, MARY G. .......... 2077 Belle St., San Bernardino
NASTOLD, MARY .............................................. 5635 Ash St., Los Angeles
NEWTON, MILDRED .......................... 700 Parnassus Ave., San Francisco
NICHOLSON, JANE D. ........... Stanford University Hospital, San Francisco
NORMAN, HELEN .......................... 169 Parnassus Ave., San Francisco
NORWAY, MARGUERITE .............. 1212 Shatto St., Los Angeles
O’LOUGHLIN, ANNE A. .......... San Francisco Hospital, San Francisco
Olsen, ADA M. .................. Stanford University Hospital, San Francisco
OLSON, ESTHER S. ................ Seaside Hospital, Long Beach
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PALMER, MABLE R. ................ 1290 Gilman Ave., San Francisco
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POORE, JEWELL M. ............... 773 Geary St., San Francisco
POPE, AMY ..................... Box 1013, San Francisco
PORTER, NELLIE M. .............. 245 S. Lucas St., Los Angeles
POUPORE, ELIZABETH S. ........ 1212 Shatto St., Los Angeles
PURCELL, ANNA L. .............. San Bernardino County Hospital, San Bernardino
REID, ANNIE F. ................ 1212 Shatto St., Los Angeles
REID, OLIVE M. .................. 2340 Clay St., San Francisco
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SHANHOLTZER, GLADYS W. ...... 447 8 Ave., San Francisco
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SMALLEY, SALLY E. ............ 3075 Fifth Ave., Sacramento
SMITH, EDITH ............. Stanford Hospital, San Francisco
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STARCHER, MARGARET A. ........... 2200 Post St., San Francisco
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SWALESTUN, RUTH A. ............... 234 E. Ave. 33, Los Angeles
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TILLEY, GLADYS MCI. .............. 235 Teresita Blvd., San Francisco
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TRACY, MARGARET ................. Univ. of California Hospital, San Francisco
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VANN, LOUISA ..................... Gilbert St., San Bernardino
VIRTUE, RENA D. .................. San Joaquin General Hospital, French Camp
WALDER, ETHEL J. ................. Box 205, Loma Linda
WARNER, GERTRUDE E. .......... 1239 S. Main St., Santa Ana
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WELLMAN, ERNA D. ............... 2340 Clay St., San Francisco
WESCOTT, RUTH A. ............... 1212 Shatto St., Los Angeles
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WILSON, JUNE ALFRETTA ...... 2200 Post St., San Francisco
WOOD, MURIEL .................. St. Francis Hospital, San Francisco
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HADALA, HELEN J.* ........................ 418 Elm St., Stamford
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HALVORSEN, EDNA M. T. ............... William W. Backus Hospital, Norwich
HARRELL, VIRGINIA ...................... Greenwich Hospital, Greenwich
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HOHENSEE, KATHERINE* ................ 92 Grand St., New Britain
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JOHNSON, RUTH C.* ...................... 350 Congress Ave., New Haven
JOHNSON, VIOLA S. ...................... Waterbury Hospital, Waterbury
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KELLEHER, MARY E.* .................... Bridgeport Hospital, Bridgeport
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M'CINTYRE, M. ELLEN ................... 181 Cook Ave., Meriden
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MEIER, Ida M. ........................... Waterbury Hospital, Waterbury
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NEAL, LORA G.* ......................... 350 Congress Ave., New Haven
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NELSON, MARJORIE T.* ............... 260 Broad St., Windsor
NEWTON, DELIA H. ...................... Middlesex Hospital, Middletown
OHOLSON, AGNES K. .................... Waterbury Hospital, Waterbury
PARDEE, JOSEPHINE G.* ............... 3200 Main St., Stratford
PARK, KATHRYN T.* ..................... 350 Congress Ave., New Haven
PARSONS, LOUISE ....................... Meriden Hospital, Meriden
PATTERSON, PEARL M. .................. Griffin Hospital, Derby
PATTON, AUGUSTA ....................... Yale University School of Nursing, New Haven
PECK, DOROTHY E.* .................... 350 Congress Ave., New Haven
PITT, R. DOROTHY* ..................... Bridgeport Hospital, Bridgeport
POSCAVAGE, FRANCES L.* .......... 281 N. Main St., Ansonia
POWERS, ELLEN D. ...................... William W. Backus Hospital, Norwich
PRENDERGAST, MARY J. ............... 4 Holcomb St., Hartford
PRINSDIVILLE, KATHRYN M. .......... Lawrence and Memorial Hospitals, New London
PRITCHARD, MARGARET I. .......... Bridgeport Hospital, Bridgeport
RADE, DOROTHY A.* ................... 144 Taft St., Stratford
REEVE, IRMA E.* ....................... 23 Barnett St., New Haven
REID, MARGARET ....................... 19 Willard St., Hartford
RICHARDSON, MILDRED A. .......... Bridgeport Hospital, Bridgeport
RUDINE, HELEN V.* .................... 486 Washington Ave., Bridgeport
RYAN, JANET OVEDIA ............... 28 Crescent St., Middletown
SCHMITT, MARY M.* .................... 188 Winthrop St., New Britain
<table>
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<tr>
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<tr>
<td>SCHUSTER, DOROTHEA E.</td>
<td>Waterbury Hospital, Waterbury</td>
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<td>SCOTT, DOROTHY B.</td>
<td>326 Washington St., Norwich</td>
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<tr>
<td>SEAMAN, ELIZABETH A.*</td>
<td>1114 Hancock Ave., Bridgeport</td>
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<tr>
<td>SENNA, HELEN N.</td>
<td>Stamford Hospital, Stamford</td>
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<td>SHANAHAN, ELEANOR*</td>
<td>Waterbury Hospital, Waterbury</td>
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<tr>
<td>SHARVAN, WINIFRED C.*</td>
<td>108 Lafayette St., Norwich</td>
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<td>SISTER MARGARET WALSH</td>
<td>St. Vincent’s Hospital, Bridgeport</td>
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<td>SISTER MARY LOUISE NAGEL</td>
<td>St. Vincent’s Hospital, Bridgeport</td>
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<td>SISTER MARY MAURICE DOYLE</td>
<td>St. Francis School of Nursing, Hartford</td>
</tr>
<tr>
<td>SISTER MARY MECHTILDE CARY</td>
<td>370 Collins St., Hartford</td>
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<td>SMITH, FLORENCE G.</td>
<td>28 Crescent St., Middletown</td>
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<td>STACK, MARGARET K.</td>
<td>175 Broad St., Hartford</td>
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<td>STREMPFEL, ELINOR F.*</td>
<td>267 Grant St., Bridgeport</td>
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<tr>
<td>SULLIVAN, MARY E.</td>
<td>2 Holcomb St., Hartford</td>
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<td>TAYLOR, EFFIE J.*</td>
<td>Yale University School of Nursing, New Haven</td>
</tr>
<tr>
<td>TRAVER, MAUD*</td>
<td>New Britain General Hospital, New Britain</td>
</tr>
<tr>
<td>VOIGTLANDER, LOUISE M.</td>
<td>Grace Hospital, New Haven</td>
</tr>
<tr>
<td>WEBER, DORIS</td>
<td>76 Grove St., New Haven</td>
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<tr>
<td>WERME, ELLEN J.*</td>
<td>Grace Hospital, New Haven</td>
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<tr>
<td>WEST, FRANCES F.</td>
<td>Middlesex Hospital, Middletown</td>
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<tr>
<td>WHITE, LILLIAN B.*</td>
<td>Stamford Hospital, Stamford</td>
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<tr>
<td>WHITMORE, MARION P.</td>
<td>Bristol Hospital, Bristol</td>
</tr>
<tr>
<td>WILCOX, ONA M.</td>
<td>28 Crescent St., Middletown</td>
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<tr>
<td>WILD, ANNA</td>
<td>Stamford Hospital, Stamford</td>
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<tr>
<td>WILSON, IRENE</td>
<td>Lawrence and Memorial Hospitals, New London</td>
</tr>
<tr>
<td>WOLCOTT, MARION A.*</td>
<td>350 Congress Ave., New Haven</td>
</tr>
</tbody>
</table>

**DELAWARE—23 Members**

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
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<tr>
<td>ABBOTT, MILDRED E.</td>
<td>The Delaware Hospital, Wilmington</td>
</tr>
<tr>
<td>BRESEE, RAMONA B.</td>
<td>Milford Hospital, Milford</td>
</tr>
<tr>
<td>BROWN, WINONA T.</td>
<td>121 W. Front St., Milford</td>
</tr>
<tr>
<td>CASTLE, ANNA V.</td>
<td>802 Adams St., Wilmington</td>
</tr>
<tr>
<td>CHAMBERS, ELLEN</td>
<td>121 W. Front St., Milford</td>
</tr>
<tr>
<td>DAVIS, WINIFRED B.</td>
<td>The Delaware Hospital, Wilmington</td>
</tr>
<tr>
<td>DUGAN, LUCILE E.</td>
<td>148 Washington St., Wilmington</td>
</tr>
<tr>
<td>EPPERSON, ESTHER MCC.</td>
<td>1303 Jackson St., Wilmington</td>
</tr>
<tr>
<td>FERRY, MARY M.</td>
<td>Wilmington General Hospital, Wilmington</td>
</tr>
<tr>
<td>FREED, MARY E.</td>
<td>Homeopathic Hospital, Wilmington</td>
</tr>
<tr>
<td>HALLOWAY, EDNA M.</td>
<td>The Delaware Hospital, Wilmington</td>
</tr>
<tr>
<td>KWICK, SWEA C.</td>
<td>1501 Van Buren St., Wilmington</td>
</tr>
<tr>
<td>LEWIS, MABEL</td>
<td>The Delaware Hospital, Wilmington</td>
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<tr>
<td>MACLUCAS, CATHERINE K.</td>
<td>The Delaware Hospital, Wilmington</td>
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<tr>
<td>MADDEN, ELLA V.</td>
<td>1501 Van Buren St., Wilmington</td>
</tr>
<tr>
<td>MANN, GEORGIA M.</td>
<td>Wilmington General Hospital, Wilmington</td>
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<tr>
<td>MILLER, GWEN M.</td>
<td>1501 Van Buren St., Wilmington</td>
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<td>MORAN, MARY A.</td>
<td>1313 Clayton St., Wilmington</td>
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<tr>
<td>Muench, Genevieve J.</td>
<td>148 Washington St., Wilmington</td>
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<tr>
<td>SISTER M. ELAINE</td>
<td>St. Francis’ Hospital, Wilmington</td>
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<tr>
<td>SPEEdLING, NELLIE F.</td>
<td>Wilmington General Hospital, Wilmington</td>
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<tr>
<td>STEVENSON, ALICE L.</td>
<td>107 W. Front St., Milford</td>
</tr>
<tr>
<td>WORTHINGTON, MABEL M.</td>
<td>Emergency Hospital, Milford</td>
</tr>
</tbody>
</table>
MEMBERS

**DISTRICT OF COLUMBIA—88 Members**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City, State</th>
</tr>
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<tbody>
<tr>
<td>Aldridge, Edith B.</td>
<td>819 Allison St., N. W., Washington</td>
<td>Washington</td>
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<tr>
<td>Anderson, Sena</td>
<td>1746 K. St., N. W., Washington</td>
<td>Washington</td>
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<tr>
<td>Baker, Ida Ann</td>
<td>Emergency Hospital, Washington</td>
<td>Washington</td>
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<tr>
<td>Baston, Josie G.</td>
<td>Gallinger Municipal Hospital, Washington</td>
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<td>Berdan, Elsie T.</td>
<td>Providence Hospital, Washington</td>
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<td>Blackman, Josephine W.</td>
<td>Sibley Memorial Hospital, Washington</td>
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<td>Bowling, Gertrude H.</td>
<td>810 Keith-Albee Building, Washington</td>
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<td>Brown, Rosalie A.</td>
<td>Emergency Hospital, Washington</td>
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<td>Burns, Helen J.</td>
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<td>Cadel, Inez L.</td>
<td>810 Keith-Albee Building, Washington</td>
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<td>Cannon, Thelma D.</td>
<td>Gallinger Municipal Hospital, Washington</td>
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<td>Homeopathic Hospital, Washington</td>
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<td>Connor, Mary C.</td>
<td>810 Keith-Albee Building, Washington</td>
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<td>Cowan, Amy R.</td>
<td>Commodore Apts. 604, New Hampshire Ave.</td>
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<td>Dalton, Bernice I.</td>
<td>T St., N. W., Washington</td>
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<td>Dom, Helen L.</td>
<td>Garfield Hospital, Washington</td>
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<td>Donovan, Irene M.</td>
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<td>Earle, Elizabeth C.</td>
<td>St. Elizabeths Hospital, Washington</td>
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<td>Fish, Janet</td>
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<td>Fleming, Ella D.</td>
<td>2300 19 St., N. W., Washington</td>
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<td>Gaffney, Clare</td>
<td>3146 Que St., N. W., Washington</td>
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<td>Gardiner, Lillian A.</td>
<td>1218 Perry St., N. W., Washington</td>
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<td>Children's Hospital, Washington</td>
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<td>Gregg, Eldon D.</td>
<td>5245 O St., N. W., Washington</td>
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<td>Griffith, Pearl A.</td>
<td>1523 Wisconsin Ave., N. W., Washington</td>
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<td>Hasselbusch, Charlotte</td>
<td>Garfield Memorial Hospital, Washington</td>
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<td>Havey, I. Malinde</td>
<td>637 Ingram St., N. W., Washington</td>
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<td>Hawthorne, Mary L.</td>
<td>American Red Cross, Washington</td>
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<td>Haydon, Edith M.</td>
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<td>The Montana, 1726 M. St., N. W., Washington</td>
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<td>Martin, Dorothy</td>
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<td>Martin, Yvonne E.</td>
<td>2926 P St., N. W., Washington</td>
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<td>McCabe, Ann H.</td>
<td>2700 Que St., N. W., Washington</td>
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<td>McWhorter, Alice E.</td>
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<td>Milliken, Sayres L.</td>
<td>Room 1809, Munitions Building, Washington</td>
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<td>Moran, Catherine E.</td>
<td>Gallinger Municipal Hospital, Washington</td>
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<td>Morrison, Pearl L.</td>
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<td>Murphy, Vivian</td>
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<td>Myers, Eunice M.</td>
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<td>Nester, Garnett A.</td>
<td>Emergency Hospital, Washington</td>
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</table>
NOYES, CLARA D. .................. American Red Cross, Washington
PATTON, SHELBY W. ................. Garfield Memorial Hospital, Washington
PINNER, MILDRED M. ............... 2222 Randolph Pl., N. E., Washington
PRENTISS, KATHARINE .............. Emergency Hospital, Washington
PRICE, MARGARET L. ............... 427 11 St., N. E., Washington
READ, KATHARINE S. .............. Treasury Dept., Bureau of Public Health Service, Washington
ROSENAU, FLORA E. ................. 1150 N. Capitol St., Washington
ROUSE, HELEN E. .................... Providence Hospital, Washington
ROYER, HAZEL ...................... Children's Hospital, Washington
SANDMAIER, BARBARA .............. Georgetown University Hospital, Washington
SCAGGS, LUCY DUL. ................. 1336 Locust Rd., N. W., Washington
SEERING, BERTHA MCA. ........... Apt. 60, 1746 K. St., N. W., Washington
SENECAL, ELIZABETH M. .......... 4012 12 St., N. E., Washington
SISTER GUY** ...................... Trinity Hall, 2929 Lincoln Rd., Washington
SISTER M. CELINE ................... Georgetown University Hospital, Washington
SISTER MARY CLARE BERG .......... Providence Hospital, Washington
SISTER M. ERHARDA ................. Georgetown University Hospital, Washington
SISTER MARY EUPHRASIA .......... Georgetown University Hospital, Washington
SISTER M. OLIVIA ................... 4801 Sargent Rd., Brookland, Washington
SISTER MAURICE SHEEHY .......... 332 Varnum St., N. E., Washington
SISTER RITA VOS ................... Providence Hospital, Washington
SISTER RODRIGUEZ ................. Georgetown University Hospital, Washington
SISTER SERENA MURPHY .......... Providence Hospital, Washington
SOLOMON, HELEN ................... Georgetown University Hospital, Washington
SPALDING, EUGENIA K. ............ 1218 Perry St., N. E., Washington
STILWELL, FLORENCE B. .......... Sibley Memorial Hospital, Washington
STIMSON, JULIA C.** .............. Army Nurse Corps, Munitions Building, Washington
STOCK, PAULINE B. ................. 810 Keith-Albee Building, Washington
STONE, ALICE C. ................... St. Elizabeths Hospital, Washington
STOUFFER, ORA L. ................. 2717 13 St., N. W., Washington
TAYLOR, ASHY ..................... Children's Hospital, Washington
TAYLOR, MILDRED I. .............. 1105 Pennsylvania Ave., S. E., Washington
TORKINGTON, Edith ............... Children's County Home, 18 St., and Bunker Hill Rd., Washington
TOUCHTON, GERTRUDE .......... 1350 L St., N. W., Washington
WALTON, FLORENCE ................. 3217 Walbridge Pl., N. W., Washington
WEIR, MILLIE E. ................. Gallinger Hospital, Washington

FLORIDA—13 Members

BENHAM, LOUISA B. .......... McMeckin Pl., Hawthorne
BROWN, MARY D. .......... 531 E. Church St., Gainesville
GLENNDING, ISABELLA J. .. Jackson Memorial Hospital, Miami
GUTWALD, KATHRYN R.** .... Good Samaritan Hospital, West Palm Beach
KENNEDY, MARTHA .......... Mound Park Hospital, St. Petersburg
MEIKS, MAY ..................... Mound Park Hospital, St. Petersburg
MISCELLY, ELIZABETH .... Good Samaritan Hospital, West Palm Beach
MOORE, FLORENCE .......... Orange General Hospital, Orlando
PAGONES, MARGARET .... Good Samaritan Hospital, West Palm Beach
PRUIS, EDNA C. ............ Tampa Municipal Hospital, Tampa
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SISTER MIHIAIM HAROLD .. St. Vincent's Hospital, Jacksonville
ZEALY, MABEL E. ........... 2841 Park St., Jacksonville
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GEORGIA—42 Members

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BABIN, RUTH A. .......... Piedmont Hospital, Atlanta
BANKS, MATTIE L. .......... 701 Forsyth St., Macon
BISHOP, DAISY* .......... 657 Horne Ave., Atlanta
BISCHOFF, LILLIAN M. .......... 1355 Peachtree Terrace, Atlanta
BRANHAM, HELEN T. .......... Ware County Hospital, Waycross
BROWN, E. ALMA .......... University Hospital, Augusta
CAMPBELL, MARY .......... 1309 Oglethorpe St., Macon
CANDLISH, JESSIE M. .......... 640 Forrest Ave., N. E., Atlanta
DAVIS, EFFIE .......... Patterson Hospital, Cuthbert
DICKERSON, DURICE A. .......... 131 Forrest Ave., N. E., Atlanta
FEEBECK, ANNIE B. .......... Grady Hospital, Atlanta
GARRON, GENEVIEVE .......... Piedmont Hospital, Atlanta
HALL, MATTIE Y. .......... 640 Forrest Ave., N. E., Atlanta
HARMICK, SHIRLEY N. .......... 727 S. Main St., Cedartown
HANEY, MARY J.* .......... Grady Hospital, Atlanta
HARKNESS, FRANCES R. .......... 640 Forrest Ave., N. E., Atlanta
HAWTHORNE, MRS. J. F. .......... 410 Arnold St., N. E., Atlanta
HOOD, MARTHA .......... 116 Huntington St., Savannah
HOPE, WILLIE .......... Piedmont Hospital, Atlanta
HORNE, MARY E. .......... Georgia Baptist Hospital, Atlanta
JONES, MAE M. .......... P. O. Box 525, Milledgeville
JONES, MARY E.* .......... Grady Hospital, Atlanta
JORDAN, SELMA V.* .......... Grady Hospital, Atlanta
LYNN, JULIET V.* .......... Grady Hospital, Atlanta
MACE, LUCY I. .......... 272 Courtland St., Atlanta
MCNALLY, MARY A. .......... 521 E. Liberty St., Savannah
NASH, FRANCES L.* .......... Grady Hospital, Atlanta
NELSON, LILLIAN O. .......... Piedmont Hospital, Atlanta
RAY, LYDE M.* .......... Grady Hospital, Atlanta
ROBISON, LAURA .......... Grady Hospital, Atlanta
RYAN, LILLIAN J. .......... Station Hospital, Fort Benning
SCOVILLE, FRANCES* .......... Grady Hospital, Atlanta
SCHAEFER, ANNA J.** .......... 512 Capitol Ave., Atlanta
SISTER MARY THERESA BYERLY .......... St. Joseph's Infirmary, Atlanta
STEWART, ALICE F. .......... University Hospital, Augusta
STOUTAMIRE, LOIS E. .......... Grady Hospital, Atlanta
SWANSON, CLARA E. .......... 517 S. 8 St., Griffin
TUCKER, EMMA L. .......... Milledgeville State Hospital, Milledgeville
TUPMAN, EVA S. .......... 754 Piedmont Ave., Atlanta
VAN DE VREDE, JANE .......... 546 Highland Ave., N. E., Atlanta
ZUBER, LILLIAN** .......... The Capitol, Room 111, Atlanta

IDAHO—2 Members

PINE, EMILY .......... St. Luke's Hospital, Boise
SMITH, HELEN A. .......... St. Luke's Hospital, Boise

ILLINOIS—341 Members

ABRAMS, SARA M. .......... 6400 Irving Park Blvd., Chicago
AIHERNS, MINNIE H. .......... Community Hospital, Geneva
ALLEN, MARY L. .......... Peoria State Hospital, Peoria
ANDERSON, CLARA B.* .......... 427 Garfield Ave., Chicago
ANDERSON, Emma .................................................. 2816 Ellis Ave., Chicago
ANDRESEN, Olga E. ............................................... 2449 S. Dearborn St., Chicago
ANTE, Marie C. .................................................. St. Luke’s Hospital, Chicago
BACHLE, Helen F.* ............................................... 2816 Ellis Ave., Chicago
BALZER, Laverne L. ............................................... 1931 Wilson Ave., Chicago
BARNETT, Margaret S. ........................................... 2816 Ellis Ave., Chicago
BAUER, Sophie A. ................................................ 1519 Warren Blvd., Chicago
BAUMGARDT, Beatrice S. ......................................... 4050 Thomas St., Chicago
BECK, Frances E. .................................................. 2650 Ridge Ave., Evanston
BEBBY, Nell V. ..................................................... 738 Clarence Ave., Oak Park
BELL, Alice J.* .................................................... 1439 S. Michigan Ave., Chicago
BENDER, Edith D. .................................................. 700 Fullerton Ave., Chicago
BENSON, Mabel I.* ................................................ 2650 Ridge Ave., Evanston
BERGQUIST, Edith A. .............................................. Roseland Community Hospital, Chicago
BEUCHAT, Kathryn W. ........................................... 1416 Indiana Ave., Chicago
BICKNELL, Waverly M.* ......................................... 700 Fullerton Parkway, Chicago
BIESTERFELDT, Elsie M. ......................................... 4057 N. Kostner Ave., Chicago
BIGGERT, Helen ................................................... 536 Webster Ave., Chicago
BIGLER, Rose ...................................................... 6400 Irving Park Blvd., Chicago
BINNER, Beatrice .................................................. 700 Fullerton Parkway, Chicago
BINNER, Mabel W. .................................................. 707 Fullerton Ave., Chicago
BLACK, Lena ....................................................... 1515 W. Monroe St., Chicago
BLAKE, Florence G. ............................................... 2816 Ellis Ave., Chicago
BOGARDUS, Mary I. ............................................... 950 E. 59 St., Chicago
BORAX, Gertrude C.* ........................................... 1931 Wilson Ave., Chicago
BRADING, Hattie E. .............................................. 1668 W. Ogden Ave., Chicago
BRADLEY, Grace V. ............................................... 509 S. Honore St., Chicago
BRANDT, Sena H. .................................................. Blessing Hospital, Quincy
BRAUCKLE, Mabel M. ............................................. Francis Willard Hospital, Chicago
BRUCE, Aurora E. ................................................ 2816 Ellis Ave., Chicago
BRUCK, Helen O.* .................................................. 700 Fullerton Parkway, Chicago
BUCKINGHAM, Attalee May ..................................... 6400 Normal Blvd., Chicago
CALEY, Gladys M. .................................................. 221 N. Glen Oak, Peoria
CAMPBELL, Mabel S. ............................................. 950 E. 59 St., Chicago
CARLSON, Agnes A. .............................................. 411 Garfield Ave., Chicago
CARLSON, Amelia ................................................. Frances E. Willard Hospital, Chicago
CARLSON, Atina* ................................................ 1931 Wilson Ave., Chicago
CARLSON, Olga E.* ................................................ 2816 Ellis Ave., Chicago
CARRINGTON, Margaret** ...................................... 2816 Ellis Ave., Chicago
CARROLL, Katherine ............................................. 725 S. Lincoln St., Chicago
CHAMBERLAIN, Amy B. .......................................... 427 Garfield Ave., Chicago
CHATHAM, Ellen B. ............................................... 2816 Ellis Ave., Chicago
COMSTOCK, Ann ................................................... 2816 Ellis Ave., Chicago
COOPER, N. Florence* .......................................... 7428 N. Damen St., Chicago
COX, Winnie A. ................................................... 509 S. Honore St., Chicago
CRAGIN, Ella O. .................................................. 1515 W. Monroe St., Chicago
CROCKER, Ada Rietz** ........................................... 8 S. Michigan Ave., Chicago
CROUCH, May L. .................................................. 1900 W. Polk St., Chicago
DAEGER, Frances M. ............................................. 656 Wrightwood Ave., Chicago
DAHLGREN, Emelia .............................................. Lutheran Hospital, Moline
DALLMAN, Eleanor B. ........................................... 1931 Wilson Ave., Chicago
DALTON, Beulah I. ................................................ 1750 W. Congress St., Chicago
DAWSON, Ellen G. ................................................ Evanston Hospital, Evanston
DECKER, Ada M. ................................................... 403 E. First St., Dixon
DEXHEIMER, Harriet G.* ....................................... 700 Fullerton Ave., Chicago
DIESON, ALMA .................................. 509 S. Honore St., Chicago
DILGE, LULA M. .............................. 1416 Indiana Ave., Chicago
EASTIN, RUTH E. ....................... Silver Cross Hospital, Joliet
EBERS, ELLA L.* .......................... 2816 Ellis Ave., Chicago
EGLE, LOUISE ............................. 509 S. Honore St., Chicago
EHMAN, IDA ................................. 1600 Maypole Ave., Chicago
EIMERMANN, LUCILLE* .................. 700 Fullerton Parkway, Chicago
ELDREDGE, ADDA** ........................ 8 S. Michigan Ave., Chicago
ELSOME, ANNA D. ..................... Passavant Memorial Hospital, Jacksonville
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FABER, MARION J. .................................. 509 S. Honore St., Chicago
FAGAN, HELEN M.* .......................... 2816 Ellis Ave., Chicago
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FANNING, JANE .............................. 218 E. Carroll St., Macomb
FAY, ALICE M. .............................. 700 Fullerton Parkway, Chicago
FERDIN, GRACE S. .......................... 411 Garfield Ave., Chicago
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FOLEY, EDNA L. ........................... 104 S. Michigan Ave., Chicago
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FRANKENTHAL, ANNE E. .............. 4825 Woodlawn Ave., Chicago
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FRED, RHODA E.* .......................... 1416 Indiana Ave., Chicago
FRIST, OLIVE M. ............................ 1416 Indiana Ave., Chicago
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GAPINGER, ERYTHE L. ................... 3851 Washington Blvd., Chicago
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HESTER, LUCILE M. .........221 N. Glen Oak, Peoria
HILL, ETTA G. ..........509 S. Honore St., Chicago
HILLQUIST, SIGNE ..........1420 Clarendon Ave., Chicago
HOFSETH, ASTRID .........Hotel Monnett, Evanston
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KOECHLING, AGNES ..........509 S. Honore St., Chicago
KOGER, ORPHA E. ..........6400 Irving Park Blvd., Chicago
KORNOLD, JANET FENMORE ....St. Luke’s Hospital, Chicago
KOST, CASSIE E. ..........509 S. Honore St., Chicago
LACKARD, ELIZABETH* ..........2650 Ridge Ave., Evanston
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LARSON, LUella M. ..........234 Wilson Ave., Chicago
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Olson, Anna M. .............. 536 Webster Ave., Chicago
Oram, Florence .............. 2816 Ellis Ave., Chicago
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>O'Shea, Lyda</td>
<td>4322 Drexel Blvd., Chicago</td>
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<tr>
<td>Overton, Belva L.**</td>
<td>422 E. 51 St., Chicago</td>
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<tr>
<td>Paton, Grace M.</td>
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<td>Paul, Elizabeth</td>
<td>1200 Gilpin Pl., Chicago</td>
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<td>Pearson, Martha E.</td>
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<td>Peterson, Ada J.</td>
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<td>Petley, Olive</td>
<td>4408 Drexel Blvd., Chicago</td>
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<td>Place, Sara B.</td>
<td>203 N. Wabash Ave., Chicago</td>
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<td>Plogher, Millie E.</td>
<td>420 S. Harlem Ave., Freeport</td>
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<td>Poole, Elizabeth</td>
<td>722 Simpson St., Evanston</td>
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<td>Powell, Frances L.</td>
<td>1515 W. Monroe St., Chicago</td>
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<td>Powell, Katherine C.</td>
<td>628 University Pl., Evanston</td>
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<td>Prentice, Daisy*</td>
<td>2816 Ellis Ave., Chicago</td>
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<td>Prutsman, Lela D.</td>
<td>1515 W. Monroe St., Chicago</td>
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<td>Purcell, Margaret E.</td>
<td>2517 S. Prairie Ave., Chicago</td>
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<td>Richter, Henrietta</td>
<td>6020 Drexel Ave., Chicago</td>
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<td>Rider, Madolin O.*</td>
<td>6146 Kenwood Ave., Chicago</td>
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<td>Ridley, Marie</td>
<td>1931 Wilson Ave., Chicago</td>
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<td>Robeson, Kathryn A.</td>
<td>2816 Ellis Ave., Chicago</td>
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<tr>
<td>Robinson, Frances B.</td>
<td>700 Fullerton Ave., Chicago</td>
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<tr>
<td>Robinson, Lorna</td>
<td>509 S. Honore St., Chicago</td>
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<tr>
<td>Robinson, Thelma</td>
<td>6400 Irving Park Blvd., Chicago</td>
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<tr>
<td>Rodgers, Idav*</td>
<td>Passavant Memorial Hospital, Jacksonville</td>
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<tr>
<td>Rogers, Dorothy</td>
<td>University of Chicago, Chicago</td>
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<tr>
<td>Rohrbeck, Martha A.</td>
<td>Augustana Hospital, Chicago</td>
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<tr>
<td>Rosendahl, Geda J.</td>
<td>1044 N. Francisco Ave., Chicago</td>
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<tr>
<td>Ross, Evelyn O.*</td>
<td>950 E. 59 St., Chicago</td>
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<tr>
<td>Rothweiler, Ella L.</td>
<td>850 Irving Park Blvd., Chicago</td>
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<td>Rudolph, Elsa A.</td>
<td>1416 Indiana Ave., Chicago</td>
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<tr>
<td>Russell, May L.</td>
<td>1750 W. Congress St., Chicago</td>
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<td>Sackett, Ruth*</td>
<td>1439 S. Michigan Ave., Chicago</td>
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<td>Sallee, Lena M.*</td>
<td>2816 Ellis Ave., Chicago</td>
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<tr>
<td>Sandwell, Ruth M.</td>
<td>537 Deming Pl., Chicago</td>
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<td>Schenkens, Erna F.</td>
<td>950 E. 59 St., Chicago</td>
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<td>Schmidt, Dorothy A.</td>
<td>2443 Pearson St., Chicago</td>
</tr>
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<td>Schultejann, Kathryn A.</td>
<td>2875 W. 19 St., Chicago</td>
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<tr>
<td>Schwedler, Alice E.</td>
<td>St. Luke's Hospital, Chicago</td>
</tr>
<tr>
<td>Sedmihradsky, Lillian</td>
<td>1067 Argyle St., Chicago</td>
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<tr>
<td>See, Alverna C.</td>
<td>310 E. Springfield Ave., Champaign</td>
</tr>
<tr>
<td>Sellew, Gladys**</td>
<td>721 N. La Salle St., Chicago</td>
</tr>
<tr>
<td>Senour, Wilma R.</td>
<td>202 W. Ash St., Normal</td>
</tr>
<tr>
<td>Schaffner, Helen I.*</td>
<td>8 S. St. Louis Ave., Chicago</td>
</tr>
<tr>
<td>Shannon, Mabel I.</td>
<td>St. Luke's Hospital, Chicago</td>
</tr>
<tr>
<td>Shirkey, Mary A.*</td>
<td>1501 17 St., East Moline</td>
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<tr>
<td>Shoemaker, Berla B.</td>
<td>1931 Wilson Ave., Chicago</td>
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<tr>
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<td>6104 Woodlawn Ave., Chicago</td>
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<tr>
<td>Short, Mildred L.*</td>
<td>2816 Ellis Ave., Chicago</td>
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<tr>
<td>Sister Blais St. Louis</td>
<td>St. Mary's Hospital, Urbana</td>
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<td>Sister Helen Jarrell,*</td>
<td>6357 Harvard Ave., Chicago</td>
</tr>
<tr>
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<td>St. John's Hospital, Springfield</td>
</tr>
</tbody>
</table>
Sister M. Agnes Cummings ........ 1209 S. Walnut Ave., Freeport
Sister M. Alberta Hoffman ....... St. Joseph’s Hospital, Elgin
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Spellman, Alice L. ........ 700 Fullerton Ave., Chicago
Stafford, Hortense P. ........ 600 Main St., Alton
Stanard, Roberta .......... 2816 Ellis Ave., Chicago
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Strasen, Ida E. .......... 4521 Malden St., Chicago
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Swarthout, Lucile .......... 1515 W. Monroe St., Chicago
Taylor, Florence M. .... 2449 Washington Blvd., Chicago
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Thie, Amelia L. .......... 2449 Washington Blvd., Chicago
Thilk, Frances M. .......... 533 Grant Pl., Chicago
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Thornton, Mary J. .......... 1138 N. Leavitt St., Chicago
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Travis, Hettie B. .......... 1044 N. Francisco Ave., Chicago
Vande Steeg, Evelyn .... St. Luke’s Hospital, Chicago
Van Horn, Ella M. .......... 1750 W. Congress St., Chicago
Van Schoick, Mildred .... 1441 E. 60 St., Chicago
Vaughn, Florence .......... 2816 Ellis Ave., Chicago
Walderbach, Helena M. .... 4950 Thomas St., Chicago
Watson, Mary ................ 551 Grant Pl., Chicago
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Weltman, Estelle R. .... 616 S. Michigan Ave., Chicago
Westphal, Mary E. .... 104 S. Michigan Ave., Chicago
Weyer, Jeannette* .......... 518 N. Austin Blvd., Oak Park
Wheeler, Beatrice* .......... 509 S. Honore St., Chicago
WHITFORD, MAE L. .................. 427 Jefferson Building, Peoria
WHITTAKER, ELEANOR .......... 2645 Girard Ave., Evanston
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WINGATE, MYRTLE E. ......... 2650 Ridge Ave., Evanston
WINNIE, BEULAH I. .......... 2816 Ellis Ave., Chicago
WUBBENA, ELLA ............ 830 N. La Salle St., Chicago

† INDIANA—60 Members

BISCHOFF, PAULINE G. .... 3024 Fairfield Ave., Fort Wayne
BONWHUIS, CLARA .......... Veteran's Administration Hospital, Marion
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MCKINLEY, ADA .......... Ball Memorial Hospital, Muncie
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Upjohn, Gertrude .......... Deaconess Hospital, Evansville
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Dickson, Mary G .......... Children's Hospital, Iowa City
Egenes, E. Louise .......... Westlawn, Iowa City
Ellis, Clara B .......... University Hospital, Iowa City
Fahey, Mary A .......... Mercy Hospital, Mason City
Faltis, Tracie E .......... Westlawn, Iowa City
Frazer, Sara .......... Westlawn, Iowa City
Friske, Blenda L .......... Mary Frances Skiff Memorial Hospital, Newton
Gearing, Alice I .......... Finley Hospital, Dubuque
Hamilton, Regina .......... Westlawn, Iowa City
Hartz, Alma E .......... Public Health Nursing Bureau, Cedar Rapids
Haynes, Edith E.* .......... Westlawn, Iowa City
Hefner, Augusta J .......... St. Joseph's Hospital, Sioux City
Heggen, Martha .......... Iowa Lutheran Hospital, Des Moines
Henchen, Clara .......... Finley Hospital, Dubuque
Henderson, Laura .......... Broadlaw General Hospital, Des Moines
Hobbs, Alida A .......... 1117 Pleasant St., Des Moines
Hornaday, Olive V .......... Westlawn, Iowa City
Hulet, Mamie R .......... Methodist Hospital, Sioux City
Jacobson, Beatrice A .......... Westlawn, Iowa City
Jenkins, Harriet K .......... Westlawn, Iowa City
Johnson, Loula A .......... Box 207, Ottumwa
Kampmeier, Bertha E .......... Westlawn, Iowa City
Lacey, Katherine M .......... St. Vincent's Hospital, Sioux City
Larsen, Lutie B .......... 127 Lafayette St., Waterloo
Lindsay, Lola .......... University Hospital, Iowa City
Lofgren, Beatrice I .......... 406 Center St., Des Moines
Love, Agnes D .......... 1117 Pleasant St., Des Moines
Lynes, Mattie E .......... 323 Second St., W., Waverly
Marble, J. Maureen .......... University Hospital, Iowa City
McAhren, Myrtle A .......... St. Luke's Hospital, Cedar Rapids
MCURR, BLANCHE C. University Hospital, Iowa City
MERRILL, FLORENCE M. University Hospital, Iowa City
METHER, MOLLIE A. Westlawn, Iowa City
MEYERS, ELIZABETH C. Westlawn, Iowa City
MUNGOVAN, GENEVA E. Mercy Hospital, Cedar Rapids
NASH, RITA C. Mercy Hospital, Mason City
NELSON, EDITH A. 645 15 Ave., S. W., Cedar Rapids
PACZKA, ALAISIE University Hospital, Iowa City
REINHART, EDITH Jane Lamb Memorial Hospital, Clinton
RODABAUGH, CLARA L. Mercy Hospital, Des Moines
RODGERS, RETA O. Westlawn, Iowa City
ROTHENBERG, ALICE Westlawn, Iowa City
SAGE, VERA M. Burlington Hospital, Burlington
SAYRE, MABEL A. Methodist Hospital, Sioux City
SCHLAPPE, EMMA Jane Lamb Memorial Hospital, Clinton
SCHUKAR, MADELINE Lutheran Hospital, Sioux City
SHIELDS, RUTH E. Westlawn, Iowa City
SISTER ERNA SCHWEER* Evangelical Deaconess Hospital, Marshalltown
SISTER MARIE E. HOPP Evangelical Deaconess Hospital, Marshalltown
SISTER MARIE WOZESCHKE Evangelical Deaconess Hospital, Marshalltown
SISTER MARY ALBERTA Mercy Hospital, Council Bluffs
SISTER MARY ALOISE Sacred Heart Hospital, Le Mars
SISTER M. ALVERNA St. Anthony Hospital, Carroll
SISTER M. ANNUNCIATA St. Joseph’s Mercy Hospital, Mason City
SISTER M. BENEDICTA Mercy Hospital, Des Moines
SISTER MARY BENIGNA MANNING St. Joseph’s Hospital, Mason City
SISTER MARY CAJETON Mercy Hospital, Cedar Rapids
SISTER MARY CAMILLAS Mercy Hospital, Council Bluffs
SISTER MARY CLEMETTA Sacred Heart Hospital, Le Mars
SISTER M. IMMACULATA Mercy Hospital, Des Moines
SISTER MARY IMMACULATA St. Joseph’s Mercy Hospital, Dubuque
SISTER MARY IRENE Mercy Hospital, Davenport
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SISTER M. RITA Mercy Hospital, Iowa City
SISTER MARY THOMAS Mercy Hospital, Council Bluffs
SOOK, ANN Westlawn, Iowa City
SQUIRE, ESTHER M. Community Hospital, Grinnell
STROHMAIER, CLEMATIS R. Westlawn, Iowa City
STUTSMAN, ALICE M. Broadlawns, Des Moines
SUTTON, MAUDE E. State Department of Health, State House, Des Moines

TRAVIS, EUNICE A. 1017 Rider St., Iowa City
WAGNER, ALMA G. St. Joseph’s Hospital, Ottumwa
WALSH, JULIA J. Westlawn, Iowa City
WATT, MARY J. Burlington Hospital, Burlington
WEBER, FLORA C. Westlawn, Iowa City
WESSLUND, FLORENCE H. Iowa Methodist Hospital, Des Moines
WILLIS, HELENA L. Psychopathic Hospital, Iowa City
WILSON, MAY S. 1117 Pleasant St., Des Moines
YACKEY, GRACE L. Westlawn, Iowa City
YACKEY, MILDRED A. 1508 Fulton St., Keokuk
ZICHER, MARIANNE 206 Masonic Temple, Marshalltown
‡ KANSAS—45 Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Hospital/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bungert, Frances M.</td>
<td>Ellsworth Hospital, Ellsworth</td>
</tr>
<tr>
<td>Cox, Minnie</td>
<td>McPherson County Hospital, McPherson</td>
</tr>
<tr>
<td>Duncan, C. Blanche</td>
<td>McPherson County Hospital, McPherson</td>
</tr>
<tr>
<td>Elmore, Edna</td>
<td>Bethany Hospital, Kansas City</td>
</tr>
<tr>
<td>Fritzemeier, Martha Helen</td>
<td>Grace Hospital, Hutchinson</td>
</tr>
<tr>
<td>Froehlke, Henrietta</td>
<td>Bell Memorial Hospital, Kansas City</td>
</tr>
<tr>
<td>Guest, Maude E.</td>
<td>Winfield Hospital, Winfield</td>
</tr>
<tr>
<td>Harner, Alfa G.</td>
<td>Christ's Hospital, Topeka</td>
</tr>
<tr>
<td>Hastings, Ethel L.</td>
<td>Bethany Hospital, Kansas City</td>
</tr>
<tr>
<td>Kanauer, Neola R.</td>
<td>Wesley Hospital, Wichita</td>
</tr>
<tr>
<td>Landis, Maude</td>
<td>325 Main St., Lawrence</td>
</tr>
<tr>
<td>Law, Irma</td>
<td>Wesley Hospital, Wichita</td>
</tr>
<tr>
<td>Martin, Wilmina P.</td>
<td>Extension Division K.S.A.C., Manhattan</td>
</tr>
<tr>
<td>McFarland, Katherine</td>
<td>Bethany Hospital, Kansas City</td>
</tr>
<tr>
<td>Miller, Cora A.</td>
<td>1224 N. Market St., Emporia</td>
</tr>
<tr>
<td>Patterson, Sara A.</td>
<td>Bethany Hospital, Kansas City</td>
</tr>
<tr>
<td>Redmond, Mary M.</td>
<td>St. Margaret's Hospital, Kansas City</td>
</tr>
<tr>
<td>Reih, Helena</td>
<td>St. Frances' Hospital, Topeka</td>
</tr>
<tr>
<td>Riehle, Rosemary*</td>
<td>St. Margaret's Hospital, Kansas City</td>
</tr>
<tr>
<td>Sister Ann Dolores</td>
<td>Providence Hospital, Kansas City</td>
</tr>
<tr>
<td>Sister Cornelia</td>
<td>St. Mary College, Leavenworth</td>
</tr>
<tr>
<td>Sister Frances Clare</td>
<td>St. John's Hospital, Leavenworth</td>
</tr>
<tr>
<td>Sister Lena M. Smith</td>
<td>Bethel Deaconess Hospital, Newton</td>
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<tr>
<td>Sister Macrina Kuhn</td>
<td>St. Margaret's Hospital, Kansas City</td>
</tr>
<tr>
<td>Sister Mary Aurelia</td>
<td>18 and Barnett Sts., Kansas City</td>
</tr>
<tr>
<td>Sister Mary B. Freely</td>
<td>Mercy Hospital, Fort Scott</td>
</tr>
<tr>
<td>Sister M. Domitilla</td>
<td>St. John's Hospital, Leavenworth</td>
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<tr>
<td>Sister Mary Ferdinand</td>
<td>St. John's Hospital, Salina</td>
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<tr>
<td>Sister M. Gonzaga Betzen</td>
<td>St. Francis' Hospital, Wichita</td>
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<tr>
<td>Sister Mary Stella</td>
<td>Wichita Hospital, Wichita</td>
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<tr>
<td>Sister M. Theresita Schrick</td>
<td>St. Francis' Hospital, Wichita</td>
</tr>
<tr>
<td>Sister M. Victorina Barrins</td>
<td>St. Anthony's Murdock Memorial Hospital, Sabetha</td>
</tr>
<tr>
<td>Sister M. Winifred Sheehan</td>
<td>St. Anthony's Hospital, Dodge City</td>
</tr>
<tr>
<td>Sister Rose Victor</td>
<td>St. Mary's College, Leavenworth</td>
</tr>
<tr>
<td>Sister Theodosia Harns</td>
<td>Bethel Deaconess Hospital, Newton</td>
</tr>
<tr>
<td>Steck, Aleta L.</td>
<td>Wesley Hospital, Wichita</td>
</tr>
<tr>
<td>Swan, Florence</td>
<td>3927 Eaton St., Kansas City</td>
</tr>
<tr>
<td>Swenson, Irene</td>
<td>Bell Memorial Hospital, Kansas City</td>
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<tr>
<td>Templin, Ethel</td>
<td>Wesley Hospital, Wichita</td>
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<tr>
<td>Thomas, Florence</td>
<td>Cushing Memorial Hospital, Leavenworth</td>
</tr>
<tr>
<td>Uppendahl, Frieda</td>
<td>306 W. Washington St., Sterling</td>
</tr>
<tr>
<td>Wayne, Anna L.</td>
<td>Bell Memorial Hospital, Kansas City</td>
</tr>
<tr>
<td>White, Anna M.**</td>
<td>4420 Lloyd St., Kansas City</td>
</tr>
<tr>
<td>Wilson, Jessie</td>
<td>1404 University Ave., Wichita</td>
</tr>
<tr>
<td>Woodley, Callie D.</td>
<td>Station Hospital, Fort Leavenworth</td>
</tr>
</tbody>
</table>

‡ KENTUCKY—50 Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>Adams, Emma M.</td>
<td>202 E. Southern Ave., Covington</td>
</tr>
<tr>
<td>Applegate, Myrtle C.</td>
<td>2051 Sherwood Ave., Louisville</td>
</tr>
<tr>
<td>Blair, Mabel</td>
<td>City Hospital, Bowling Green</td>
</tr>
<tr>
<td>Breckenridge, Mary</td>
<td>Wendover, Leslie County</td>
</tr>
</tbody>
</table>
CARROLL, RHODA K. Good Samaritan Hospital, Lexington
CARSON, MARY E. 1023 S. Fourth St., Louisville
CIRVES, CATHERINE P. Norton Memorial Infirmary, Louisville
DELIN, ELZIE L. Children’s Free Hospital, Louisville
FOREMAN, MARY E. City Hospital, Louisville
GIBSON, FLORENCE I. College Hospital, Berea
GOBIN, MARY F. 1924 Preston St., Louisville
GREATHOUSE, JESSIE Shriners’ Hospital for Crippled Children, Lexington
HARE, NANNIE A. Berea College Hospital, Berea
HENNINGER, EDNA City Hospital, Louisville
HENRY, LAVINIA B. Good Samaritan Hospital, Lexington
HUGHES, ADELINE M. Jewish Hospital, Louisville
KEEFER, MARTHA L. 512 W. Kentucky St., Louisville
MASON, DR. ORA K. William Mason Memorial Hospital, Murray
MCCOLLUM, RUTH K. Berea College Hospital, Berea
MC DONALD, BETTIE W. 215 E. Walnut St., Louisville
MERRIFIELD, RUTH K. M. E. Deaconess Hospital, Louisville
MURPHY, HONOR 96 Valley Rd., Castletwood
O’ROKE, AGNIE E. Kosair Crippled Children’s Hospital, Louisville
PERRY, MARGARET L. Norton Memorial Infirmary, Louisville
PITMAN, CHARLOTTE E. 1054 Cherokee Rd., Louisville
POTTINGER, LOUISE 1023 S. Fourth St., Louisville
PAULSON, NettiE 3035 Preston St. Rd., Louisville
PURCELL, LILLIAN M. Massie Memorial Hospital, Paris
SALT, SUSAN R. 641 Park Ave., Newport
SCHULTZ, GELA H. Riverside Hospital, Paducah
SISTER AGNES M. PAYNE St. Mary and Elizabeth Hospital, Louisville
SISTER AURELIA St. Elizabeth Hospital, Covington
SISTER JOSELLA CONLON St. Mary and Elizabeth Hospital, Louisville
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SISTER MARGARET TERESA St. Joseph’s Hospital, Lexington
SISTER MARY BRIDGID St. Joseph Infirmary, Louisville
SISTER MARY CORINNE St. Joseph Infirmary, Louisville
SISTER MARY P. BOONE St. Mary and Elizabeth Hospital, Louisville
SISTER MIRIAM PATRICIA St. Joseph Infirmary, Louisville
SISTER M. TATIANA St. Anthony’s Hospital, Louisville
SISTER PRAXIDES St. Elizabeth’s Hospital, Covington
STANLEY, ANNA Good Samaritan Hospital, Louisville
STEINHAUER, SOPHIA Speer Memorial Hospital, Dayton
STORY, VIVIAN E. Norton Memorial Infirmary, Louisville
TAYLOR, NOLA General Hospital, Middlesboro
TUCKER, OLIVE St. Elizabeth’s Hospital, Covington
VINCENT, HELEN Kentucky Baptist Hospital, Louisville
WILKERS, OLLIE E. Kentucky Baptist Hospital, Louisville
WOODS, CARRIE M. Norton Memorial Infirmary, Louisville
WOLFE, LYDIA B. Big Laurel, Harlan County

‡ LOUISIANA—77 Members

ALEMAN, RUTH G. 1422 Short St., New Orleans
AYCOCK, SADIE C. Hotel Dieu, New Orleans
BARNES, CHARLOTTE North Louisiana Sanitarium, Shreveport
BARR, ANNA M. 1001 Canal Bank Building, New Orleans
BOYER, BEATRICE M. 1406 Baddenger St., Algiers
MEMBERS

BOYETT, CHRISTINE .............. Tri State Hospital, Shreveport
BROUSSARD, EUNICE ............. Touro Infirmary, New Orleans
COLOMB, BESSIE B. ............. Touro Infirmary, New Orleans
CROCHET, GENEVIEVE .......... Charity Hospital, New Orleans
DANSEAUER, MARCELLE ....... P. O. Box 1704, Alexandria
DISCON, ANITA I. ............. Hotel Dieu, New Orleans
FABREGAS, SUE ................ Charity Hospital, New Orleans
FRY, LOUISE G. ............... Tri State Hospital, Shreveport
GOLDEN, LORA C. .............. Baton Rouge General Hospital, Baton Rouge
GREENE, ANNIE M. ............. 1240 Texas Ave., Shreveport
GUIDRY, HAZEL M. ............. Charity Hospital, New Orleans
GUIDRY, LOUISE M. .......... Charity Hospital, New Orleans
HERSCHMANN, MARIETTA E. ... Touro Infirmary, New Orleans
HORNSBY, EVELYN M. ........... Charity Hospital, New Orleans
INGERBORG, JANE C. .......... 954 Margaret Pl., Shreveport
KOENIG, MARY E. .............. Charity Hospital, New Orleans
LANCASTER, KATHERINE D. ... 211 S. Cortez St., New Orleans
LANDRY, ELVINA E. .......... Charity Hospital, New Orleans
LYLES, MARY L. ................. Charity Hospital, Shreveport
MATHER, HARRIET L.** ........ Southern Baptist Hospital, New Orleans
MAURIN, EMMA .................. 150 Rosewood Dr., Metairie, New Orleans
MCMAHON, MARY A.** ........ St. Francis Sanitarium, Monroe
MILLER, MARIE* ............... Hotel Dieu, New Orleans
MOORE, MIRIAM C. ............. 2941 Gr. Rte., St. John
MYERS, DELLA .................. Baton Rouge General Hospital, Baton Rouge
NEWBREY, KATHERINE W. ...... 4414 Baronne St., New Orleans
NEWMAN, PEARL ................. 1240 Texas Ave., Shreveport
PAGAUD, MARY V. .............. 739 Carondelet St., New Orleans
PEPPER, MAMIE ................ Touro Infirmary, New Orleans
PRICE, MARGARET A. .......... 2801 St. Charles Ave., New Orleans
RICE, HARRIET ................. Elizabeth Sullivan Memorial Hospital, Bogalusa
ROBichaux, EMERANTEE ........ Charity Hospital, New Orleans
SISTER AGNES M. FITZSIMONS . St. Francis Sanitarium, Monroe
SISTER CELESTINE STROSINA** Hotel Dieu, New Orleans
SISTER GONZAGA WALL ........ Charity Hospital, New Orleans
SISTER HENRIETTA DEDISSE .. Our Lady of the Lake Sanitarium, Baton Rouge
SISTER HENRIETTA GUYOT .... Charity Hospital, New Orleans
SISTER JULIA CASSELS ........ Charity Hospital, New Orleans
SISTER LAURENTIA WALSH ...... Charity Hospital, New Orleans
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SISTER MARIE A. YOUNG ....... St. Francis Sanitarium, Monroe
SISTER MARIE B. DONEGAN .... St. Francis Sanitarium, Monroe
SISTER MARIE DE L. LAWTON ... St. Francis Sanitarium, Monroe
SISTER MARIE DE NAZARETH ... St. Francis Sanitarium, Monroe
SISTER MARIE MADELINE ...... Our Lady of the Lake Sanitarium, Baton Rouge
SISTER MARY A. VERNE ...... Our Lady of the Lake Sanitarium, Baton Rouge
SISTER M. B. BROUSSARD ...... Mercy Hospital Soniat Memorial, New Orleans
SISTER MARY B. CROWLY ...... Schumpert Sanitarium, Shreveport
SISTER MARY B. KEMP ........ Hotel Dieu, New Orleans
SISTER MARY F. DONOVAN ...... St. Patrick's Hospital, Lake Charles
SISTER MARY G. HENNESY ...... Our Lady of the Lake Sanitarium, Baton Rouge
SISTER MARY H. MINTKIN ...... Mercy Hospital Soniat Memorial, New Orleans
SISTER MARY I. BROUSSARD ... Mercy Hospital Soniat Memorial, New Orleans
SISTER M. J. WALSH ............ Mercy Hospital Soniat Memorial, New Orleans
SISTER M. P. MURPHY ........... St. Patrick's Hospital, Lake Charles
SISTER MATILDA BRENNER ........................................... 2004 Tulane Ave., New Orleans
SISTER ROBERTA DEGNAN ............................................ Hotel Dieu, New Orleans
SISTER ST. MICHAEL O’SHEA ........................................ Our Lady of the Lake Sanitarium, Baton Rouge
SISTER ST. PATRICK COMERFORD .................................. St. Francis Sanitarium, Monroe
SISTER STANISLAUS MALONE ........................................ Charity Hospital, New Orleans
SISTER STANISLAUS PHILLIPS ....................................... Hotel Dieu, New Orleans
SISTER SYLVIA BROWN ................................................ Charity Hospital, New Orleans
SISTER ZOE SCHIESWOHL ............................................. U. S. Marine Hospital, Carville
SOMMERS, ELMORE M. .................................................. 1240 Josephine St., New Orleans
SMITH, HAZEL V. ....................................................... Baton Rouge General Hospital, Baton Rouge
STEWART, STELLA ..................................................... Highland Sanitarium, Shreveport
STUART MARY J. ......................................................... Charity Hospital, New Orleans
TEBO, JULIE C. ......................................................... 1015 Pere Marquette Building, New Orleans
WEBRE, JOSEPHINE E. .................................................. Hotel Dieu, New Orleans
WHITNEY, WINIFRED .................................................. Touro Infirmary, New Orleans
WRIGHT, CHRISTINE .................................................... Charity Hospital, New Orleans
YARBROUGH, MARY I. .................................................. Charity Hospital, New Orleans

MAINE—13 Members

ANDERSON, THERESA A. ............................................. 80 Chapel St., Augusta
BAILEY, HARRIET** ................................................... 28 Grant St., Bangor
BROWN, NORAH E. ..................................................... Bath City Hospital, Bath
CLELAND, R. HELEN .................................................... Dennysville
DAILY, ELLEN C. ....................................................... Knox County General Hospital, Rockland
FISHER, PEARL R. ..................................................... Thayer Hospital, Waterville
HENESSY, AGNES V. .................................................... Rumford Community Hospital, Rumford
LOWD, BEATRICE A. L. .................................................. 300 Main St., Lewiston
MORSE, ALICE M. ..................................................... Eastern Maine General Hospital, Bangor
OSBORNE, MARY R. ................................................... Maine General Hospital, Portland
TRAFFORD, MARY C. .................................................. Bangor State Hospital, Bangor
WHITE, CLAIRE L.** .................................................. Maine General Hospital, Portland
YOUNG, MADELINE A. .................................................. 489 State St., Bangor

MARYLAND—103 Members

ADAMSON, JANE ................................................... Johns Hopkins Hospital, Baltimore
ALLEN, NAOMI* ...................................................... 620 W. Lombard St., Baltimore
AMES, MIRIAM ....................................................... Johns Hopkins Hospital, Baltimore
BALDWIN, ESTELLA C. ............................................ University Hospital, Baltimore
BARTLETT, HELEN C. .................................................. 604 Reservoir St., Baltimore
BELLEA, MARGARET S. ............................................ Sheppard and Enoch Pratt Hospital, Towson
BETZOLD, K. VIRGINIA* .............................................. 624 N. Broadway, Baltimore
BLACK, MARJORIE O. ............................................... Johns Hopkins Hospital, Baltimore
BRANLEY, FRANCES M. ........................................... St. Joseph's Hospital, Baltimore
BRILLHART, GERTRUDE B. ......................................... Sinai Hospital, Baltimore
BRIFFITT, BERNICE E. ................................................ 620 W. Lombard St., Baltimore
BRUDE, LUCY A. ..................................................... University Hospital, Baltimore
BUNTING, I. GERTRUDE ............................................ Sheppard and Enoch Pratt Hospital, Towson
Caldwell, Crystal J. ............................................... Johns Hopkins Hospital, Baltimore
Caswell, Nellie T.* .................................................. 3026 Guilford Ave., Baltimore
Conner, Evelyn A.* ................................................ 620 W. Lombard St., Baltimore
Craigie, Claire ...................................................... Union Memorial Hospital, Baltimore
Crawford, Helen H. ................................................ Johns Hopkins Hospital, Baltimore
Creentzburg, Freda L. .............................................. Church Home and Infirmary, Baltimore
DAHLMER, RUTH E.* .......................... 620 W. Lombard St., Baltimore
DOBBINS, VERA P.* .......................... 620 W. Lombard St., Baltimore
DURRANT, CONSTANCE S. ..................... Church Home and Infirmary, Baltimore
EARLING, HANNAH T. .......................... Maryland General Hospital, Baltimore
ELLIOTT, MARGARET ......................... Church Home and Infirmary, Baltimore
FREDERICK, HESTER K. ........................ Johns Hopkins Hospital, Baltimore
FRIEND, MARTHA E. ......................... 604 Reservoir St., Baltimore
GARDNER, MAUD M. ........................... Hospital for Women of Maryland, Baltimore
GASSAWAY, HELEN M. .......................... Church Home and Infirmary, Baltimore
GAVIN, MARY ................................. General Dispensary, United States Army, Baltimore
GERHOLD, ELLA M.* ........................... Johns Hopkins Hospital, Baltimore
GRANDE, MYRTLE R. ........................... Johns Hopkins Hospital, Baltimore
GREEN, MARY L.* ............................. Johns Hopkins Hospital, Baltimore
GROSS, ELSIE ................................ South Baltimore General Hospital, Baltimore
HAHN, ANNE M.* ............................. Johns Hopkins Hospital, Baltimore
HANSON, HAZEL ............................... Sinai Hospital, Baltimore
HARDIN, MAURICE* ............................ 620 W. Lombard St., Baltimore
HAY, MABEL N. ............................... Johns Hopkins Hospital, Baltimore
HEMLE, DOROTHY ANNA ...................... 2116 Lake Ave., Baltimore
HILDEBRANDT, MARY A. ...................... Baltimore City Hospital, Baltimore
HINES, MYRTLE N.** .......................... Maryland General Hospital, Baltimore
HOFFMAN, BERLIMA ........................... University Hospital, Baltimore
HOFFMAN, HARMINE ......................... 3715 Norton Ave, Baltimore
HOKE, LILLIE R. .............................. University Hospital, Baltimore
HOLDBROOK, MARGARET E. ................... Johns Hopkins Hospital, Baltimore
HUSSEY, ELMA J. ............................. Johns Hopkins Hospital, Baltimore
HYTTON, MARY B. ............................ 801 N. Broadway, Baltimore
JAMES, S. EDYTH ............................. 707 Carroll Ave., Takoma Park
JOHNSON, MARIE L. ........................... 2905 N. Charles St., Baltimore
KELLER, KATHERINE ........................... Church Home and Infirmary, Baltimore
KENNEDY, LOUIA E. ........................... 105 St. John's Rd., Baltimore
KOLB, LOUISA ................................. Johns Hopkins Hospital, Baltimore
LAB, JANE ................................... 3523 Wabash Ave., Baltimore
LAWLER, ELSIE M.** ........................... Johns Hopkins Hospital, Baltimore
LONG, FLORENCE W. ......................... Union Memorial Hospital, Baltimore
LUDWIG, RUTH B. ............................. South Baltimore General Hospital, Baltimore
MARTIN, SARAH F. ........................... 414 Kensington Rd., Ten Hills, Baltimore
MARTZ, HELEN ............................... Church Home and Infirmary, Baltimore
McBRIDE, DOROTHY F. ...................... 2 W. Second St., Frederick
MCDANIEL, LILLIAN K. ...................... 1601 Bolton St., Baltimore
MEISTER, MARGARET W.* .................... 624 N. Broadway, Baltimore
MITL, DOROTHY .............................. St. Agnes' Hospital, Baltimore
MOWBRAY, M. RUTH ......................... Maryland General Hospital, Baltimore
MULLIN, BERNADETTE A. .................... Johns Hopkins Hospital, Baltimore
MYERS, EDNA G. ............................. Johns Hopkins Hospital, Baltimore
NASH, JANE E. ............................... Church Home and Infirmary, Baltimore
NIES, MARY L. ............................... Frederick City Hospital, Frederick
NORTHAM, ETHEL ............................. Johns Hopkins Hospital, Baltimore
PACKARD, MARY C. ........................... 414 Kensington Rd., Ten Hills, Baltimore
PIERSON, AMELIA J.* ........................ Johns Hopkins Hospital, Baltimore
POWELL, BLANCHE G. ....................... 1211 Cathedral St., Baltimore
REILLY, EMILIE V.* .......................... Union Memorial Hospital, Baltimore
RICE, M. ELIZABETH* ....................... 620 W. Lombard St., Baltimore
RUFFLE, MARGARET M.* ..................... 620 W. Lombard St., Baltimore
ROSENTHAL, ADA R. .......... Sinai Hospital, Baltimore
SAVAGE, LOUISE .......... Sinai Hospital, Baltimore
SHEP, ISABELLE* ......... 620 W. Lombard St., Baltimore
SHEARSTON, HELEN E. ...... Hospital for the Women of Maryland, Baltimore
SHERWOOD, ELIZABETH W. ... Johns Hopkins Hospital, Baltimore
SHIPLEY, CAMASDEL ....... 6 E. Read St., Baltimore
SISTER ANNE JOSEPH ....... St. Agnes Hospital, Baltimore
SISTER FIDELIS NAGEL ...... Allegany Hospital, Cumberland
SISTER MARY H. RYAN ...... Mercy Hospital, Baltimore
SISTER M. HILDEGARD HOLBEIN ... Mercy Hospital, Baltimore
SISTER MARY V. DUNNIGAN ... Mercy Hospital, Baltimore
SLOUGH, IONE .......... Washington County Hospital, Hagerstown
SMITHSON, BESSIE ......... Union Memorial Hospital, Baltimore
SNYDER, WILDA L.* ....... 620 W. Lombard St., Baltimore
STEINWEDEL, LOIS M.* ...... 620 W. Lombard St., Baltimore
STUMPF, SOPHIE .......... Sinai Hospital, Baltimore
SUMPTER, Lelia B. .......... Union Memorial Hospital, Baltimore
SWARTZ, VESTA L. .......... University Hospital, Baltimore
THOMAS, MARGARET W.* ...... Hospital for the Women of Maryland, Baltimore
THUMA, MARION E.* ...... Johns Hopkins Hospital, Baltimore
WALKER, M. EVELYN ....... 1601 Bolton St., Baltimore
WALKER, VIRGINIA H. ...... Johns Hopkins Hospital, Baltimore
WARFIELD, ELIZABETH ...... 219½ E. North Ave., Baltimore
WATKINS, MARION B.* ...... 3026 Guilford Ave., Baltimore
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BROWN, NORA A. .......... Symmes Hospital, Arlington
BURGESS, MARY A. .......... 37 Union St., Plymouth
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAIN, CATHERINE R.*</td>
<td>71 Jacques Ave., Worcester</td>
</tr>
<tr>
<td>CAMPBELL, ELISIE L.</td>
<td>1820 Highland Ave., Fall River</td>
</tr>
<tr>
<td>CAMPBELL, KATHARINE A.</td>
<td>Lynn Hospital, Lynn</td>
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<tr>
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<td>City Hospital, Boston</td>
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<td>CARLTON, ELIZABETH G.</td>
<td>25 Deaconess Rd., Boston</td>
</tr>
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<td>CARPENTER, EDITH M.</td>
<td>221 Longwood Ave., Boston</td>
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<td>CARTLAND, MILDRED H.</td>
<td>18 Goodway Rd., Jamaica Plain</td>
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<td>14 Embankment Rd., Boston</td>
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<td>COX, EDITH I.</td>
<td>Robert B. Brigham Hospital, Boston</td>
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<td>Worcester City Hospital, Worcester</td>
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<td>195 Eliot St., Milton</td>
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<td>Saxonville</td>
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<td>Newton Hospital, Newton</td>
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<tr>
<td>DEVITT, VERA</td>
<td>21 Warren Ave., Woburn</td>
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<td>DIETER, MARGARET</td>
<td>Massachusetts Memorial Hospital, Boston</td>
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<td>DOUGLASS, LOUISE B.</td>
<td>Goddard Hospital, Brockton</td>
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<td>DUNN, MINNIE F.</td>
<td>State Infirmary, Tewksbury</td>
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<td>DURGIN, KATHERINE</td>
<td>State Infirmary, Tewksbury</td>
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<td>EICKE, BETTY</td>
<td>Norwood Hospital, Norwood</td>
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<td>EKLUND, LYLIL I.</td>
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<td>721 Huntington Ave., Boston</td>
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<td>GRANEY, MARY W.*</td>
<td>1153 Center St., Jamaica Plain</td>
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<td>GREIG, DOROTHY B.</td>
<td>Newton Hospital, Newton Lower Falls</td>
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<td>GRINDI, EDITH L.</td>
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<td>GUSTAFSON, ALICE</td>
<td>Holyoke Hospital, Holyoke</td>
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<td>Tannant State Hospital, Taunton</td>
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<td>400 Walk Hill St., Mattapan</td>
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<td>HILL, ELEANOR M.</td>
<td>52 Fruit St., Boston</td>
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<td>HITCHCOCK, KATHERINE</td>
<td>40 Commonwealth Ave., Boston</td>
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<td>HOSTETTER, NELL A.</td>
<td>2014 Washington St., Newton Lower Falls</td>
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<td>HOWLETT, MARJORIE V.</td>
<td>10 Stoughton St., Boston</td>
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<td>HUMPHREYS, RUTH I.</td>
<td>Framingham Hospital, Framingham</td>
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<tr>
<td>HUNT, BERTHA A.</td>
<td>Brockton Hospital, Brockton</td>
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HUNTLY, MABEL F. .......... Wesson Memorial Hospital, Springfield
INCH, EFFIE M. ............. 6 Roanoke Rd., Wellesley
JACOBUS, ROSABELLE .......... 2 State St., Worcester
JOHNSON, MARION C. ......... Whidden Memorial Hospital, Everett
JOHNSON, MARJorie A. ........ Faulkner Hospital, Jamaica Plain
JOHNSON, SALLY** .................. Massachusetts General Hospital, Boston
JOHNSTON, LENA F. ........... 170 Governors Ave., Medford
JONES, DELIGHT S. .......... Truesdale Hospital, Fall River
JORDON, ISABELLE M. ......... Children's Hospital, Boston
KENDALL, GRACE P. .......... 12 Terrill St., Worcester
KEPLER, AURA E. .......... 49 Englewood Ave., Brookline
KEY, SARA L. ............... St. Luke's Hospital, New Bedford
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KNUTSON, MARTHA F. ......... Lawrence General Hospital, Lawrence
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LARKIN, MARGARET M. ......... 71 Jacques Ave., Worcester
LARTER, MARY .............. North Adams Hospital, North Adams
LEE, HELENE G. .............. 36 Aborn St., Peabody
LEHR, BEULAH E. ............ Massachusetts General Hospital, Boston
LEMKE, META E. ............. Salem Hospital, Salem
LEPPER, EDNA S. .......... Springfield Hospital, Springfield
LEWIS, IDA M. .............. 35 Harvard Ave., Brookline
MACADAM, CHRISTINA* .......... Lynn Hospital, Lynn
MACALPINE, MARGARET M.* ..... 100 Bellingham St., Chelsea
MACKAY, MARY J. .......... Henry Heywood Memorial Hospital, Gardner
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MADDOCKS, CLARA L. ........ McLean Hospital, Waverly
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MARSH, ALICE W. ........... Whidden Memorial Hospital, Everett
MARSH, ELIZABETH W. ...... Waltham Hospital, Waltham
MAY, RUTH I. .............. 1820 Highland Ave., Fall River
McCORMACK, HELEN .......... Carney Hospital, South Boston
McCRAE, ANNABELLA ........ The Pioneer, 410 Stuart St., Boston
MCDONALD, ANNE G. ........ State Infirmary, Tewksbury
MEWAN, DORA E. ............ Beverly Hospital, Beverly
MCILVANA, LAURA C. .......... 32 Fruit St., Boston
MCKAY, MINA A. ............. Massachusetts General Hospital, Boston
MCKENNA, FRANCES M. ....... Burbank Hospital, Fitchburg
McLEAN, GRAZIELLA .......... Box 8, Waverly
MCVIEKER, MABEL .......... N. E. Deaconess Hospital, Boston
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MURRAY, MARGARET .......... 14 Embankment Rd., Boston
NELSON, GERTRUDE B. ........ 23 Arbella St., Salem
NELSON, SOPHIE C. .................................. 197 Clarendon St., John Hancock Mutual Life Insurance Co., Boston
NEWHALL, HELEN A. ................................ 721 Huntington Ave., Boston
NORCROSS, MARY E. ................................. Children's Hospital, Boston
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PEKRUL, NELLIE H. .................................. N. E. Baptist Hospital, Boston
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RUEL, EMMA A. ....................................... 10 Stoughton St., Boston
SANDSTROM, DOROTHY S. ......................... 212 Boston St., Lynn
SAYLES, MARTHA O. ................................ 721 Huntington Ave., Boston
SEARLE, LILLIE M. .................................... Murray Hill Rd., Malden
SHAHEEN, ANNA ..................................... The Memorial Hospital, Worcester
SHEPARD, MARY E. .................................. 7 Page St., Hyde Park
SINCLAIR, BERNICE J. ............................... 721 Huntington Ave., Boston
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STEELE, KATHARINE M. .................. Worcester State Hospital, Worcester
STEVenson, ERMINIE J. .............................. 71 Jacques Ave., Worcester
STIMSON, MARJORY .................................. 300 The Fenway, Boston
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STRAND, EDITH F. ................................... New England Sanitarium and Hospital, Melrose
SULLIVAN, ELIZABETH ............................... 16 Buchanan Rd., West Roxbury
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WALKER, HAZEL M. .................................. 88 Washington St., Taunton
WALKER, LORRAINE H. ............................... 120 High St., Springfield
WARBURTON, OLEGA I. .............................. Faulkner Hospital, Jamaica Plain
WATSON, SUSIE A. ................................... 370 Longwood Ave., Boston
WHARTON, MERNETTA S. ......................... 100 Bellingham St., Chelsea
Whitteker, Juliet A. 24 Belmont Ave., Northampton
Whitten, Dorothy M. Newton Hospital, Newton Lower Falls
Wiggins, Bernice L. 149 Hillside Ave., Arlington Heights
Williams, Barbara 41 Hyde St., Newton Highlands
Wood, Helen 1036 Walnut St., Newton Highlands
Wood, Marguerite W. 8 Columbia Park, Haverhill
Woolbridge, Florence M. Hospital Rd., Harding
Zutter, Louise S. Boston Lying-In Hospital, Boston

‡MICHIGAN—143 Members

Anderson, Amanda Norway
Anderson, Lyda W. 25 E. Palmer Ave., Detroit
Ball, Martha M. 3740 John R. St., Detroit
Bartlett, Barbara H. 3080 Natural Science Building, University of Michigan, Ann Arbor
Bayer, Christine C. Evangelical Deaconess Hospital, Detroit
Beard, Kathryn E. 7401 Woodward Avenue, Detroit
Beers, Adelaide Hackley Hospital, Muskegon
Beers, Amy Hackley Hospital, Muskegon
Black, Margaret N. 3740 John R. St., Detroit
Brehm, Alma L. 3740 John R. St., Detroit
Budden, Ellenora Grace Hospital, Detroit
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Campbell, Winifred C. Saginaw General Hospital, Saginaw
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Charon, Florence E.* 104 Forest Ave., Ann Arbor
Clark, Frances S. 1916 Nelson Ave., S. E., Grand Rapids
Clark, Violetta E.* 3740 John R. St., Detroit
Cowley, Helen A. City Hospital, Grand Rapids
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Gillies, Dorothy G.* 3740 John R. St., Detroit
Gillies, Grace M. 3740 John R. St., Detroit
Gillies, Mary M. 3740 John R. St., Detroit
Gretter, Lystra 887 Pallister Ave., Detroit
Hallstead, Eleanor 7647 Byron Ave., Detroit
Hanke, Hedwig H.** Saginaw General Hospital, Saginaw
Harder, Daisy B. State Hospital, Kalamazoo
Harsch, Selma E.* 3740 John R. St., Detroit
Hart, Katherine Blodgett Memorial Hospital, Grand Rapids
Hebeler, Helen M.* 1130 E. Huron St., Ann Arbor
Henry, Jean* 3740 John R. St., Detroit
Herc, Mileinka 51 W. Warren Ave., Detroit
Holmes, Georgia Highland Park General Hospital, Highland Park
Hubbell, Ada M. Harper Hospital, Detroit
Huber, Lillian E. Couzens Hall, Ann Arbor
Huey, Margaret E. 300 E. State St., St. Johns
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JOHNSON, ESTHER ........................................ Couzens Hall, Ann Arbor
JOHNSON, GLADYS ......................................... 235 E. Alexandrine St., Detroit
KNAPP, LOUISE .......................................... 25 E. Palmer Ave., Detroit
KRIEGER, DOROTHY ....................................... 3740 John R. St., Detroit
KUITU, HELEN ........................................ Children's Hospital, Detroit
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MACDOUGALL, MARIAN* ............................... 3740 John R. St., Detroit
MACKEEN, AMY B. .................................. Children's Hospital, Detroit
MCCLENCH, CORA C. ................................... 1019 Berkshire Road, Ann Arbor
MCDONALD, THELMA* ................................ 3740 John R. St., Detroit
MCELLENN, RUTH ..................................... Bronson Methodist Hospital, Kalamazoo
MCMANMON, GRACE .................................... 260 N. Van Buren St., Bay City
MELSON, MAUDE ....................................... Nichols Memorial Hospital, Battle Creek
MITCHELL, MARY A.* .................................. 3740 John R. St., Detroit
MORAN, ELIZABETH S. ................................. 26 E. Palmer Ave., Detroit
MORSE, ELBA L. ..................................... Northern Michigan Children's Hospital, Marquette
MUFF, MARY ............................................... Box A, Kalamazoo
MULLEN, MARIANA R. ............................... St. Lawrence Hospital, Lansing
MURDIE, ELLA M. .................................. Evangelical Deaconess Hospital, Detroit
NICHOLS, ADAH ....................................... 70 E. Palmer Ave., Detroit
NICHOLS, ELIZABETH L. .................................. 176 N. Union St., Battle Creek
NICHOLSON, HELEN F. .............................. Harper Hospital, Detroit
NORTH, HELEN B. .................................... 3740 John R. St., Detroit
OSWALD, C. JEANETTE E. .......................... University Hospital, Ann Arbor
PEEBLES, ANNA Y. .................................. Woman's Hospital, Detroit
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POTTS, HENRIETTA J. .................................. Children's Hospital, Detroit
PRINGLE, MARGARET .................................. St. Luke’s Hospital, Marquette
RAMSEY, JUNE A. ..................................... Harper Hospital, Detroit
RAND, WINIFRED ................................... 71 Ferry Ave., E., Detroit
RANKIN, EMILY N. .................................. 2404 W. Grand Blvd., Detroit
RATAHRZAK, DOROTHY M. .......................... 20 Parkview, Mt. Clemens
REAMY, MARY A. .................................... Couzens Hall, Ann Arbor
REHM, ESTHER H. .................................... Blodgett Memorial Hospital, Grand Rapids
REYNOLDS, AMY T. .................................... Highland Park General Hospital, Highland Park
ROBINSON, NORA G. .................................. 3740 John R. St., Detroit
ROGERS, MARGARET A. ................................ Children's Free Hospital, Detroit
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SARGENT, EMILIE G. .................................. 659 Webb St., Detroit
SCHAFFER, MARGARET K.* ......................... 104 S. Forest Ave., Ann Arbor
SCHAU, ELIZABETH C. .............................. Box C, Traverse City
SEWELL, OLIVE ...................................... 206 Capital Loan & Savings Building, Lansing
SHADOWEN, ALLENE* .................................. 3740 John R. St., Detroit
SHEICK, FERN ....................................... Sparrow Hospital, Lansing
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SISTER CALLISTA MEYER ................. 850 Jefferson Ave., Saginaw
SISTER EMMANUEL MIEZKE ............... Evangelical Deaconess Hospital, Detroit
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SISTER M. X. KINNEY .................. Mercy Hospital, Bay City
SISTER M. XAVIER ................. 900 Woodward St., Pontiac
SKEEOCH, MARY E. .................. St. Luke’s Hospital, Marquette
SMITH, ELEANOR .................. Couzens Hall, Ann Arbor
SMITH, MABEL E.* ................. 200 Hollister Building, Lansing
STAHNNER, ELLA L. .................. Herman Kiefer Hospital, Detroit
STALEY, MARGARET E. ............. St. Joseph’s Mercy Hospital, Ann Arbor
STIVERSON, SUSAN L. ............. 1130 E. Huron St., Ann Arbor
SULLIVAN, DOROTHY E. ............. Bailly Nurses Home, Bay City
SWEET, LEONE .................. Sanitarium, Battle Creek
SYMBINGTON, GRETEL ................. 1465 Ferry Park Ave., Detroit
TABBERER, ADA ................. 215 Auburn Ave., Grand Rapids
TAYLOR, ERM a B. ............. Henry Ford Hospital, Detroit
THOMAS, GERTRUDE E. ........... 1632 N. Michigan Ave., Saginaw
THORPE, LULU V. ................. 1005 N. University, Ann Arbor
TIBBETTS, GRACE ................. Highland Park General Hospital, Highland Park
TOBIN, DOROTHY C.* ............... 1130 E. Huron, Ann Arbor
UDGAARD, MILDRED I. ............. Henry Ford Hospital, Detroit
WADDELL, ELIZABETH ................. Woman’s Hospital, Detroit
WALLACE, KATE M. ................. Detroit Tuberculosis Sanitarium, Detroit
WANZIE, MARIE J. ................. 1125 E. Huron St., Ann Arbor
WELLIAND, ISABELLE ................. 3740 John R. St., Detroit
WENZEL, ADELE C. ................. 5503 Lakepoint, Detroit
WOLF, ALETA .................. Harper Hospital, Detroit
WRIGHT, MARION J.* ............... 3740 John R. St., Detroit
YDSE, LAURA CAMILLA ................. Woman’s Hospital, Detroit
ZIEGLER, WILHELMINE H. ............ Hurley Hospital, Flint

‡ MINNESOTA—180 Members

ACKERMAN, ETHEL A. ................. Bethesda Hospital, St. Paul
AMASS, STELLA H. ................. Fergus Falls State Hospital, Fergus Falls
ANDERSON, ELLEN M. ............. 2508 Tenth Ave., S., Minneapolis
ANDERSON, FLORENCE B.* ......... General Hospital, Minneapolis
ANDERSON, VIVIAN* .................. Ancker Hospital, St. Paul
BAER, LUCILLE ................ General Hospital, Minneapolis
BAER, MAPLE A. St. John’s Hospital, St. Paul
BAUDIN, PHYLLIS M.* University Hospital, Minneapolis
BEARINGER, HATTIE V. 916 E. 15 St., Minneapolis
BENDZICK, BERNICE.* University Hospital, Minneapolis
BENSON, MARGARET E.* General Hospital, Minneapolis
BENTON, IRMA D.* University Hospital, Minneapolis
BERGH, INGER 1421 E. 24 St., Minneapolis
BILTZ, JULIA Ancker Hospital, St. Paul
BISSONNETTE, LAURENE E. 2500 Sixth St., S., Minneapolis
BLACK, IDA L. 2627 Chicago Ave., S., Minneapolis
BLANKENBILIER, HARRIET* 501 Washington Ave., S. E., Minneapolis
BREAMER, HELEN* Glen Lake Sanatorium, Oak Terrace
BROBAKKEN, MARGUERITE* General Hospital, Minneapolis
BUNNELL, LUCILE* General Hospital, Minneapolis
BURGGREN, HANNAH Swedish Hospital, Minneapolis
BURLINGAME, INEZ T.* General Hospital, Minneapolis
BURTZERIN, FULA B. 101 Millard Hall, U. of Minnesota, Minneapolis
CAMPBELL, JEAN H. St. Luke’s Hospital, St. Paul
CARLSRUD, GERTRUDE E. 500 Essex St., S. E., Minneapolis
CHILD, CLARA* General Hospital, Minneapolis
CORLISS, IONE University Hospital, Minneapolis
CORNELISEN, DORA M. 1602 Berkeley Ave., St. Paul
COUTIER, LULU M. 2 Second Ave., S. W., Rochester
Crisler, Louise* University Hospital, Minneapolis
DANIELSON, MARY 222 Earl St., St. Paul
DELMORE, MARJORIE Ancker Hospital, St. Paul
DENSFORD, KATHARINE J.* University Hospital, Minneapolis
DODDS, THELSA M. 120 W. Summit St., St. Paul
DOWD, ELEANOR* General Hospital, Minneapolis
DRAPER, LAURA A. 404 S. 8 St., Minneapolis
EHRENBERG, MURIEL L. General Hospital, Minneapolis
ELINSON, EMMA C. Glen Lake Sanatorium, Oak Terrace
ELMORE, CARLIE B. General Hospital, Minneapolis
ENGELSTAD, ELLA M.* General Hospital, Minneapolis
ENGLE, IRENE R. Kahler Hospital, Rochester
ERDMANN, LUCY J. 1717 First Ave., S., Minneapolis
ERICSON, ELFIE M. 501 W. Franklin St., Minneapolis
ERICSON, HAZEL* General Hospital, Minneapolis
ERVEN, MARGARET E. 1003 Ivy St., St. Paul
FELIEN, EDITH I.* University Hospital, Minneapolis
FESNEMEYER, IRMA* University Hospital, Minneapolis
FISCHER, EMMA A. General Hospital, Minneapolis
FLEMING, AGNES University Hospital, Minneapolis
FOWLE, MARY J. 1003 Ivy St., St. Paul
FREDERICK, PHILENA University Hospital, Minneapolis
FRIES, ALICE M. Ancker Hospital, St. Paul
FULLER, GENEVA* University Hospital, Minneapolis
GABRIELSON, HAZEL E. St. Luke’s Hospital, Duluth
GARTLEY, NORMA A.* General Hospital, Minneapolis
GERE, MARION E.* University Hospital, Minneapolis
GINTER, LENA St. Joseph’s Hospital, St. Paul
GIVEN, LEILA I. Kahler Hospital, Rochester
GOLDSMITH, ELLEN E. M.* General Hospital, Minneapolis
GOPLIN, ANNA S. R. D. 4, Zumbrota
GOUTEFOLD, BEULAH* 500 Essex St., S. E., Minneapolis
GRANT, Helen O. ........................................ 2406 Fremont Ave., S., Minneapolis

GRETHEN, Katherine .................................. Ancker Hospital, St. Paul

GUSTAFSON, Ruth ....................................... 200 Earl St., St. Paul

GYNILD, Ragna E. ...................................... Lutheran Deaconess Hospital, Minneapolis

HAGMAN, Olga ........................................ Bethesda Hospital, St. Paul

HAL, Dorothy R.* ..................................... Minneapolis General Hospital, Minneapolis

HALVORSEN, Leila ...................................... 619 State Office Building, St. Paul

HALVORSEN, Lucille M.* .................................. 500 Essex St., S. E., Minneapolis

Hauge, Cecelia H. ..................................... University Hospital, Minneapolis

HEIN, Sophia .......................................... 219 S. Lexington Ave., St. Paul

HEINZ, Marguerite* ................................... University Hospital, Minneapolis

HESTAD, Alice C.* ..................................... Children's Hospital, St. Paul

HIESSCHE, Hazelle A. ................................. St. Peter State Hospital, St. Peter

HODGKINS, Myrtle ..................................... Minneapolis General Hospital, Minneapolis

HUMMEL, Ida H. ........................................ Eitel Hospital, Minneapolis

IRVINE, Jane ............................................ University Hospital, Minneapolis

JOHNSON, Elsa Anna C. ................................. Ancker Hospital, St. Paul

JOHNSON, Mildred V.* .................................. General Hospital, Minneapolis

JOHNSON, Ruby* ........................................ Minneapolis General Hospital, Minneapolis

JOHNSON, Ruth D. ..................................... Minneapolis General Hospital, Minneapolis

JORGENSEN, HELEN* .................................. University Hospital, Minneapolis

 KING, Mary ............................................. Naeye Hospital, Albert Lea

KINSLER, Eva B.* ...................................... University Hospital, Minneapolis

KOELZER, Ethel M.* .................................. General Hospital, Minneapolis

KRUEGER, Caroline M. ................................. 222 Earl St., St. Paul

KURTZMAN, Dorothy S. ................................ University Hospital, Minneapolis

KUSCHEL, MABELLE* .................................. General Hospital, Minneapolis

LAPHAM, Nellie L.* ................................... Ancker Hospital, St. Paul

LARSEN, Frances E.* .................................. General Hospital, Minneapolis

LARSON, Mabel L. ...................................... General Hospital, Minneapolis

LINDGREN, Ruth C. .................................... University Hospital, Minneapolis

LOCKTON, Esther L.* .................................. General Hospital, Minneapolis

LOHOFENFELDER, Frieda M. ............................ St. John's Hospital, Red Wing

LUBBERTS, Etta ......................................... Ancker Hospital, St. Paul

LUCIER, Frances M. ..................................... Northwestern Hospital, Minneapolis

LUNDE, Bertha .......................................... Lutheran Deaconess Hospital, Minneapolis

MAYAL, Sadie S.* ..................................... 569 Grand Ave., St. Paul

McCARRICK, Evelyn S. ................................ Ancker Hospital, St. Paul

McDONALD, Ida M. ..................................... General Hospital, Minneapolis

McGREGOR, Margaret A. ............................... Gillette State Hospital, St. Paul

McKENNA, Helen C. .................................... St. Mary's Hospital, Minneapolis

MCNAUGHTON, Margaret A. ............................ 653 W. Wabasha St., Winona

MELBY, Sylvia M. ...................................... Fairview Hospital, Minneapolis

MIDTLEIN, Verna M.* .................................. University Hospital, Minneapolis

MILLER, Julia M.* ...................................... General Hospital, Minneapolis

MOCK, Eleanor F.* .................................... Ancker Hospital, St. Paul

MONAHAN, Dorothea P.* ............................... St. Mary's Hospital, Rochester

MONTAG, Mildred ........................................ University Hospital, Minneapolis

MORGAN, BLOOMWEN C.* ............................... Minneapolis General Hospital, Minneapolis

MUCKLEY, MARY M. .................................... 1100 Donaldson Building, Minneapolis

NAYSMITH, Sue T. ..................................... Glen Lake Sanatorium, Oak Terrace

NELSON, Alpha F.* .................................... General Hospital, Minneapolis

NELSON, Minnie I.* .................................... 712 S. 5 St., S., Minneapolis

NEWCOMBE, Louise ..................................... St. Luke's Hospital, Duluth

NIBBE, Margaret L. ................................... St. John's Hospital, Red Wing
NICOLL, FLORENCE T.  .  .  .  .  .  .  .  .  Ancker Hospital, St. Paul
OFFLEY, THELMA*  .  .  .  .  .  .  .  .  University Hospital, Minneapolis
OLSON, ALICE M.  .  .  .  .  .  .  .  .  Children's Hospital, St. Paul
OLSON, M. L YLA  .  .  .  .  .  .  .  .  Kahler Hospital, Rochester
OLSON, NELLIE*  .  .  .  .  .  .  .  .  General Hospital, Minneapolis
OLSTAD, MATTIE*  .  .  .  .  .  .  .  .  Ancker Hospital, St. Paul
ORDHAH, OLENA  .  .  .  .  .  .  .  .  1515 Charles St., St. Paul
PARISA, FLORENCE R.  .  .  .  .  .  .  .  . Minneapolis General Hospital, Minneapolis
PAULSON, MYRTLE V.  .  .  .  .  .  .  .  . St. Luke's Hospital, St. Paul
PEARSON, SIGNE*  .  .  .  .  .  .  .  .  General Hospital, Minneapolis
PETERSON, JULIA R.*  .  .  .  .  .  .  .  . General Hospital, Minneapolis
PETERSON, OLIVIA T.  .  .  .  .  .  .  .  . 15 Millard Hall, Minneapolis
PETRY, LUCILLE  .  .  .  .  .  .  .  .  University Hospital, Minneapolis
PETTCH, DOROTHY L.*  .  .  .  .  .  .  .  General Hospital, Minneapolis
PFEANER, LOTTIE J.  .  .  .  .  .  .  .  . Ancker Hospital, St. Paul
PFEFFER, CATHERINE M.  .  .  .  .  .  .  .  . 501 W. Franklin Ave., Minneapolis
POWER, ISABELLE A.  .  .  .  .  .  .  .  . General Hospital, Winona
RAMSEY, GUNDA*  .  .  .  .  .  .  .  .  General Hospital, Minneapolis
RANKIELLOUR, CAROLINE  .  .  .  .  .  .  .  . 2642 University Ave., St. Paul
RASMUSSON, ELLEN*  .  .  .  .  .  .  .  . General Hospital, Minneapolis
RAU, MAGDALENA  .  .  .  .  .  .  .  .  St. John's Hospital, St. Paul
REYNOLDS, ELIZABETH M.  .  .  .  .  .  .  .  Ancker Hospital, St. Paul
RHODES, M. DOROTHY**  .  .  .  .  .  .  .  . St. Barnabas Hospital, Minneapolis
RICHARDSON, JANICE M.*  .  .  .  .  .  .  .  University Hospital, Minneapolis
RINDE, GLADYS S.*  .  .  .  .  .  .  .  .  General Hospital, Minneapolis
ROBERTS, HAZEL A.*  .  .  .  .  .  .  .  . Glen Lake Sanatorium, Oak Terrace
SANDEN, LOUISE J.*  .  .  .  .  .  .  .  . General Hospital, Minneapolis
SANDS, MARY C.  .  .  .  .  .  .  .  .  .  .  . Ancker Hospital, St. Paul
SAUNDERS, LULU A.  .  .  .  .  .  .  .  . Kahler Hospital, Rochester
SCHAUER, ADELNE C.*  .  .  .  .  .  .  .  General Hospital, Minneapolis
SCHMIEBE, GLADYS E.  .  .  .  .  .  .  .  . 120 W. Summit, St. Paul
SEEMANN, MARCELLA*  .  .  .  .  .  .  .  . University Hospital, Minneapolis
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SISTER MARY VICTOR  .  .  .  .  .  .  .  . St. Mary's Hospital, Rochester
SKANSE, CATHARINE  .  .  .  .  .  .  .  . 4009 Park Ave., Minneapolis
SKOUHOLT, RUTH  .  .  .  .  .  .  .  .  . 14 and Willow Sts., Minneapolis
SMITKA, ELLA*  .  .  .  .  .  .  .  .  .  . University Hospital, Minneapolis
SOLOMON, HARRIE M.  .  .  .  .  .  .  .  . Ancker Hospital, St. Paul
SPRINGER, FLORENCE  .  .  .  .  .  .  .  . 1717 First Ave., S., Minneapolis
STARBUCK, MARGARET*  .  .  .  .  .  .  .  . University Hospital, Minneapolis
STENSETH, JEANETTE  .  .  .  .  .  .  .  . Glen Lake Sanatorium, Oak Terrace
STODDART, MARGARET F.  .  .  .  .  .  .  . Ancker Hospital, St. Paul
STROM, CHRISTINE D.  .  .  .  .  .  .  .  . Lakeview Memorial Hospital, Stillwater
STROM, MYRTLE*  .  .  .  .  .  .  .  .  .  . General Hospital, Minneapolis
TAYLOR, AGNES J.  .  .  .  .  .  .  .  .  .  . Ashbury Hospital, Minneapolis
TAYLOR, JEAN  .  .  .  .  .  .  .  .  .  .  .  . 702 Fourth St., S. E., Minneapolis
TERAVA, Freia* .................................. University Hospital, Minneapolis
TOFFE, Birgit .................................. Ancker Hospital, St. Paul
TRUDEL, Anne-Marie* ......................... Glen Lake Sanatorium, Oak Terrace
TURNER, Alice* .................................. 1805 15 Ave., S., Minneapolis
URCH, Daisy Dean** ............................ 619 State Office Building, St. Paul
WAAGEN, Louise ................................ University Hospital, Minneapolis
WILK, Merle M. .................................. 2640 Chicago Ave., S., Minneapolis
WILLIAMS, Donnie H. ........................... Gillette State Hospital, St. Paul
WILSON, Alice J. ................................ University Hospital, Minneapolis

MISSISSIPPI—11 Members

DORSEY, Mary E. .................................. King’s Daughters Hospital, Greenville
CHILD, Mary R. .................................. 106 E. Front St., Winona
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JONES, Berthe G.* ................................. Mississippi State Sanatorium, Sanatorium
KLEIN, Iva W. .................................. Meridian Sanitarium, Meridian
LORD, Kate Lou .................................. P. O. Box 525, Hattiesburg
MAY, Frances C. .................................. Mississippi State Sanatorium, Sanatorium
RICHARDSON, Mabel ............................ Field Memorial Hospital, Centreville
VARNAO, Maude E. ......................... Second Ave., Laurel
TATUM, Tama B. .................................. 121 N. President St., Jackson

‡MISSOURI—86 Members

BAYLESS, Cora A. .................................. General Hospital, Kansas City
BEATTIE, Mabel .................................. 3711 Bellefontain Ave., Kansas City
BENZ, Gladys* .................................. 416 S. Kingshighway, St. Louis
BISHOP, Almina T. ................................. 4915 W. Pine St., St. Louis
BOLLINGER, Mayme W. ........................... 216 S. Kingshighway, St. Louis
BRASE, Ella .................................. 6055 Waterman St., St. Louis
BRUEGEMANN, Elvera* ........................... 2646 Potomac St., St. Louis
BREEZE, Catharine ................................. 5535 Delmar Blvd., St. Louis
BRENNER, Frieda M. .............................. Lutheran Hospital, St. Louis
CARLSON, Anna .................................. General Hospital, Kansas City
CHURNEY, Julia .................................. 512 N. 7 St., Hannibal
COLEMAN, Clara A. .............................. 1515 Lafayette Ave., St. Louis
COLLINS, Marion ................................. Mercy Hospital, Kansas City
DACEY, Phyllis M. ................................. V. N. A., Kansas City
DAVIS, Jessie V. .................................. St. Luke’s Hospital, St. Louis
Dawson, Mary E. .................................. 1621 Grattan St., St. Louis
DERSCH, Esther H. ................................. Research Hospital, Kansas City
DESHLER, Frances ................................. St. John’s Hospital, St. Louis
DORAN, Ruth .................................. 416 S. Kingshighway, St. Louis
DURBIN, Mary N. ................................. 1515 Lafayette Ave., St. Louis
ELKINS, Amy Ledger ............................. University Hospital, Columbia
FARNWORTH, Helen ............................... 4420 Lloyd St., Kansas City
FLANAGAN, Jannett G. .......................... Mercy Hospital, Kansas City
FLOWERS, Pearl B. ............................... 305 S. 6 St., Columbia
FORD, Virginia E. ............................... 216 S. Kingshighway, St. Louis
FRAUEN, Grace .................................. 711 E. 54 Terrace, Kansas City
GARTISER, Louise ................................. 416 S. Kingshighway, St. Louis
HASLAM, Carolyn C. ............................ 5535 Delmar Blvd., St. Louis
HEISLER, Anna .................................. 416 S. Kingshighway, St. Louis
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>HELMKAMP, Talitha</td>
<td>2945 Lawton Rd., St. Louis</td>
</tr>
<tr>
<td>HOBLETZELLE, Lucy F.</td>
<td>416 S. Kingshighway, St. Louis</td>
</tr>
<tr>
<td>HOLLI, Grace</td>
<td>216 S. Kingshighway, St. Louis</td>
</tr>
<tr>
<td>HOTT, Ella</td>
<td>4924 Buckingham Court, St. Louis</td>
</tr>
<tr>
<td>INGRAM, Ruth</td>
<td>416 S. Kingshighway, St. Louis</td>
</tr>
<tr>
<td>KALLISTER, Letitia E.</td>
<td>5600 Arsenal St., St. Louis</td>
</tr>
<tr>
<td>KARSTENSEN, Huldah A.</td>
<td>Lutheran Hospital, St. Louis</td>
</tr>
<tr>
<td>KIELY, Theresa H.</td>
<td>305 S. Euclid Ave., St. Louis</td>
</tr>
<tr>
<td>KLEIN, Clara</td>
<td>Lutheran Hospital, St. Louis</td>
</tr>
<tr>
<td>LANDSKY, Frieda</td>
<td>Lutheran Hospital, St. Louis</td>
</tr>
<tr>
<td>LEONARD, Alta</td>
<td>1315 Lafayette St., St. Louis</td>
</tr>
<tr>
<td>Lindquist, Ada</td>
<td>Methodist Hospital, St. Joseph</td>
</tr>
<tr>
<td>LOVELAND, Hazel L.</td>
<td>General Hospital, Kansas City</td>
</tr>
<tr>
<td>LOWELL, Iva D.</td>
<td>4107 Locust St., Kansas City</td>
</tr>
<tr>
<td>MacKenzie, Margaret</td>
<td>5535 Delmar Blvd., St. Louis</td>
</tr>
<tr>
<td>Marrodick, Jewel</td>
<td>Lutheran Hospital, St. Louis</td>
</tr>
<tr>
<td>MARTIN, Helen A.</td>
<td>Mercy Hospital, Kansas City</td>
</tr>
<tr>
<td>MAULL, Alice P.</td>
<td>416 S. Kingshighway, St. Louis</td>
</tr>
<tr>
<td>MCKINLEY, Margaret</td>
<td>4543 Westminster Pl., St. Louis</td>
</tr>
<tr>
<td>McClaskie, Maude</td>
<td>Missouri Baptist Hospital, St. Louis</td>
</tr>
<tr>
<td>McCLELLAN, Rose A.</td>
<td>216 S. Kingshighway, St. Louis</td>
</tr>
<tr>
<td>Montgomery, Mable</td>
<td>2945 Lawton Blvd., St. Louis</td>
</tr>
<tr>
<td>Moore, Marjorie M.</td>
<td>416 S. Kingshighway, St. Louis</td>
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<tr>
<td>Mueller, Alma</td>
<td>Lutheran Hospital, St. Louis</td>
</tr>
<tr>
<td>Nahm, Helen</td>
<td>828 E. Eastwood, Marshall</td>
</tr>
<tr>
<td>OVER, Gladys</td>
<td>416 S. Kingshighway, St. Louis</td>
</tr>
<tr>
<td>Peterson, Hazel M.</td>
<td>1621 Grattan St., St. Louis</td>
</tr>
<tr>
<td>Pittman, Mary H.</td>
<td>4524 Forest Park Blvd., St. Louis</td>
</tr>
<tr>
<td>RAHE, Lela M.</td>
<td>708 W. 47 St., Kansas City</td>
</tr>
<tr>
<td>ROBSON, Emilie G.</td>
<td>2221 Locust St., St. Louis</td>
</tr>
<tr>
<td>Rounseville, Viola</td>
<td>216 S. Kingshighway, St. Louis</td>
</tr>
<tr>
<td>Sanderson, Mildred T.</td>
<td>5707 McPherson, St. Louis</td>
</tr>
<tr>
<td>Scrivner, Ruth S.</td>
<td>416 S. Kingshighway, St. Louis</td>
</tr>
<tr>
<td>Sister Beata M. Schiek</td>
<td>6150 Oakland St., St. Louis</td>
</tr>
<tr>
<td>Sister Hilda Mark</td>
<td>6150 Oakland St., St. Louis</td>
</tr>
<tr>
<td>Sister Margaret Keenan</td>
<td>St. Joseph's Hospital, St. Joseph</td>
</tr>
<tr>
<td>Sister Mary A. Brune</td>
<td>6420 Clayton Rd., St. Louis</td>
</tr>
<tr>
<td>Sister Mary A. Schmucki</td>
<td>St. Joseph's Hospital, Boonville</td>
</tr>
<tr>
<td>Sister Mary Brendan</td>
<td>305 S. Euclid St., St. Louis</td>
</tr>
<tr>
<td>Sister M. de C. Blakely</td>
<td>6420 Clayton Rd., St. Louis</td>
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<tr>
<td>Sister Mary G. Koechner</td>
<td>East Morgan, Boonville</td>
</tr>
<tr>
<td>Sister M. G. Phillips</td>
<td>St. Joseph's Hospital, Kansas City</td>
</tr>
<tr>
<td>Sister Rose Helene Vaughn</td>
<td>St. Joseph's Hospital, Kansas City</td>
</tr>
<tr>
<td>Smith, Madeleine</td>
<td>Research Hospital, Kansas City</td>
</tr>
<tr>
<td>Stephenson, Mary E.</td>
<td>5928 Maple Ave., St. Louis</td>
</tr>
<tr>
<td>Stewart, Myrtle F.</td>
<td>5535 Delmar Blvd., St. Louis</td>
</tr>
<tr>
<td>Trott, Lona</td>
<td>5512 Delmar Blvd., St. Louis</td>
</tr>
<tr>
<td>Vagnino, Edna E.</td>
<td>5820 Cabanne, St. Louis</td>
</tr>
<tr>
<td>Vaughan, Elsbeth H.</td>
<td>416 S. Kingshighway, St. Louis</td>
</tr>
<tr>
<td>Wall, Edna</td>
<td>Lutheran Hospital, St. Louis</td>
</tr>
<tr>
<td>Wegener, Esther H.</td>
<td>Research Hospital, Kansas City</td>
</tr>
<tr>
<td>Wegmann, Bertha L.</td>
<td>Bethesda Hospital, St. Louis</td>
</tr>
<tr>
<td>Williams, Edith</td>
<td>416 S. Kingshighway, St. Louis</td>
</tr>
<tr>
<td>Worrell, Dorothy</td>
<td>416 S. Kingshighway, St. Louis</td>
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<tr>
<td>Yenicek, Bertha O.</td>
<td>416 S. Kingshighway, St. Louis</td>
</tr>
</tbody>
</table>
MONTANA—15 Members

BANE, MONTA
Brown, Edith L.
Buckles, Gertrude
Cherry, Mary T.
Fagan, Lucille
Gobel, Marie C.
Linfeld, H. Grace
Martin, Mary E.
Sister Francis Xavier
Sister Gerard
Sister Mary Alexine
Sister M. Germaine Berlinger
Sister Mary Rita
Sister M. William
Witte, Regina A.

Bozeman Deaconess Hospital, Bozeman
Box 928, Helena
Deaconess Hospital, Billings
St. James' Hospital, Butte
Holy Rosary Hospital, Miles City
Montana Deaconess Hospital, Great Falls
Kennedy Deaconess Hospital, Havre
St. James' Hospital, Butte
St. Vincent Hospital, Billings
St. Joseph's Hospital, Lewistown
St. James' Hospital, Butte
Sacred Heart Hospital, Havre
St. John's Hospital, Helena
320 N. Jordan Ave., Miles City
St. Vincent Hospital, Billings

‡NEBRASKA—62 Members

Anderson, Irene O.
Baker, Ruth L.
Barker, Delsie F.
Breen, Mercedes M.
Burgess, Charlotte
Carlson, Elenore C.
Chamberlain, Helen E.
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Clarke, Florence
Collins, Anne M.
Cullenberg, Olga
Dean, Myrtle
DeLand, Fern
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Dunlap, Mary M.
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Hendrickson, Mary A.
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Jacobsen, Della
Krog, Dorothy
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Lindberg, Henrietta
Lundberg, Esther E.
MacDonald, Jessie L.
Martin, Carol L.
Meister, Cecelia

Immanuel Hospital, Omaha
Bryan Memorial Hospital, Lincoln
Methodist Hospital, Omaha
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University Hospital, Omaha
3706 N. 24 St., Omaha
Methodist Hospital, Omaha
Lord Lister Hospital, Omaha
University Hospital, Omaha
University Hospital, Omaha
Immanuel Hospital, Omaha
Bryan Memorial Hospital, Lincoln
Lincoln General Hospital, Lincoln
University Hospital, Omaha
Nicholas Senn Hospital, Omaha
216 N. 23 St., Omaha
Bryan Memorial Hospital, Lincoln
Bryan Memorial Hospital, Lincoln
3706 N. 24 St., Omaha
Lincoln General Hospital, Lincoln
Immanuel Hospital, Omaha
411 N. 40 St., Omaha
2100 Howard St., Omaha
Immanuel Hospital, Omaha
Immanuel Hospital, Omaha
Clarkson Memorial Hospital, Omaha
Evangelical Covenant Hospital, Omaha
Immanuel Hospital, Omaha
Clarkson Memorial Hospital, Omaha
Clarkson Memorial Hospital, Omaha
State House, Dept. Public Welfare, Lincoln
Clarkson Memorial Hospital, Omaha
MEMBERS

MILLER, AMELIA .......................... Mary Lanning Memorial Hospital, Hastings
MORTENSEN, DOROTHEA E. ................. Bryan Memorial Hospital, Lincoln
NELSON, FLORENCE I. ..................... 3706 N. 24 St., Omaha
OLSON, RUTH O. .......................... Evangelical Covenant Hospital, Omaha
PALMER, ESTHER M. ...................... University Hospital, Omaha
PENNEN, URSULA L. ....................... Mennonite Hospital, Beatrice
PETERSON, EDITH L ......................... 3706 N. 24 St., Omaha
PETERSON, EUNICE D. ..................... Immanuel Hospital, Omaha
RHOADES, CLARA ......................... Beatrice Sanitarium, Beatrice
ROBBINS, IVA ............................. Orthopedic Hospital, Lincoln
SAP, MYRTLE .............................. Evangelical Covenant Hospital, Omaha
SHAVER, JEANETTE ......................... Clarkson Memorial Hospital, Omaha
SHAFFER, ANNA M. ....................... Methodist Episcopal Hospital, Omaha
SISTER M. A. HATKE ....................... St. Elizabeth Hospital, Lincoln
SISTER M. JOHN O'CONNOR ................. St. Catherine's Hospital, Omaha
SISTER MARY K. CORCORAN .......... St. Catherine's Hospital, Omaha
SISTER M. LIVINA ......................... St. Joseph's Hospital, Omaha
SISTER M. LUDWIGA ........................ St. Francis' Hospital, Grand Island
SISTER MARY SCHOLASTICA ............... 3300 N. 60 St., Omaha
SISTER MYRTLE A. PETERSON .............. Immanuel Hospital, Omaha
SISTER OLIVE CULLENBERG** ............. Immanuel Hospital, Omaha
SISTER RUTH MORRIS ..................... Immanuel Hospital, Omaha
SMITHS, GLADYS G. ...................... Lincoln General Hospital, Lincoln
SOMMER, IDA B. ......................... Byran Memorial Hospital, Lincoln
STACK, KATHLEEN ......................... St. Francis' Hospital, Grand Island
STEEL, MARY E. ......................... Lincoln General Hospital, Lincoln
TORS, JESSIE ............................. St. Francis' Hospital, Grand Island
TOWNSEND, INA B. ....................... University Hospital, Omaha
TUCKER, MYRA ............................ University Hospital, Omaha
WALKER, MARY C. ......................... Lincoln General Hospital, Lincoln

†NEW HAMPSHIRE—42 Members

BACHMAN, MARGARET P. .................. St. Joseph's Hospital, Nashua
BATCHelder, CHARLOTTE ................. Portsmouth Hospital, Portsmouth
BREENE, DOROTHY ........................ 105 Pleasant St., Concord
CALLAHAN, BARBARA ..................... 29 Perley St., Concord
COREY, JESSIE R. ......................... Hilllsboro Hospital, Grasmere
CURTIS, ANNA S. .......................... Elliot Community Hospital, Keene
DENIO, BESSIE A. .......................... New Hampshire State Hospital, Concord
DUNSWORTH, A. MYRTLE ............... New Hampshire State Hospital, Concord
FULLER, HAZEL E. ........................ Elliot Hospital, Manchester
GORDON, RUBY J. ........................ Laconia Hospital, Laconia
GRIFFIN, ROSE E.** ...................... Mary Hitchcock Memorial Hospital, Hanover
GRIGGS, MARY H. ........................ New Hampshire State Hospital, Concord
KENNEALLY, C. MILDRED ............. New Hampshire Memorial Hospital, Concord
KNOWLES, FLORENCE M. ................. Portsmouth Hospital, Portsmouth
LARRABEE, M. GLADYS .................. Claremont General Hospital, Claremont
LOCKE, MABEL B. ........................ Laconia Hospital, Laconia
MACASKILL, CHRISTINE .................. Claremont General Hospital, Claremont
MACDONALD, CHARLOTTE C. .... State Board of Public Welfare, Concord
MCREEVY, KATHERINE ................... Laconia Hospital, Laconia
MESSER, JENNIE B. ....................... Balch Hospital for Children, Manchester
MESSER, MARY A. ........................ Balch Hospital for Children, Manchester
MOORE, ADDIE M. ....................... Hillsboro County Hospital, Grasmere
NICHOLL, SARAH S. ................ Exeter Hospital, Exeter
MILES, MAUD A.** ................ New Hampshire Memorial Hospital, Concord
O’DONOGHUE, ROSANNA .............. Portsmouth Hospital, Portsmouth
PRATT, THELMA A. ................ 105 Pleasant St., Concord
ROBERTS, HILDA C. ................ 26 Green St., Concord
SHORDON, ARDELIA L. .............. New Hampshire State Hospital, Concord
SIMPSON, FLORENCE W. .......... New Hampshire Memorial Hospital, Concord
SISTER EISSETTE .................. St. Louis Hospital, Berlin
SISTER GUY ........................ St. Joseph’s Hospital, Nashua
SISTER MARIE R. LARIVEE ......... Notre Dame Hospital, Manchester
SISTER M. BERNARDUS ............ Sacred Heart Hospital, Manchester
SISTER MARY DOLOROSA ......... Sacred Heart Hospital, Manchester
SISTER MARY VIRGINIA .......... Sacred Heart Hospital, Manchester
SMITH, HAZEL M. .................. New Hampshire State Hospital, Concord
THOMPSON, LOUISE H. ............ Elliot Community Hospital, Keene
VALENTINE, BELLE G. .......... New Hampshire State Hospital, Concord
VAN PELT, ALMA B. ............... Elliot Hospital, Manchester
WARK, DORIS M. ................... Claremont General Hospital, Claremont
WILDE, AMY ........................ New Hampshire State Hospital, Concord
WILLIAMS, LILLIAN G. ............ Laconia Hospital, Laconia

*NEW* JERSEY—190 Members

AHT, ERNESTINE M. ................ Newark City Hospital, Newark
AHLERS, CAROLINE C. ............. 220 Engle St., Englewood
ALLEN, MARGARET ................ Orange Memorial Hospital, Orange
ANDERSON, BERNICE E. .......... Mountainside Hospital, Montclair
APPLETON, GRACE G. .......... St. Mary’s Hospital, Hoboken
ASHMUN, MARGARET ............... Orange Memorial Hospital, Orange
ATKINSON, AUGUSTINA J. ....... Burlington County Hospital, Mt. Holly
AUSTIN, IDA F. ..................... 91 Prospect St., East Orange
AYRES, GERTRUDE E. .......... Margaret Hague Maternity Hospital, Jersey City
BAILEY, SARAH M. ............... Christ Hospital, Jersey City
BATES, GYDA ....................... New Jersey State Hospital, Greystone Park
BAUMANN, LYDIA ................... Orange Memorial Hospital, Orange
BEEHNER, CLARA .................. Women’s and Children’s Hospital, Newark
BENNETT, ISABEL ................. Somerset Hospital, Somerville
BERNUS, EMMA ..................... 88 Clifton Pl., Jersey City
BITZ, NAOMI ...................... Somerset Hospital, Somerville
BLACK, LYDIA A. ................ West Jersey Homeopathic Hospital, Camden
BLACKMAN, ABIGAIL ............... Bridgeton Public Schools, Bridgeton
BLAUVELT, MINNIE P. .......... Essex County Homeopathic Hospital, East Orange
BORDA, MAUDE R. ................. 313 High St., Millville
BOYD, EVELYN ..................... General Hospital, Passaic
BRIGGS, ETHELYN F. ............. Monmouth Memorial Hospital, Long Branch
BUCKLEY, THELMA M. .......... Memorial Hospital, Orange
BURNS, FLORENCE P. .......... The Babies’ Hospital, Newark
CADDY, EVA ....................... Hospital of St. Barnabas, Newark
CASPERSON, ELSIE ............... Atlantic City Hospital, Atlantic City
CAVANA, ANN C. .................. Monmouth Memorial Hospital, Long Branch
CLEVELAND, IDA T. ............... St. Francis’ Hospital, Jersey City
CODINGTON, MARTHA L. ......... Orange Memorial Hospital, Orange
CODY, MARY V. .................... Orange Memorial Hospital, Orange
COHEN, MARY E. .................. Greenville Hospital, Jersey City
COLE, ANNA I. ..................... 101 Wanaque Ave., Pompton Lakes
<table>
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<tr>
<th>Name</th>
<th>Address/Location</th>
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<td>IRELAND, MRS. R.</td>
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<td>JIMMERSO, EVA W.</td>
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<td>KEENER, ANNE</td>
<td>88 Clifton Pl., Jersey City</td>
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<td>KONRAD, CLARA M.</td>
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<td>LAUGHLIN, SADIE V.</td>
<td>1825 Boulevard, Jersey City</td>
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<td>LETENDRE, EVA L.</td>
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<td>LIGGETT, MABEL</td>
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<td>LONGCO, SARAH E.</td>
<td>Passaic General Hospital</td>
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<td>MACLAY, CATHERINE</td>
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<td>MILLER, SUSAN W.</td>
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<td>MOORE, ANNA J.</td>
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<td>POMEROY, EDNA B.</td>
<td>Middlesex General Hospital</td>
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<td>RANDOLPH, MARY W.</td>
<td>Memorial Hospital</td>
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<td>READ, RUTH C.</td>
<td>Orange Memorial Hospital</td>
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<td>REESE, ANNE E.</td>
<td>317 Franklin Pl., Plainfield</td>
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<td>ROBINSON, JEAN M.</td>
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<td>SCHMOKER, CAROLYN</td>
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Scott, Martha M.  
Seifert, Hettie W.  
Sister M. Dolores  
Sister Mary Dornic  
Sister M. Francesca  
Sister M. H. Joseph  
Sister M. Madeline  
Sister M. Paschal  
Sister Tarscia  
Smith, Bertha  
Smith, J. Winifred  
Smith, Victoria  
Souza, Marion  
Springsteen, Gladys A.  
Squarewood, Ida D.  
Stafford, Anna M.  
Stewart, Peggy Z.  
Stickler, Myrtle L.  
Stivers, Cora E.  
Swartz, Cora A.  
Sweeney, Ethel  
Tassie, Rebecca  
Thompson, Kathryn A.  
Thompson, Lilian M.  
Tianen, Ann  
Tilton, Hettie B.  
Torr-op, Hilda M.  
Twidale, Wilhelmina A.  
Van Brunt, Sarah J.  
Van Gelder, Sarah  
Vanholt, Margaret  
Vaughn, Nellie E.  
Wales, Frances L.  
Watson, Grace  
Weber, Laura M.  
Weller, Etta  
White, Barbara C.  
White, Lillian  
Whitney, Susie L.  
Wilson, Margaret S.  
Windish, Margaret L.  
Wood, Marion S.  
Wooders, Marie A.  
Wurts, Anne B.  
Yates, Ona B.  
Yoffa, Esther R.  
Yuckman, Mildred L.  
Zweiman, Adele  

‡ NEW YORK—553 Members

Abernethy, Ruth D.  
Ackley, Stella  
Adams, Estelle M.  
Adams, Margaret M.
<table>
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LENORTHY, Sara E. ............ 736 Irving Ave., Syracuse
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TETREAUl T, MARY V. 158 W. 12 St., New York
THOMAS, EDITH R. Jamaica Hospital, Richmond Hill
THOMAS, MURIEL L. P. O. Box 288, Riverhead, Long Island
THOMPSON, MARY B. Rockefeller Institute Hospital, New York
THUMM, HELEN M. Syracuse General Hospital, Syracuse
TIBBITTS, BESSIE B. 30 Grant St., Utica
TIHELKE, GERTRUDE E. 1 Kings County Hospital, Brooklyn
TITTMAN, ANNA L. 130 E. 22 St., New York
TOBIN, NORA 224 Alexander St., Rochester
TOUNDE, CLOVYS L. 161 N. Pearl St., Albany
TOWSEND, LELIN B. 700 W. 168 St., New York
TREIBER, MARGERY G. 1320 York Ave., New York
UNWIN, FLORANCE R. Brooklyn State Hospital, Brooklyn
VALE, EMILY A. 567 Prospect Pl., Brooklyn
VANDERBILT, FLORENCE N. 179 Fort Washington Ave., New York
VANHEKLE, INA R. 141 W. 109 St., New York
VESLEY, JULIA Lenox Hill Hospital, New York
WABERSICH, ROSE Lenox Hill Hospital, New York
WALES, MARGUERITE A. 99 Park Ave., New York
WALKER, KATHERYN N. Greenpoint Hospital, Brooklyn
WARCHTER, MARGARET E. 610 W. 165 St., New York
WARREN, A. GRACE 5 E. 98 St., New York
WARRANT, CORA 130 Spring St., Rochester
WATKINS, LOUISE C. Babies' Hospital, New York
WEDDGE, DOROTHY 426 E. 26 St., New York
WEIGEL, ELNORA 450 E. 64 St., New York
WELLS, MARGARET 622 W. 168 St., New York
WELLS, MARION H. Faxton Hospital, Utica
WEST, BEatrice M. Rochester General Hospital, Rochester
WESTON, ALICE A. Highland Hospital, Rochester
WHALEN, MARY K. 511 New York Ave., Ogdensburg
WHEELER, CLARIBEL A. 50 W. 50 St., New York
WHITE, JEAN M. Mount Vernon Hospital, Mount Vernon
WHITTERM, HAZEL B. Hospital of the Good Shepherd, Syracuse
WIEDENBACH, ERNESTINE 50 W. 20 St., New York
Wiencko, Viola A. Coney Island Hospital, Brooklyn
Wilcox, Elizabeth 735 W. 172 St., New York
WILDE, DELPHINE 3312 Giles Pl., New York
WILES, RUTH A. Amsterdam Hospital, Amsterdam
WILLIAMS, HARRIET L. Lenox Hill Hospital, New York
WILLIAMS, RUTH C. 635 W. 165 St., New York
WILSON, E. GENEVIEVE** Ellis Hospital, Schenectady
WILSON, FLORENCE K. 1320 York Ave., New York
WILSON, OTILIE T. 454 Riverside Dr., New York
WILSON, TRUE* Roosevelt Hospital, New York
WILSON, VIVIAN D. Draper Hall, Welfare Island
WITHAM, EDNA N. Willard Parker Hospital, New York
WITTE, FRANCES W. Rockland State Hospital, Orangeburg
WOLF, ANNA D.* 525 E. 68 St., New York
WOLPERT, FLORA M. Flower Hospital, New York
WOOD, GERTRUDE S. Nassau Hospital, Mineola, L. I.
WOOD, RUTH B. Methodist Hospital, Brooklyn
WOODFALL, RUTH E. 1320 York Ave., New York
WYATT, MARGARET E. 1320 York Ave., New York
YOUNG, EILEEN M. Nassau Hospital, Mineola, L. I.
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>YOUNG, FRANCES L.</td>
<td>219 Bryant St., Buffalo</td>
</tr>
<tr>
<td>YOUNG, HELEN**</td>
<td>179 Fort Washington Avenue, New York</td>
</tr>
<tr>
<td>YOUNG, KATHLEEN F.</td>
<td>New Rochelle Hospital, New Rochelle</td>
</tr>
<tr>
<td>ZABRISKIE, LOUISE</td>
<td>599 First Ave., New York</td>
</tr>
<tr>
<td>ZACHARI, ANNA A.</td>
<td>Lenox Hill Hospital, New York</td>
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**NORTH CAROLINA—37 Members**

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<tr>
<th>Name</th>
<th>Hospital</th>
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<tbody>
<tr>
<td>BAKER, BESSIE</td>
<td>Duke Hospital, Durham</td>
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<tr>
<td>BROWNSBERGER, ELSIE</td>
<td>Mountain Sanitarium and Hospital, Fletcher</td>
</tr>
<tr>
<td>CHAPMAN, BESSIE M.</td>
<td>Box 1588, Greensboro</td>
</tr>
<tr>
<td>CLOMBORNE, FRANCES R.</td>
<td>Park View Hospital, Rocky Mount</td>
</tr>
<tr>
<td>CLARY, MINNIE</td>
<td>St. Peter’s Hospital, Charlotte</td>
</tr>
<tr>
<td>CRAWFORD, ANNIE L.</td>
<td>Highland Hospital, Asheville</td>
</tr>
<tr>
<td>DICKHUT, HULDA-G.</td>
<td>City Memorial Hospital, Winston-Salem</td>
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<tr>
<td>FISHER, LELA G.</td>
<td>Memorial Hospital, Reidsville</td>
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<td>FULP, ORA L.</td>
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<td>GUFFIN, LOUISE R.</td>
<td>Appalachian Hall, Asheville</td>
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<td>HEINZELING, EDNA L.</td>
<td>Baptist Hospital, Winston-Salem</td>
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<tr>
<td>HERNDON, KATE</td>
<td>Baker Sanatorium, Lumberton</td>
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<td>HILL, ELIZABETH</td>
<td>Davis Hospital, Statesville</td>
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<td>HOFSTETTER, AUGUSTA C.</td>
<td>Duke Nurses Home, Durham</td>
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<td>JOHNSON, HAZEL I.</td>
<td>Burrus Memorial Hospital, High Point</td>
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<td>JOHNSON, MARY L.</td>
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<td>KELLEY, E. A.*</td>
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<td>LAWLOR, NANCY L.</td>
<td>Watts Hospital, Durham</td>
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<td>MACNICHOLS, ELLA H.</td>
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<td>MARSHBANKS, FUCHSIA V.</td>
<td>Rex Hospital, Raleigh</td>
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<td>MCKAY, VIRGINIA O.</td>
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<td>MUSE, GILBERT</td>
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<td>NEWMAN, MARTHA C.</td>
<td>North Carolina Sanitarium, Sanatorium</td>
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<td>PERRY, ADELAIDE M.</td>
<td>Mission Hospital, Asheville</td>
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<td>REDWINE, EDITH M.</td>
<td>Grace Hospital, Banners Elk</td>
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<td>REINHARDT, HETTIE</td>
<td>N. C. Baptist Hospital, Winston-Salem</td>
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<td>SCHLECHTER, CLARA K.</td>
<td>Davis Hospital, Statesville</td>
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<tr>
<td>SCHULKEN, ALICE K.</td>
<td>Box 713, Durham</td>
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<tr>
<td>SISTER M. ANASTASIA BERGIN</td>
<td>Mercy Hospital, Charlotte</td>
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<tr>
<td>SLEDGE, MARION G.</td>
<td>St. Luke’s Hospital, New Bern</td>
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<td>STEPHENS, ELEANOR M.</td>
<td>James Walker Hospital, Wilmington</td>
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<td>WEST, LULA</td>
<td>Mt. Airy</td>
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<td>WILLIAMS, HAZEL</td>
<td>St. Peter’s Hospital, Charlotte</td>
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<td>WOODALL, CLIDA L.</td>
<td>Rex Hospital, Raleigh</td>
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<td>WOODRY, EFFIE M.</td>
<td>Taylor Hospital, Washington</td>
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<td>WORRALL, FRANCES A.</td>
<td>St. Agnes Hospital, Raleigh</td>
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**NORTH DAKOTA—12 Members**

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<td>BUZELL, PAULINE</td>
<td>Bismarck Hospital, Bismarck</td>
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<td>CLARK, MILDRED</td>
<td>General Hospital, Devils Lake</td>
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<tr>
<td>HERTSGAARD, MABEL O.</td>
<td>St. Luke’s Hospital, Fargo</td>
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<tr>
<td>KNOX, ADA</td>
<td>610 13 St., Fargo</td>
</tr>
<tr>
<td>KOENEMAN, GERTRUDE A.</td>
<td>St. Luke’s Hospital, Fargo</td>
</tr>
<tr>
<td>ODDEN, DELIA</td>
<td>Trinity Hospital, Minot</td>
</tr>
<tr>
<td>PAULSON, LUCILLE V.</td>
<td>Deaconess Hospital, Grand Forks</td>
</tr>
</tbody>
</table>
MEMBERS

SHEAFFER, SUSAN V. ................. Bismarck Hospital, Bismarck
SISTER MARY EVELYN .............. St. Joseph’s Hospital, Minot
SISTER MAXIMINE FIRMER .......... St. Alexius Hospital, Bismarck
SKEIM, ANNA R. .................. 1043 Hill Ave., Grafton
STENNES, JOSEPHINE ............. Good Samaritan Hospital Ass’n, Rugby

OHIO—128 Members

AGERTER, CARLOTTA H. .......... 2057 Adelbert Rd., Cleveland
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ANDREWS, FERN ................. Grant Hospital, Columbus
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BELGER, ANNE S.* ............ 1812 E. 105 St., Cleveland
BENDEROFF, OLGA ............ 1830 E. 97 St., Cleveland
BOAL, MARGARET I.* .......... City Hospital, Springfield
BORGEE, GLADYS H. ............ City Hospital, East Liverpool
BOWER, IRENE ................ 2063 Adelbert Rd., Cleveland
BOYD, MARY E. ............... City Hospital, East Liverpool
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BROUSE, CLARA F. .......... 21 W. Broad St., Columbus
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CARLSAN, RUBIE M.* .......... 1812 E. 105 St., Cleveland
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ERWIN, E. J. ................. 39 Arch St., Akron
EWING, NAM H. .............. The Toledo Hospital, Toledo
EVANS, RUTH ............... 2058 Abingdon Rd., Cleveland
FADDIS, MARGENE O. .... Lakeside Hospital, Cleveland
FAVILLE, KATHARINE E. .. 2065 Adelbert Rd., Cleveland
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HOUSE, DOROTHY E. .......... 2015 E. 115 St., Cleveland
HOWELL, MARION G.*** .......... 2063 Adelbert Rd., Cleveland
HUBBARD, ELIZABETH B. .......... 39 Arch St., Akron
JANSON, EVA E. ............... 690 Euclaire Ave., Bexley
KAHL, RUTH .................. Box 214, Hiram
KELLEY, H. MARIE ............ 2065 Adelbert Rd., Cleveland
KELLEY, IRENE V. ............ 1418 W. 80 St., Cleveland
KEMPFF, FLORENCE C. ......... 2065 Adelbert Rd., Cleveland
KLOTZ, RUTH M. .............. Grant Hospital School, Columbus
KOCH, ESTELLE C. .......... Cleveland City Hospital, Cleveland
LAWSON, KATHERINE E. ..... 1812 E. 105 St., Cleveland
LEADER, HELEN* ............. Christ Hospital, Cincinnati
LENZ, MARY B. .............. 3409 Woodland Ave., Cleveland
LEVERING, NINA M. .......... 2058 Abington Rd., Cleveland
LOHMAN, E. LAURA .......... 11311 Shaker Blvd., Cleveland
MARGERUM, MARY L ........... Fostoria City Hospital, Fostoria
MARTIN, HELEN G. .......... Ohio Valley Hospital, Steubenville
MASON, LIDA M.* ............. 1803 Valentine Ave., Cleveland
MASON, MARIAN C.*** ....... The Deaconess Hospital, Cincinnati
MCLELLAND, MILDRED J. .... 1800 E. 105 St., Cleveland
MCCLYMON, RUTH I. ......... The Children's Hospital, Cincinnati
MC COMAS, LUella N. ......... Youngstown Hospital Association, Youngstown
MC COWN, VIANA .............. 3259 Elland Ave., Cincinnati
MC DONEL, HELEN M .......... 11100 Euclid Ave., Cleveland
MC NEIT, ESTA H. .......... City Hospital, Cleveland
MEARS, MARY E.* .......... 11100 Euclid Ave., Cleveland
MEEKER, VERA J. .......... St. Luke's Hospital, Cleveland
MULEN, MARGARET G. ....... City Hospital, East Liverpool
MUNZ, MARIE T.* ............. 1812 E. 105 St., Cleveland
NAJEM, ALICE M. .......... City Hospital, East Liverpool
NEAMAN, MARY Z. .......... Fort Hamilton Hospital, Hamilton
NICHOLS, GLADYS L. ......... White Cross Hospital, Columbus
ODEGARD, ETHEL J. ......... The Miami Valley Hospital, Dayton
OFFENBACHER, HAZEL ......... 1812 E. 105 St., Cleveland
OSTLIE, SOPHIE L ............ 39 Arch St., Akron
PARKS, NELLIE S. .......... Western Reserve University, Cleveland
PERKINS, RUTH A. .......... University Hospital, Columbus
PINGEL, MARTHA M. ......... Coshocton City Hospital, Coshocton
PORTER, HELEN .............. 98 Buttes Ave., Columbus
READ, RUTH A. .............. 98 Buttes Ave., Columbus
REBER, ANNA A. ............. 2085 Cornell Rd., Cleveland
REILLY, MARGARET M ......... Starling-Loving Hospital, Columbus
REIN, HELEN ................. 124 Front St., Ripley
REINECK, IRMA M. .......... 1263 Jackson Ave., Lakewood
ROBINSON, A. ELIZABETH .... Rainbow Hospital, South Euclid
ROSNAIGLE, LAURA E. ....... General Hospital, Cincinnati
SCHRAITZ, HILDA T. ......... St. Thomas Hospital, Akron
SCHREPEL, MARY A. .......... Grant Hospital, Columbus
SELFE, MABEL F. .......... St. Luke's Hospital, Cleveland
SETTLE, NELL B. ............ City Hospital, East Liverpool
SHANK, HELEN ............... 21 W. Broad St., Columbus
SISTER ADELAIDE .......... Good Samaritan Hospital, Cincinnati
SISTER ANDREW HANLON ... Good Samaritan Hospital, Cincinnati
SISTER DE CARY ............. St. Vincent's Hospital, Toledo
SISTER DE CHANTAL .......... Good Samaritan Hospital, Cincinnati
SISTER EMMANUEL .......... St. Mary's Hospital, Cincinnati
SISTER FLORENCE M. KREKELER ... Good Samaritan Hospital, Dayton
SISTER MARGARET KENNEDY .......... Good Samaritan Hospital, Cincinnati
SISTER M. ALICE .................. 3409 Woodland Ave., Cleveland
SISTER M. ALVERA................ 5305 McBride Ave., Cleveland
SISTER M. CARMELA .............. St. Thomas Hospital, Akron
SISTER MARY E. BAILEY .......... Mercy Hospital, Canton
SISTER MARY ELVA ............... 7911 Detroit Ave., Cleveland
SISTER MARY G. BARRY .......... Mercy Hospital, Hamilton
SISTER M. GERMAINE .......... 1044 Belmont Ave., Youngstown
SISTER MINALIA HARRIGAN ....... St. Elizabeth Hospital, Dayton
SISTER VICTORIA CLARE FREDRICK .. Good Samaritan Hospital, Cincinnati
SITLER, DISA W. .................. 1800 E. 105 St., Cleveland
SNIDER, IDA .................... Toledo Hospital, Toledo
SPECHT, FLORENCE A. .......... Lakewood City Hospital, Lakewood
STAHL, ADELE G. ................. 1446 E. 110 St., Cleveland
STEINER, MARY J.* .......... 11100 Euclid Ave., Cleveland
STEWART, HELEN F. .......... 3131 Coleridge Rd., Cleveland Heights
SZANTI, GISELLA C. ............. 267 Klotter Ave., Cincinnati
TOMLINSON, ELINOR V. .......... Cincinnati General Hospital, Cincinnati
TROUPE, KATHERINE E. .......... 11311 Shaker Blvd., Cleveland
TUNSTEAD, EDITH ............... 3305 Franklin Ave., Cleveland
UPHAM, ECHO K. .................. Children's Hospital, Cincinnati
WALLINGER, EL vie M. .......... Children's Hospital, Cincinnati
WALN, CLARA E. ................ 1468 W. 117 St., Cleveland
WEBSTER, KATHERINE .......... 1800 E. 105 St., Cleveland
WHITEMAN, DORIS ............... R. R. 4, Napoleon
YOUNG, LENORE B. ............. Women's and Children's Hospital, Toledo
ZEBACH, VIOLA .................. City Hospital, East Liverpool

**OKLAHOMA—23 Members**

BIDDLE, JESSIE A. ............... 1101 E. 12 St., Oklahoma City
CLARK, MARY L. ................. 510 Medical Arts Building, Oklahoma City
DEVINE, MARY M. ............... 518 Baltimore, Muskogee
DREIS, JULIA M. ............... St. John's Hospital, Tulsa
EDMONDS, RUTH S. .......... Fargo
ELLEDGE, ALLIE L. .......... Wesley Hospital, Oklahoma City
HOCK, MARGARET M. ........ Kiowa Indian Hospital, Lawton
HYDER, BRYAN, MRS. .......... 899 Court St., Clinton
KERR, RUTH S. ................. 518 Baltimore, Muskogee
LESSLEY, GEORGIA E. .......... Muskogee General Hospital, Muskogee
LINVILLE, CLO I. ............. Wesley Hospital, Oklahoma City
ROCKEFELLER, EDNA M. ....... Muskogee General Hospital, Muskogee
SHICK, LORA MCD. .......... Holdenville Hospital, Holdenville
SISTER M. GRATIANA** ........... St. John's Hospital, Tulsa
SISTER M. GREGORY .......... Ponca City Hospital, Ponca City
SISTER MARY MARGARET ....... St. Anthony Hospital, Oklahoma City
SISTER M. MONICA ............. St. Anthony Hospital, Oklahoma City
SISTER MARY PANCRATIA .... St. Anthony Hospital, Oklahoma City
SLIEF, GOLDA B. ............. 717 Culbertson Dr., Oklahoma City
STRONG, WILLIAMINA H. ...... Wesley Hospital, Oklahoma City
TRIPLETT, EDDYTHE S. ....... State University Hospital, Oklahoma City
TUCK, HAZEL C. ............ Oklahoma General Hospital, Oklahoma City
WATKINS, EULA M. .......... City Hospital, Okmulgee
### OREGON—50 Members

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>BAILLIE, GERTRUDE J.</td>
<td>726 Northrup St., Portland</td>
</tr>
<tr>
<td>BALSER, MARY A.</td>
<td>Box 1035, Roseburg</td>
</tr>
<tr>
<td>CAMPBELL, MARY C.</td>
<td>1001 Public Service Building, Portland</td>
</tr>
<tr>
<td>CLIFF, LOUISE H.</td>
<td>1214 N. E. 37 Ave., Portland</td>
</tr>
<tr>
<td>CROWE, MARION G.</td>
<td>Visiting Nurse Association, Portland</td>
</tr>
<tr>
<td>EGGERS, JOHANNA</td>
<td>University of Oregon Medical School, Portland</td>
</tr>
<tr>
<td>EICKMAN, LINDA A.</td>
<td>Multnomah County Hospital, Portland</td>
</tr>
<tr>
<td>GAVIN, JANE D.</td>
<td>305 Stevens Building, Portland</td>
</tr>
<tr>
<td>GILL, ERNESTINE</td>
<td>636 S. E. 60 Ave., Portland</td>
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<tr>
<td>HUMPHREY, LETHA</td>
<td>Shriners Hospital, Portland</td>
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<td>JONES, EMMA E.</td>
<td>Multnomah County Hospital, Portland</td>
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<tr>
<td>KIDD, GENEVIEVE E.</td>
<td>614 Medical Arts Building, Portland</td>
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<td>LARSEN, CHRISTINE A.</td>
<td>Good Samaritan Hospital, Portland</td>
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<tr>
<td>LEE, BERNICE M.</td>
<td>Salem General Hospital, Salem</td>
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<tr>
<td>LOVEIDGE, EMILY L.</td>
<td>1312 N. E. Hancock St., Portland</td>
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<td>MARLON, VIRGINIA E.</td>
<td>St. Mary’s Hospital, Astoria</td>
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<td>MCDONALD, LILLIAN M.</td>
<td>Salem General Hospital, Salem</td>
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<td>MOFFATT, AGNES T.</td>
<td>R. F. D. 5, Box 41, Portland</td>
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<td>OSBORN, HARRIETT E.</td>
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<td>PHELPS, GRACE</td>
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<td>RICHTER, ROBERTA</td>
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<td>SISTER GENEVIEVE</td>
<td>St. Vincent’s Hospital, Portland</td>
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<td>SISTER ZEPHRIN</td>
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<td>THOMSON, Elnora E.</td>
<td>814 Oregon Building, Portland</td>
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<td>VAN SCHUYVER, MARGARET K.</td>
<td>Multnomah County Hospital, Portland</td>
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<td>VREELAND, JOHANNA R.</td>
<td>2475 N. W. Westover Rd., Portland</td>
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<td>WHEELOCK, RUTH V.</td>
<td>University of Oregon Medical School, Portland</td>
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<td>WILSON, BERTHA G.</td>
<td>2266 N. W. Marshall St., Portland</td>
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<tr>
<td>YOUNG, PAULINE</td>
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### PENNSYLVANIA—346 Members

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<tr>
<td>AMMERMAN, CATHERINE F.</td>
<td>Altoona Hospital, Altoona</td>
</tr>
<tr>
<td>ANDERSON, INEZ M.</td>
<td>Eagleville Sanatorium, Eagleville</td>
</tr>
<tr>
<td>ANSPACH, ETHEL G.</td>
<td>Reading Hospital, Reading</td>
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<tr>
<td>ANTROBUS, EDNA M.</td>
<td>53 W. Bryn Mawr Ave., Lansdowne</td>
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<tr>
<td>AUL, HARRIET L.</td>
<td>State Hospital, Danville</td>
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<tr>
<td>BALLAMY, EMMA S.</td>
<td>Wilkes-Barre General Hospital, Wilkes-Barre</td>
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<tr>
<td>BARBER, SEGRID</td>
<td>Woman’s Medical College Hospital, East Falls, Philadelphia</td>
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<tr>
<td>BARNETT, NELLIE A.</td>
<td>George F. Geisinger Memorial Hospital, Danville</td>
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<tr>
<td>BARRON, MABEL A.</td>
<td>Western Pennsylvania Hospital, Pittsburgh</td>
</tr>
<tr>
<td>BARTLETT, CLARA</td>
<td>320 S. 34 St., Philadelphia</td>
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<td>BARTON, CLARA T.</td>
<td>Philadelphia General Hospital, Philadelphia</td>
</tr>
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<td>BAUMAN, CHARLOTTE L.</td>
<td>Reading Hospital, Reading</td>
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<td>BAUMANN, KATHERINE</td>
<td>Eye and Ear Hospital, Pittsburgh</td>
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<tr>
<td>BAYER, OLIVE M.</td>
<td>Altoona Hospital, Altoona</td>
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<td>BEAMISH, GRACE E.</td>
<td>Hamot Hospital, Erie</td>
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<td>BEARDSLEY, CATHERINE</td>
<td>Jewish Hospital, Philadelphia</td>
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<tr>
<td>BEARE, MARY</td>
<td>C. H. Buhl Hospital, Sharon</td>
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<td>BECK, ALMA E.</td>
<td>722 Pawnee St., Bethlehem</td>
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<tr>
<td>BEHMAN, ANNA B.</td>
<td>Protestant Episcopal Hospital, Philadelphia</td>
</tr>
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<td>BELL, PEARL</td>
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<td>Porter, Elizabeth K.</td>
<td>Western Pennsylvania Hospital, Pittsburgh</td>
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<td>Pratt, Helen</td>
<td>Valley Hospital, Sewickley</td>
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<td>Pritchard, Dorothy A.</td>
<td>Presbyterian Hospital, Pittsburgh</td>
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<td>Purdy, Frances I.</td>
<td>State Hospital, Hazleton</td>
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<td>Quigg, Henrietta Y.</td>
<td>Pittsburgh City Home and Hospitals, Mayview</td>
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<td>Quivvy, Lena</td>
<td>Sewickley Valley Hospital, Sewickley</td>
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<td>Reed, M. Elizabeth</td>
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<td>Reeser, Dorothy M.</td>
<td>Polyclinic Hospital, Harrisburg</td>
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<td>Reichert, Wilhelmine</td>
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<td>Western Pennsylvania Hospital, Pittsburgh</td>
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<td>Rittmann, Katharine G.</td>
<td>Lankenau Hospital, Philadelphia</td>
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<td>Roberts, Pauline</td>
<td>Women's Medical College Hospital, Philadelphia</td>
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<td>ROSE, GENEVIEVE C.</td>
<td>Western Pennsylvania Hospital, Pittsburgh</td>
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<td>ROSS, ELIZABETH B.</td>
<td>Graduate Hospital, University of Pennsylvania, Philadelphia</td>
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<tr>
<td>ROWAN, KATHLEEN</td>
<td>Bryn Mawr Hospital, Bryn Mawr</td>
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<td>RUTHMILLER, BETTY C.</td>
<td>Western Pennsylvania Hospital, Pittsburgh</td>
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<td>SACHS, ELIZABETH J.</td>
<td>Children's Hospital, Pittsburgh</td>
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<td>SAVILLE, JUDITH</td>
<td>Palmerston Hospital, Palmerston</td>
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<td>SCHEIRER, LYDIA M.</td>
<td>Presbyterian Hospital, Philadelphia</td>
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<td>SCHROCK, KATHERINE N.</td>
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<td>SCOTT, ELIZABETH H.</td>
<td>University of Pennsylvania Hospital, Philadelphia</td>
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<td>SHANK, DORA F.</td>
<td>Mt. Sinai Hospital, Philadelphia</td>
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<td>SHELENGER, MILDRED H.</td>
<td>Presbyterian Hospital, Philadelphia</td>
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<td>SHERER, JULIA S.</td>
<td>Easton Hospital, Easton</td>
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<td>SHERRICK, ELLEN</td>
<td>Homeopathic Hospital, Pittsburgh</td>
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<td>SHIELDS, ALLETA</td>
<td>St. Christopher's Hospital for Children, Philadelphia</td>
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<td>SHIELDS, THERESA E.</td>
<td>Miners' Hospital, Spangler</td>
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<td>SHOEMAKER, NORA E.</td>
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<td>SHUPP, ANNA E.</td>
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<td>SISTER ANNA MARIE</td>
<td>Mercy Hospital, Pittsburgh</td>
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<td>SISTER DOLORES MARY</td>
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<td>SISTER EDITH E. BUBE</td>
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<td>SISTER M. PLACIDE MCCOGY</td>
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<td>SKOOGlund, CHARLOTTE S.</td>
<td>Philadelphia General Hospital, Philadelphia</td>
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<td>SMITH, BLANCHE R.</td>
<td>Abington Hospital, Abington</td>
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<td>SMITH, EMMA A.</td>
<td>Magee Hospital, Pittsburgh</td>
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<td>SMITH, ETHEL R.</td>
<td>Philadelphia General Hospital, Philadelphia</td>
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<td>SMITH, EUNICE E.</td>
<td>St. Luke's Hospital, Bethlehem</td>
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<td>SMITH, MILDRED E.</td>
<td>Allentown Hospital, Allentown</td>
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SMITH, SARAH H. ................. Moses Taylor Hospital, Scranton
SMITIEN, FLORENCE E. .......... 3065 Delwood Ave., Station 16, Pittsburgh
SNEIDEL, LIDA .................. Lankenau Hospital, Philadelphia
SNYDER, E. MILDRED ........... St. Christopher’s Hospital, Philadelphia
SNYDER, LOUISE M. .................. 360 Education Building, Harrisburg
SPARKS, MARY E. .................. 637 Valley View Head, Ardmore
SPARGO, BEATRICE C. .......... Geisinger Memorial Hospital, Danville
STEEL, CLARA B. ............... Homeopathic Hospital, Pittsburgh
STEHMAN, MARY E. .............. University of Pennsylvania Hospital, Philadelphia
STEVENN, HELEN V. ............. 15 Fernando St., Pittsburgh
STEWARD, ALICE E. ............. C/O Tuberculosis League, Pittsburgh
STEWART, ALICE E. ............. 15 Fernando St., Pittsburgh
STEWLE, MARY O. .................. Uniontown Hospital, Uniontown
STOCKFORD, EMILY M. .......... Presbyterian Hospital, Pittsburgh
STONER, BESS V. .................. South Side Hospital, Pittsburgh
SUTHERLAND, GERTRUDE ........ Western Pennsylvania Hospital, Pittsburgh
TINSLEY, ESTHER J. ............. Pittston Hospital, Pittston
TOBIN, MARY W. .............. Duquesne University, Pittsburgh
TOMBLE, MARY J. ............... St. Luke’s Hospital, Bethlehem
TROXELL, ALMA M. .............. Washington Hospital, Washington
TRUNK, ALBERTA P. ............. Warren State Hospital, Warren
TUCKER, KATHARINE .......... Department of Nursing Education, University of Pennsylvania, Philadelphia
UBQUIART, JESSIE G. .......... Jewish Hospital, Philadelphia
VAUGHN, DOROTHY M. .......... Presbyterian Hospital, Pittsburgh
VICHUER, GUSIE E. .............. Presbyterian Hospital, Philadelphia
WAGNER, SARA P. .............. Presbyterian Hospital, Philadelphia
WALKERFIELD, EVA L. .......... Presbyterian Hospital, Philadelphia
WALKER, E. MAE .................. 320 S. 34th St., Philadelphia
WALTON, KATIE L. .............. Philadelphia General Hospital, Philadelphia
WARD, ELIZA G. .................. 5000 Woodland Ave., Philadelphia
WARMBROAT, BERTHA .......... Homeopathic Hospital, Pittsburgh
WELSPH, MARGARET A. .......... State Hospital, Danville
WENK, ELIZABETH F. .......... Ashland State Hospital, Ashland
WERNER, REY M. .............. St. Luke’s Hospital, Bethlehem
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WHISNER, WILHELMINA L. ...... Philadelphia General Hospital, Philadelphia
WHITE, CONSTANCE J. .......... Philadelphia General Hospital, Philadelphia
WHITE, RENNA L. .............. Mt. Sinai Hospital, Philadelphia
WHITNEY, MARY L. .............. 6203 B Jefferson St., Philadelphia
WILDETT, LILLIAN E. .......... Columbia Hospital, Wilkinsburg
WILLIAMS, ALTHEA .......... St. Luke’s Hospital, Bethlehem
WILLIAMS, AETIE I. .......... State Hospital, Danville
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WILLSON, LETITIA .................. 4401 Market St., Philadelphia
WILLSON, MARY B. .............. Pittsburgh Home for Babies, Ingram
WITTEN, SUSAN K. .......... Pennsylvania Hospital, Philadelphia
WITWER, EVA O. .............. Presbyterian Hospital, Philadelphia
WOLFF, MARGARET H. .......... Eagleville Sanatorium and Hospital, Eagleville
WORKINGER, MARJORIE ........ 127 S. 11 St., Philadelphia
WRAY, ANNA C. .............. 1222 N. Third St., Harrisburg
WURTHNER, ALMENIA E. ........ 202 N. Penn St., York
YINGST, EDITH E. ..........Harrisburg Hospital, Harrisburg
YOUNG, HARRIET F. ......Kirby Health Center, Wilkes-Barre

*RHODE ISLAND—103 Members

AVERY, L. M. BELLE..........Rhode Island Hospital, Providence
AYERS, LUCY C. ............459 Carrington Ave., Woonsocket
BARRY, ELIZABETH ..........State Hospital, Howard
beckwith, HELEN S.* .......50 Maude St., Providence
BOWBY, ALICE M. ..........50 Maude St., Providence
BRADLEY, MYRA .............Memorial Hospital, Pawtucket
BROCK, ALICE V. ...........Memorial Hospital, Pawtucket
BROWN, LUCY* ..............Homeopathic Hospital, Providence
CAHALAN, ISABEL* .........Homeopathic Hospital, Providence
CAHIR, CATHERINE* .......Homeopathic Hospital, Providence
CALLAGHAN, VERA M.* ...50 Maude St., Providence
CALWELL, EMMA* ..........Homeopathic Hospital, Providence
CHAPIN, WILMA B.* ** ....825 Chalkstone Ave., Providence
CHASE, ADALINE ...........100 N. Main St., Providence
CHASE, ELOISE* ..........Homeopathic Hospital, Providence
CHRISTENSEN, Verna ......Providence Lying-In Hospital, Providence
CONNELLY, GLADYS B.* ....305 Blackstone Blvd., Providence
COOMBS, BLANCHE V. .......Providence Lying-In Hospital, Providence
COX, ALICE E. .............125 Governor St., Providence
CRANSTON, MARGARET L. ...825 Chalkstone Ave., Providence
CURBAN, CATHERINE J. ....50 Maude St., Providence
DAILEY, MARGARET M. ....Newport Hospital, Newport
DES ILES, MARY S. .......Charles V. Chapin Hospital, Providence
DILL, MADELINE F. .......Rhode Island Hospital, Providence
DILLON, NELLIE R. .........16 Health Ave., Providence
DOCKHAM, CLARA O. ......Crawford Allen Hospital, East Greenwich
DUNN, EMMA L.* ** .........97 Irving Ave., Providence
DU TILLY, MARTHA B. ......Memorial Hospital, Pawtucket
DYKSTRA, MATILDA E.* ....Rhode Island Hospital, Providence
EARLEY, ANNIE M. ........72 Hilltop Ave., Providence
EDWARDS, DORIS ..........Charles V. Chapin Hospital, Providence
ERICKSON, MABEL H. ......825 Chalkstone Ave., Providence
ERICSON, MAUDE S. .......825 Chalkstone Ave., Providence
ESTEY, M. JEAN ............State Hospital, Howard
FITZPATRICK, WINIFRED I. ..62 Forest St., Providence
FLATLEY, CATHERINE ......Memorial Hospital, Pawtucket
FOLEY, FRANCES J. .......825 Chalkstone Ave., Providence
GARDNER, MARY S. .........2 Angell St., Providence
GARRICK, HELEN* ..........Memorial Hospital, Pawtucket
GARTLAND, JOSEPHINE* ...Memorial Hospital, Pawtucket
GOODNOW, MINNIE .........Newport Hospital, Newport
GOULD, ALICE M. ..........Crawford Allen Hospital, East Greenwich
GROOP, ELVIA* ............Homeopathic Hospital, Providence
GROVES, BARBARA ..........Memorial Hospital, Pawtucket
HALL, FRANCES W. .......Rhode Island Hospital, Providence
HANSON, ELVA G. ..........Memorial Hospital, Pawtucket
HENRY, MARBELLE F. .....825 Chalkstone Ave., Providence
HIGGINS, HELEN H. .........778 Pontiac Ave., Cranston
HORMAN, MARION ..........825 Chalkstone Ave., Providence
HORAN, CATHERINE M.* ...Homeopathic Hospital, Providence
HUGHES, Eva N. ..................... Rhode Island Hospital, Providence
IVANISIN, Anna B.* ................ Rhode Island Hospital, Providence
JACKSON, Gertrude H. ................ 825 Chalkstone Ave., Providence
JOHNSTON, Dorothy ................ Butler Hospital, Providence
JUTRAS, Bertha E. .................. 109 Woodbine St., Cranston
Kirk, Virginia ...................... 88 Taft Ave., Providence
LABORDE, Helen ...................... Memorial Hospital, Pawtucket
LEE, Mildred T. ...................... 151 Ocean Ave., Edgewood
LILLEY, Mary R. ..................... Rhode Island Hospital, Providence
MacDOUGALL, Jessie A. .............. 825 Chalkstone Ave., Providence
MACINTOSH, Annie E. ................. Rhode Island Hospital, Providence
MacLEAN, Mary ...................... Butler Hospital, Providence
MacVICAR, Marguerite ............... Memorial Hospital, Pawtucket
MAHER, Mary A. ..................... Rhode Island Hospital, Providence
MALLORY, Olga A. .................... Homeopathic Hospital, Providence
MARCEAU, Caroline* ................ Homeopathic Hospital, Providence
McGIBSON, Anna K. .................. Butler Hospital, Providence
McKAY, Marion* ..................... Memorial Hospital, Pawtucket
McPhee, Alice E.* ................... 50 Maude St., Providence
Moreau, Alexina O. .................. Charles V. Chapin Hospital, Providence
MORTENSON, Alice* .................. Memorial Hospital, Pawtucket
MOULSON, Ruth* ...................... Memorial Hospital, Pawtucket
MUGRDECHIAN, Lucy .................. 50 Maude St., Providence
Murray, Mary A. ..................... St. Joseph's Hospital, Providence
O'Brien, Alice ....................... 50 Maude St., Providence
OLIVER, Christy R. .................. 14 Jewett St., Providence
O'NEILL, Catherine G. ............... Charles V. Chapin Hospital, Providence
PARKER, Hope* ....................... Homeopathic Hospital, Providence
PEARCE, Vera S.* .................... Homeopathic Hospital, Providence
POTTER, Helen O. .................... Rhode Island Hospital, Providence
POWELL, Anna M. .................... 50 Maude St., Providence
POWERS, Helen M. ................... Memorial Hospital, Pawtucket
SCHINZEL, Irene F.* ................ 50 Maude St., Providence
SCHROEDER, Madeleine M. .......... Memorial Hospital, Pawtucket
SHERMAN, Elizabeth F. .............. 11 Medway St., Providence
Sister Mary Joanilla ................. St. Joseph's Hospital, Providence
SMALL, Ruth* ....................... Memorial Hospital, Pawtucket
SMITH, Eunice ....................... Homeopathic Hospital, Providence
SMITH, Jean* ....................... Homeopathic Hospital, Providence
Thielbar, Frances C. ................ Butler Hospital, Providence
Tilton, Marion E. ................... Chapin Hospital, Providence
Tracy, Catherine .................... 64 Keene St., Providence
Tracy, Marion* ...................... 50 Maude St., Providence
Walsh, Cecilia E. ................... 136 Whitford Ave., Providence
WALTERS, Ellijay* .................. Homeopathic Hospital, Providence
Ward, Helen G.* ...................... 50 Maude St., Providence
WEIGNER, Florence M.* .............. Homeopathic Hospital, Providence
White, Louisa ....................... Rhode Island Hospital Providence
WILKINSON, Katherine M. ........... 825 Chalkstone Ave., Providence
Williams, Grace W. ................ Rhode Island Hospital, Providence
Wilson, Tabitha* .................... 305 Blackstone Blvd., Providence
Wright, Alice M. ................... Memorial Hospital, Pawtucket
Young, Mary ......................... Memorial Hospital, Pawtucket
SOUTH CAROLINA—14 Members

ANDELL, Marguerite .......................... Roper Hospital, Charleston
CAMPBELL, Cornelia .......................... 109 S. Meminger St., Greenville
COBB, Ida E. ................................. City Hospital, Greenville
DOGGETT, Sarah F. ............................ Greenville General Hospital, Greenville
ENGELBERG, Meyeral ......................... Roper Hospital, Charleston
HUFF, Kathleen ............................... Meminger St., Greenville
LUNNEY, Anne ................................. Greenville City Hospital, Charleston
McALISTER, Mary C. .......................... 134 Broad St., Charleston
McKNIGHT, Kathryn ........................... City Hospital, Greenville
Quigley, Caroline ............................ Greenville City Hospital, Greenville
SHELL, Grace ................................. Greenville City Hospital, Greenville
WELBORN, Mary M. ............................ 509 Pendleton St., Greenville
WELSH, Marguerite J. ....................... Columbia Hospital, Columbia
WOODSIDE, Grace B. .......................... City Hospital, Greenville

SOUTH DAKOTA—8 Members

ABILD, Gladys ................................. University of South Dakota, Vermillion
CLIFT, Carrie E. .............................. 1205 West Blvd., Rapid City
KING, Ethel A. B. ............................. Britton Hospital, Britton
NELSON, Elvira ............................... 803 South St., Rapid City
OCHS, Mary F. ................................. Bartron Hospital, Watertown
RICE, Clara M. ................................. Britton Hospital, Britton
SISTER MARY CONCEPTION DOYLE .......... St. Luke's Hospital, Aberdeen
THOMPSON, Agnes B. .......................... Luther Hospital, Watertown

†TENNESSEE—42 Members

ADDS, Jennie L. ............................... 860 Madison, Memphis
ARCHER, Myrtle M. ........................... Baptist Memorial Hospital, Memphis
BURLINGTON, Ethel F. ........................ 1001 E. Third St., Chattanooga
Cawthon, Brie L. R. ........................... 1634 N. Parkway, Memphis
Chernery, Grace M. ............................ 2000 Hayes St., Nashville
CHRISTENSEN, Alice L. ....................... Vanderbilt University Hospital, Nashville
CREIGHTON, Marguerite ........................ Baptist Memorial Hospital, Memphis
Cunningham, Frances .......................... 1265 Union St., Memphis
DITTS, Florence ............................... Rural Sanitorium and Hospital, Madison
DUNN, Mary J. ................................. Vanderbilt University Hospital, Nashville
EBS, Dorothy D. ............................... Baroness Erlanger Hospital, Chattanooga
ELDER, Frances W. ............................ Knoxville General Hospital, Knoxville
ELROD, Virginia K. ........................... Memphis General Hospital, Memphis
GARRISON, Nina E. ............................ Peabody College, Nashville
GILES, Mary D. ............................... Vanderbilt University Hospital, Nashville
Gilmore, Bettie J. ............................ Gartyt Ramsey Hospital, Memphis
GOFF, Hazel L. ............................... Fort Sanders Riverside Hospital, Knoxville
HANCE, Magerie ............................... Vanderbilt University Hospital, Nashville
HINTON, Ella G. ............................... Memphis General Hospital, Memphis
HOCK, Sarah M. ............................... Knoxville General Hospital, Knoxville
KILLEN, Elizabeth H. .......................... Fort Sanders Riverside Hospital, Knoxville
LATTIN, Irene F. .............................. Baptist Memorial Hospital, Memphis
LINGHAM, Gertrude E. ........................ Rural Educational Association, Madison
LONG, Mary C. ............................... 2302 Kirby Ave., Chattanooga
LUDWIG, Edna L. .............................. Vanderbilt University Hospital, Nashville
MASEY, Lucy E. ............................... State Health Department, Nashville
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<td>Miller, Alma</td>
<td>860 Madison, Memphis</td>
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<td>Newman, Elizabeth</td>
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<td>860 Madison, Memphis</td>
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<td>Sister Leander Cook</td>
<td>St. Thomas Hospital, Nashville</td>
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<td>Vanderbilt University School of Nursing, Nashville</td>
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<td>Walker, Zuleima</td>
<td>2000 Hayes St., Nashville</td>
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<td>General Hospital, Knoxville</td>
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‡TENNESSEE—92 Members

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<tr>
<td>Abrahams, Helen D.</td>
<td>Providence Sanitarium, Waco</td>
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<td>Baker, Beulah</td>
<td>Herman Hospital, Houston</td>
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<td>Brals, Eliza M.</td>
<td>Parkland Hospital, Dallas</td>
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<td>Bhael, Inez</td>
<td>Seton Infirmary, Austin</td>
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<td>Boeker, Bertha</td>
<td>John Sealy Hospital, Galveston</td>
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<td>Bratton, Jimmie K.</td>
<td>Lubbock Sanitarium, Lubbock</td>
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<td>Breihan, Olga M.</td>
<td>Baylor University Hospital, Dallas</td>
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<td>Brient, Ellen L.</td>
<td>Nix Hospital, San Antonio</td>
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<td>Cole, Laura</td>
<td>Scott and White Hospital, Temple</td>
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<td>Connelly, Mary K. B.</td>
<td>3020 San Jacinto St., Houston</td>
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<td>Cooper, Joanna</td>
<td>Texarkana Hospital, Texarkana</td>
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<td>Cunningham, Marguerite</td>
<td>1110 Lipscomb St., Fort Worth</td>
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<td>Cooze, Maud</td>
<td>Stamford Sanitarium, Stamford</td>
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<td>Danheim, Emma H.</td>
<td>Memorial Hospital, Houston</td>
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<td>Dick, Katherine R.</td>
<td>408 Hawthorne Ave., Houston</td>
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<td>Dietrich, A. Louise</td>
<td>1001 F. Nevada St., El Paso</td>
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<td>Dreis, Josephine B.</td>
<td>Cameron Hospital, Cameron</td>
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<td>Engblad, Grace</td>
<td>609 Milam Building, San Antonio</td>
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<td>Engle, Edna</td>
<td>1302 Main St., Lubbock</td>
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<td>Erickson, Agnes</td>
<td>South Western University, Georgetown</td>
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<tr>
<td>Fahey, Mollie</td>
<td>St. Paul's Sanitarium, Dallas</td>
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<tr>
<td>Farwell, Mabel F.</td>
<td>Denton Hospital, Denton</td>
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<td>Gaentner, Esther C.</td>
<td>Plain View Sanitarium, Plain View</td>
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<td>Gants, Florence</td>
<td>Texarkana Hospital, Texarkana</td>
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<td>Gilbert, Frances E.</td>
<td>Scott and White Hospital, Temple</td>
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<tr>
<td>Gilbert, Ruby B.</td>
<td>West Texas Hospital, Lubbock</td>
</tr>
<tr>
<td>Golibart, Ernestine</td>
<td>215 Camden St., San Antonio</td>
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<tr>
<td>Grote, Emma</td>
<td>St. David's Hospital, Austin</td>
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<tr>
<td>Hanna, Alyce R.</td>
<td>1001 F. Nevada St., El Paso</td>
</tr>
<tr>
<td>Harris, Lucy</td>
<td>3108 Avenue H, Fort Worth</td>
</tr>
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<td>Hassell, Alfreda P.</td>
<td>215 Camden St., San Antonio</td>
</tr>
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<td>Hodges, Agnes C.</td>
<td>Box 21, Corpus Christie</td>
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<tr>
<td>Hogg, Sarah A.</td>
<td>Paris Sanitarium, Paris</td>
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<tr>
<td>Hunter, Odelle</td>
<td>West Texas Hospital, Lubbock</td>
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<tr>
<td>Jolly, Mrs. Robert</td>
<td>Memorial Hospital, Houston</td>
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<tr>
<td>Kasmeier, Julia C.</td>
<td>609 Milam Building, San Antonio</td>
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<td>Name</td>
<td>Hospital/Location</td>
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<td>KENNEDY, Mary</td>
<td>2710 Albany St., Houston</td>
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<td>LANG, Selma A.</td>
<td>Kings Daughters Hospital, Temple</td>
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<td>LEHMANN, HELEN H.</td>
<td>Baylor University Hospital, Dallas</td>
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<td>LORENZ, MARIE E.</td>
<td>Cameron Hospital, Cameron</td>
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<td>LUCKEY, GLADYS</td>
<td>1001 E. Nevada St., El Paso</td>
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<td>LYNAM, ANNA</td>
<td>1209 Crawford St., Houston</td>
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<td>MATHIS, DORA</td>
<td>John Sealy Hospital, Galveston</td>
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<td>MAXSON, RUTH A.</td>
<td>West Texas Baptist Hospital, Abilene</td>
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<td>McANELLY, ZORA K.</td>
<td>4524 Live Oak St., Dallas</td>
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<td>McCLESKY, OLA</td>
<td>Bradford Memorial Hospital, Abilene</td>
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<td>MCCULLOUGH, STELLA</td>
<td>West Texas Baptist Hospital, Abilene</td>
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<td>MCLEAUGHLIN, KATHERINE</td>
<td>3415 Junius St., Dallas</td>
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<td>MOORE, DAISY R.</td>
<td>Memorial Hospital, Houston</td>
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<td>MORRISON, RUBY A.</td>
<td>Methodist Hospital, Fort Worth</td>
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<td>MOTHER MARY OF LOURDES</td>
<td>St. Joseph's Hospital, Fort Worth</td>
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<td>NEFF, ELSIE</td>
<td>William Beaumont General Hospital, El Paso</td>
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<td>NEWHILL, JOSEPHINE</td>
<td>4127 Avenue I, Galveston</td>
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<td>NICHOLS, JOSEPHINE E.</td>
<td>Parkland Hospital, Dallas</td>
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<td>St. David's Hospital, Austin</td>
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<td>SHELLABARGER, ELIZABETH</td>
<td>501 N. Stanton St., El Paso</td>
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<td>SISTER ANTONIO O'DONOHOUE</td>
<td>St. Paul's Hospital, Dallas</td>
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<td>SISTER FLORENCE URBINE</td>
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<td>SISTER MARY ANDREW</td>
<td>Santa Rosa Infirmary, San Antonio</td>
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<td>Fred Roberts Memorial Hospital, Corpus Christi</td>
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<td>McKinney City Hospital, McKinney</td>
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<td>SMITH, ANNE L.</td>
<td>Shannon West Texas Memorial Hospital, San Angelo</td>
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<td>SMITH, MAY F.</td>
<td>Bradford Memorial Hospital for Children, Dallas</td>
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<td>SMITH, OCTAVIA D.</td>
<td>108 E. Rosewood, San Antonio</td>
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<td>Bradford Memorial Hospital, Dallas</td>
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<td>THOMAS, LENA B.</td>
<td>Cantrell Hospital, Greenville</td>
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<td>Parkland Hospital, Dallas</td>
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<td>WANGEN, CLARE M.</td>
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<td>WEST, IRENE M.</td>
<td>St. Joseph's Hospital, Houston</td>
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<td>WHEMMERS, PEARL A.</td>
<td>Methodist Hospital, Houston</td>
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</table>
FORTY-FIRST ANNUAL CONVENTION

WRIGHT, CLARA L. .................... 118 N. 7 St., Temple
YARBROUGH, JOAN .................... John Sealy Hospital, Galveston

‡UTAH—20 Members

BLACKWOOD, ELLEN V. .................... St. Mark’s Hospital, Salt Lake City
CLARK, RHODA* ..................... L. D. S. Hospital, Salt Lake City
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PETTUS, Laura A. Petersburg Hospital, Petersburg
PETTIFER, Charlotte** Stuart Circle Hospital, Richmond
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SMITH, Ethel M. Craigsville
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ZIEGLER, Frances H. Medical College of Virginia, Richmond

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BUOB, Mary B. Deaconess Hospital, Spokane
CARLSON, Elvera R.* Tacoma General Hospital, Tacoma
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DARK, Kathryn Everett General Hospital, Everett
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CROSS, Harriet Harborview Hall, Seattle
CURTIS, Mary E. Harborview Hall, Seattle
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DOYLE, Mary T. St. Joseph's Hospital, Tacoma
FEINLER, Marie S. Sacred Heart Hospital, Spokane
FELTON, Margaret Providence Hospital, Seattle
FISH, Isabelle 1321 Colby Ave., Everett
FRASER, Anna J. Virginia Mason Hospital, Seattle
GANTZ, Ella Sacred Heart Hospital, Spokane
GHISON, Laura G. Tacoma General Hospital, Tacoma
GILLESPIE, Cora E. 327 Cobb Building, Seattle
GIST, Ellon G. Deaconess Hospital, Spokane
GRANT, Evelyn F. Columbus Hospital, Seattle
GUSTAFSON, Kathrine Swedish Hospital, Seattle
HALL, Evelyn H. Harborview Hall, Seattle
HARJU, Mary Edgecliff Sanatorium, Spokane
HARTER, Grace L. Virginia Mason Hospital, Seattle
HEALY, Mildred E. Providence Hospital, Seattle
HERTMAN, Sally St. Luke’s Hospital, Spokane
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LARUE, IONE* .......... 3018 S. Windom, Tacoma
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PEDESEN, THYRA E. .......... U. S. Veterans’ Hospital, American Lake
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Pritchard, Mary .......... 413 Maple St., Bellingham
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SAYER, SARAH E.* .......... Tacoma General Hospital, Tacoma
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SERVOS, LEDWINA H. .......... Columbus Hospital, Seattle
SIEFNER, MARJOIE M. .......... 1715 E. Cherry St., Seattle
Sister Agnes .......... Sacred Heart Hospital, Spokane
Sister John Gabriel .......... St. Vincent’s Home, Seattle
Sister Joseph of Arimathea .......... Providence Hospital, Seattle
Sister Mary .......... Sacred Heart School of Nursing, Spokane
Sister M. Christina .......... Sacred Heart Hospital, Spokane
Sister M. Cyril .......... St. Joseph’s Hospital, Bellingham
Sister M. LORETTA .......... St. Anthony’s Hospital, Wenatchee
Sister M. Magna .......... Providence Hospital, Seattle
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Steble, Coralee .......... Harborview Hospital, Seattle
Sullivan, Elizabeth J. .......... Providence Hospital, Seattle
Sutherland, Annette .......... Tacoma General Hospital, Tacoma
Tuttle, Aileen H. .......... Harborview Hospital, Seattle
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Kessler, M. C. .......... Potomac Valley Hospital, Keyser
Krause, Martha B. .......... Ohio Valley General Hospital, Wheeling
Robertson, Marie .......... Cook Hospital, Fairmont
Valentine, Josephine .......... Ohio Valley General Hospital, Wheeling

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Aird, Ellen .......... 721 N. 17 St., Milwaukee
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Berger, Esther .......... Luther Hospital, Eau Claire
MEMBERS

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BUNGE, HELEN L. .................................................... Wisconsin General Hospital, Madison
CAREY, GLADYS K. ..................................................... Wisconsin General Hospital, Madison
COLLINGS, IDA A. .................................................... Madison General Hospital, Madison
COLLINS, FAITH A. ................................................... 6308 S Ave., Kenosha
COONEY, BEATRICE C. ................................................. 146 E. Oak St., Oshkosh
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ENGEN, PEARL .......................................................... 1821 W. Wisconsin Ave., Milwaukee
ESCHBACH, ALBERTA .................................................. 2320 N. Lake Dr., Milwaukee
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ESVAL, SIGRID .......................................................... Luther Hospital, Eau Claire
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FLETCHER, LILA B. .................................................... Wisconsin General Hospital, Madison
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FRUEH, ELIZABETH ................................................... 2307 W. Center St., Milwaukee
GORDERT, TERESA .................................................... 2320 N. Lake Dr., Milwaukee
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HENNING, ELIZABETH ................................................ Luther Hospital, Eau Claire
HERIN, BERNICE ..................................................... 925 N. 13 St., Milwaukee
HOLLENSTEIN, EULALIA .............................................. 3321 N. Maryland Ave., Milwaukee
HUNNEKENS, DOROTHY .............................................. 1136 S. 10 St., Milwaukee
KAINE, CATHERINE M. ................................................ 2766 S. Wentworth Ave., Milwaukee
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KESSEL, LAURA M. .................................................... 917 N. 11 St., Milwaukee
KESSEL, J. MARTHA .................................................. 1601 W. Meinecke Ave., Milwaukee
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LANDST, CHARLOTTE F. ............................................ 1663 S. 79 St., West Allis
LESCH, LINA C. ...................................................... 908 N. 12 St., Milwaukee
LOERKE, ROSE K. .................................................... 5000 W. Chambers St., Milwaukee
LUCASSEN, BARBARA E., O ........................................ 3058 N. 51 St., Milwaukee
LUND, CONSTANCE G. ............................................... 201 S. Mills St., Madison
MCKINNON, LILLIAN .................................................. 3321 N. Maryland Ave., Milwaukee
<table>
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<th>Name</th>
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<tr>
<td>METZKER, AMALIA L.</td>
<td>St. Luke's Hospital, Racine</td>
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<td>MEYER, LENORA F.*</td>
<td>2464 N. 35 St., Milwaukee</td>
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<td>MOLDENHAUER, MILDRED*</td>
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<td>OLSON, EDITH</td>
<td>302 Norris Court, Madison</td>
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<td>OLSON, ESTHER</td>
<td>1821 W. Wisconsin Ave., Milwaukee</td>
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<td>O'NEILL, HELEN</td>
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<td>Columbia Hospital, Milwaukee</td>
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<td>REILLY, LUCILLE A.</td>
<td>5000 W. Chambers St., Milwaukee</td>
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<td>RENTMEESTER, WHILOMENE</td>
<td>430 S. Clay St., Green Bay</td>
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<td>ROBERTS, LILA</td>
<td>433 Lorch St., Madison</td>
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<td>RODEKOH, ADELE</td>
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<td>RUE, CLARA B.</td>
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<td>RUSCH, DELLA R.</td>
<td>2200 W. Kilbourne Ave., Milwaukee</td>
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<td>SAGER, MAUDE</td>
<td>Methodist Hospital, Madison</td>
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<td>SCHOLLARD, M. ALYNE</td>
<td>114 E. Brooks St., Madison</td>
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<td>SCHWAB, ANTOINETTE</td>
<td>3044 N. 52 St., Milwaukee</td>
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<td>SILL, MARGARET*</td>
<td>1415 Lorch St., Madison</td>
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<tr>
<td>SISTER ADELINDA LASKOSKI</td>
<td>St. Mary's Hospital, Wausau</td>
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<td>SISTER ALBERTA SULLIVAN</td>
<td>St. Mary's Hospital, Milwaukee</td>
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<td>SISTER CATHERINE FAUSS</td>
<td>2320 N. Lake Dr., Milwaukee</td>
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<td>SISTER EMILE NIEDHAMMER</td>
<td>2320 N. Lake Dr., Milwaukee</td>
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<tr>
<td>SISTER EMMA LERCH</td>
<td>2200 W. Kilbourne Ave., Milwaukee</td>
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<td>SISTER MAGDALINE KREBS</td>
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<td>SISTER MARGARET MURPHY</td>
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<td>SISTER M. DIGNA DESCH</td>
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<td>SISTER M. ELECTA KAUFMAN</td>
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<td>SISTER MARY FRANCIS HEIMANN</td>
<td>390 E. Division St., Fond du Lac</td>
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<td>SISTER M. OLYMPIA HEML</td>
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<td>SISTER M. VICTORIA BERGUES</td>
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<td>SISTER M. VICTORIA KUECH</td>
<td>St. Joseph’s Hospital, Ashland</td>
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<tr>
<td>SISTER ST. THERESA LAROCHÉ</td>
<td>2224 W. Juneau Ave., Milwaukee</td>
</tr>
<tr>
<td>SMITH, CLARA L.*</td>
<td>127 S. Oneida St., Green Bay</td>
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</tbody>
</table>
MEMBERS

SMITH, LILLIE .................................. 390 E. Division St., Fond du Lac
SPIELMACHER, SADIE .......................... 1110 Weeks Ave., Superior
STEILE, EDITH A. .............................. 1402 University Ave., Madison
STILES, LAURA ................................. Luther Hospital, Eau Claire
STRANDNESS, RUTH ............................. 124 Sturgeon Eddy Rd., Wausau
SWAN, MAE ...................................... St. Francis Hospital, La Crosse
TAYLOR, FRANCES .............................. 408 N. Charter St., Madison
TAYLOR-OTTO, MARGARET ..................... Milwaukee General Hospital, Milwaukee
TEASDALE, HELEN ............................... 323 W. Washington St., Madison
THIEL, Irmgard ................................. 3321 N. Maryland Ave., Milwaukee
THOMPSON, BARBARA ......................... Bureau of Nursing Education, Madison
TRAUKA, HATTIE B. ........................... 408 N. Charter St., Madison
WESMAROVICH, HELENE ....................... 146 E. Oak St., Oshkosk
WILLIAMS, FLORENCE M. ....................... 3058 N. 51 St., Milwaukee
WILLIKINGANZ, MARGARET ..................... 5000 W. Chambers St., Milwaukee
WILSON, HELEN S. .............................. 408 N. Charter St., Madison
WILSON, MARGERY S. .......................... 3321 N. Maryland Ave., Milwaukee
WINTER, RUTH E. .............................. 821 W. Capitol Dr., Milwaukee
YOERG, SOPHIE ................................. Milwaukee Children's Hospital, Milwaukee

WYOMING—1 Member

WILLIAMS, A. GRACE ........................... Pershing Memorial Hospital, Cheyenne

CANADA—5 Members

JOHNS, ETHEL .................................. 1411 Crescent St., Montreal
LOGAN, LAURA R. .............................. 43 Rupert St., Amherst, Nova Scotia
MCELLELAN, KATHERINE ....................... Hotel Dieu Hospital, Cornwall, Ontario
POTTS, FLORENCE J. ........................... 259 Fourth St., Ottawa, Ontario
RICHMOND, ISABEL D. ........................ 27 Bold St., Hamilton, Ontario

CHINA—3 Members

HODGMAN, GERTRUDE E. ....................... Peiping Union Medical College, Peiping
HIRST, ELIZABETH .............................. Peiping Union Medical College, Peiping
TENNANT, CORNELIA ........................... Peiping Union Medical College, Peiping

CUBA—1 Member

JEFFREY, GENEVIEVE R. ....................... Anglo-American Hospital, Calle 21, Núm 242,
                                          Vedado, Havana

HAWAI'I—1 Member

AYERS, ADA G. ................................. Memorial Hospital, Hilo

PORTO RIC0—2 Members

SHALE, OLIVE E. ............................... Presbyterian Hospital, San Juan
SISTER ROSITA MARIA CULLUM ................ 20 Marina St., Ponce

REPUBLIC OF PANAMA—1 Member

HOWITT, HELEN* ............................... Hospital Santo Tomas, Panama

ASSOCIATE MEMBERS—15 Members

AUGER, HELEN B. ............................ 273 School St., Berlin, New Hampshire
BEALER, NETTIE E. ........................... 7425 Fayette St., Philadelphia, Pennsylvania
FULTON, JANET .................. American Mission, Kermanshah, Persia
HERSEY, MABEL F. ................. Royal Victoria Hospital, Montreal, Quebec, Canada
HOFFMAN, LEAH M. .................. 421 10 St., N. E., Washington, D. C.
LAWRENCE, EDNA M. ............... Severance Hospital, Seoul, Korea
LUCE, MARGUERITE H. .......... Temple Hill Hospital, Chefoo, Shantung, China
LYMAN, KATHARINE .......... American University of Beirut, Beirut, Syria
PULLEN, BERTHA L. ............ Caixa Postal #49, Rio de Janeiro, Brazil
RAMSEY, JEANNETTE L. .......... 219 School St., Berlin, New Hampshire
VAN ZANDT, JANE E. ............. America University of Beirut, Lebanon
WHITESIDE, FAYE .......... Peiping Union Medical College, Peiping, China
WIDMER, CAROLYN L. .......... American University Hospital, Beirut, Syria
WYNE, MARGARET R. .......... Peiping Union Medical College, Peiping, China
ZWISLER, IRENE L. ............ 46 Pilgrim Rd., Boston, Massachusetts

TOTAL MEMBERSHIP

Honorary Members .................. 12
Life Members .................................. 1
Sustaining Members .................. 121
Active Members .................. 3,525
Junior Active Members .......... 362
Associate Members .................. 15

Total .................................. 4,036

DECEASED MEMBERS

Names from 1893 to July, 1934, are given in previous reports. The names of members whose deaths have been reported since July, 1934, are:

SISTER MARGARET LAVERY ...... died June, 1934
IDA R. FALCONER ........ June 14, 1934
JEAN M. COCHEUR .......... September 26, 1934
MARGARET E. DORNE .......... October 11, 1934
SARAH C. BARRY .......... October 19, 1934
MAY S. LOOMIS .......... October 26, 1934
MAUDE A. WOOD .......... October 28, 1934
KATHRYN K. SCHULKEN ...... November 12, 1934
EVELYN WOOD .......... November 27, 1934
BERTHA HARMER .......... December 14, 1934
LESLIE WENTZEL .......... January 1, 1935
IDA VENNER ROGERS .......... January 28, 1935
SISTER CAROLINE BRAUN .......... March 22, 1935
LUCY MINNINGERODE .......... March 24, 1935
MARI LOUIS .......... March 28, 1935
NELLIE F. W. CROSSLAND .......... April 10, 1935
ELSIE HELMERS .......... April 29, 1935
URSULA HEILEMAN .......... May 21, 1935
FANTEEN PEMBERTON .......... May, 1935

Charter Member

MARY SANDS LITTLEFIELD .......... March 14, 1934

Charter Member and Life Member

ANNA ALINE BROWN .......... December 16, 1934
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