“Coming to Grips with the Nursing Question”: The Politics of Nursing Education Reform in 1960s America

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Abstract. The 1950s and 1960s were decades of change for the American nursing profession. A new generation of nurse educators sought to create greater professional autonomy for the nurse by introducing new models of education that emphasized science-based learning over technical skills and bedside care, and creating new clinical roles for the nurse, based on advanced graduate education. They confronted resistance from an older generation of nurses who feared becoming “second-class citizens” in increasingly academic nursing schools, and from academic health care institutions all too comfortable with the gendered hierarchy on which the traditional model of nursing education and practice was predicated. Using the University of Minnesota and University of California—Los Angeles (UCLA) as case studies, and based on institutional records and more than 40 oral histories with nursing and medical faculty, this article describes the generational conflicts this new cadre of nurse educators confronted within schools of nursing, and the institutional politics they struggled with as they sought to secure greater institutional status for the schools among the universities’ other health science units.

In February 1963, the dean of the University of California—Los Angeles (UCLA) medical school wrote to UCLA’s chancellor:

It would be best to abandon a Nursing School at UCLA, except as a Hospital Diploma School . . . If a ‘School of Nursing’ is to be retained at UCLA it would require a great effort to reform it, and the ‘School’ should, in effect, become a Department of the School of Medicine.¹
Five years later at the University of Minnesota, 22 members resigned from the School of Nursing, citing their dissatisfaction with the director of the school, Edna Fritz. One resigning faculty member wrote to Fritz that

> At one time a competent and creative faculty was free to develop a nursing program to which it was committed. When I joined the faculty there was an excitement of dialogue, intellectual initiative, constructive criticism, and the push for inquiry . . . . This is no longer the case. The faculty is now fragmented and non-functioning. The curriculum is deteriorating . . . . Faculty and student morale has been seriously damaged . . . . You have encouraged fragmentation of faculty by supporting obstruction and rewarding non-productivity.

A few months later, Fritz was fired as director of the School of Nursing.

Although separated geographically, these two scenes reflect the contested politics of nursing education reform in the United States during the 1960s. Through the mid-20th century, most American nurses were trained in hospital training schools (or diploma programs) in which training and practice was, as Julie Fairman describes, “rule based, activity oriented, and relied heavily on the repetition of procedures rather than scientific or social theory-based decision making.”

Across the United States during the 1950s and 1960s, however, a new generation of nurse educators sought to create greater professional autonomy for the nurse by introducing models of education that emphasized science-based learning over technical skills and bedside care. They also sought to create new clinical roles for the nurse based on advanced graduate education. As these educational reforms were gradually implemented throughout the country, the primary site of nursing education shifted from hospital-based diploma schools to colleges and universities.

The introduction of education reform at nursing schools did not pass uncontested. Indeed, within a few years of being implemented, curriculum reforms introduced at UCLA School of Nursing in the 1950s and at the University of Minnesota School of Nursing in the early 1960s were causing problems for faculty, students, and administrators alike. The introduction of reform was also not a uniform process. Rather, the character and politics of education reform at an institution depended on the personalities involved and the local culture and politics of the specific institution. Using the University of Minnesota and UCLA as case studies, this article describes the generational conflicts this new cadre of nurse educators confronted within schools of nursing, and the institutional politics they struggled with as they sought to secure greater institutional status for the schools among the universities’ other health science units.
This article also situates the politics of nursing education reform within the broader context of state health policymaking and the politics of state-supported academic health institutions in the United States in the decades after World War II. Despite massive infusions of federal funding into health science research and health care, by the 1960s the United States had no mechanism for matching biomedical research and workforce production with the country’s health care needs. In the absence of a comprehensive national health policy, state-supported academic health institutions, like those at UCLA and the University of Minnesota, became sites in which federal and state health policies intersected and were implemented in local settings.

Thus, during the past half-century, state governments have relied on schools of medicine, nursing, dentistry, public health, pharmacy, and veterinary medicine to respond to the health care needs of state residents. In exchange for state funding, academic institutions have been required to produce enough of the “right type” of health care professionals willing to work in the state. Even when private academic health institutions have received state support, neither their constitutions nor their priorities have been shaped by the land-grant mission of state institutions. Private institutions have been able to prioritize research and specialty education without the tension of producing sufficient primary care and rural health care workers to meet the state’s health care needs. In contrast, because the UCLA and University of Minnesota Schools of Nursing sought to reform nursing education, state legislators called on them to produce more professional nurses able to meet the states’ growing health care needs. As a result, these nursing schools, along with other state-supported schools throughout the country, were sites in which federal, state, institutional, and interprofessional politics intersected in the making of the American nursing workforce and the creation of state health policies.

Nursing Education After World War II

Substantial changes took place in American nursing education after World War II. These changes were led in part by sociologist Esther Lucille Brown and nurse educators Hildegard Peplau and Virginia Henderson, who offered compelling critiques of nursing education based on new, theoretically grounded definitions of nursing practice. In 1948, on behalf of the National Nursing Council and with funding from the Russell Sage Foundation, Brown published *Nursing for the Future*, a thorough survey of the qualitative and quantitative status of nursing practice and education. Brown’s report called for
all forms of professional nursing education to be placed within institutions of higher education and for university-based nursing schools to be autonomous with the same status as the university’s other professional schools.  

Henderson and Peplau’s critiques of nursing education were influenced by the Brown report and were also based on their experiences with diploma and baccalaureate degree programs, and their disillusionment with the traditional model of nursing practice. For Henderson, “the regimented patient care” that nurses traditionally performed “and the concept of nursing as merely ancillary to medicine” were outdated concepts that should be replaced. Nursing, redefined, would primarily complement “the patient by supplying what he needs in knowledge, will, or strength to perform his daily activities and also to carry out the treatment prescribed for him by the physician.” Nursing education should be reformulated to prepare nurses for their new role as an “expert and an independent practitioner.” It was time, Henderson argued, to replace the regimented, procedure-based hands-on training of the diploma model with “a liberalizing education, a grounding in the physical, biological, and social sciences, and the ability to use analytic processes.”

Peplau, who like Henderson held a theoretically grounded and patient-oriented view of nursing practice, advocated advanced graduate nursing education to prepare nurses for expertise in specialist clinical areas such as psychiatric nursing. Beginning in the mid-1950s, Peplau advocated that psychiatric nurses should have expertise as counselors or psychotherapists. By developing “specific interpersonal techniques useful in intervening in specific pathological behavior of patients,” taught at the master’s level, the psychiatric nurse would establish a therapeutic relationship with patients. Although the psychiatric nurse engaged in specialized clinical practice, Peplau maintained, the technical work of nursing should fall to the general duty nurse.

As the nature of nursing work expanded and patient care assumed greater complexity after the war (which, nurse educators argued, necessitated the curriculum reforms), much of the so-called “traditional” bed and body work of nursing was transferred to less-trained “technical nurses” (or bedside nurses), practical nurses, and nursing assistants. Practical nurses were typically trained in 1-year programs principally located in hospital-based nursing schools or, increasingly, offered by vocational educational systems. Between 1950 and 1963, the number of practical nurse programs in the United States increased from 144 to 737. In 1951, Mildred Montag introduced the concept of a new, specialized nursing worker, the technical nurse, whose training would be more than that for a practical nurse but less than that for the diploma or baccalaureate (BS)-prepared professional nurses. Technical nurses were to assume responsibility for the hands-on bodywork of nursing. They would be trained
in 2-year associate degree programs based at community colleges, receiving general and nursing education and clinical instruction. The first three associate degree programs were established in 1952, and by 1960 there were more than 100 such programs in the United States.12

In this new educational hierarchy, the BS-prepared nurse assumed the status of the “professional nurse” and the responsibilities of the expert and independent clinical practitioner. Professional nurses, typically after completing advanced graduate education, would go on to serve as clinical supervisors, educators, or administrators. Even by the 1970s, however, the distinction between associate-degree and BS-prepared nurses had become blurred in clinical practice.13

The Division of Nursing of the U.S. Public Health Service underwrote the planning and implementation of many of these reforms. As Cynthia Connolly and Joan Lynaugh have documented, the division began funding nursing research projects in 1955, and in 1962 established the Nurse Scientist Graduate Training program, which supported nurses pursuing research-based graduate degrees in university science departments. Other sources of federal funding came from the Health Amendments Act of 1956, which “allocated money to prepare nurses to become teachers, supervisors, and nursing service administrators.” Following publication of the Surgeon General’s Consultant Group on Nursing’s report Toward Quality in Nursing Education, Congress passed the 1964 Nurse Training Act, Title VII of the Public Health Service Act. The Act provided federal funds for new teaching facilities, “curricular experimentation, faculty development, and an expanded Professional Nurse Traineeship Program.”14

From the 1950s through the 1970s, individual nursing schools around the United States debated the merits of reformulating nursing education, experimenting with new curricula that eliminated dependence on a medical model of practice and emphasized instead nursing theory and patient-centered practice. The efforts of the UCLA and the University of Minnesota Schools of Nursing to revise the undergraduate nursing curriculum reveal the highly contested nature of nursing education reform during these decades.

The Gendered Politics of Health Education at UCLA

In 1949, Lulu Wolf Hassenplug was appointed founding dean of UCLA's School of Nursing. Hassenplug had graduated with a diploma from the Army School of Nursing at Walter Reed Hospital in 1924, and earned a baccalaureate
degree from Columbia University Teachers’ College in 1927, and a Master of Public Health degree from Johns Hopkins University. She came to UCLA already a leader in nursing education, having played an instrumental role developing Vanderbilt University’s baccalaureate nursing program. At UCLA, Hassenplug oversaw the elimination of the hospital-based diploma program and the introduction of a 4-year baccalaureate in nursing in 1950 and a Master of Science graduate program in 1951. In the late 1950s, the school began planning for a doctoral program in nursing.

UCLA’s baccalaureate program was the first in the country to provide nursing students with the same preparation regardless of whether they wished to become clinicians, educators, or administrators. Students who wanted to pursue careers as educators, administrators, or clinical specialists would, after receiving their baccalaureate, enter the graduate program for advanced specialized education. All other nursing baccalaureate programs in this era tracked students into either education, clinical practice, or administration.

From the late 1950s throughout the 1960s, however, the UCLA School of Nursing was under constant attack from the surgical faculty, medical school dean, and hospital director, all of whom lamented the loss of the traditionally trained bedside nurse. As Hassenplug recalled, “we got complaints” from physicians when the School revised the nursing curriculum because “the physicians thought our students were their own.” In February 1957, for example, UCLA neurosurgeon Eugene Stern wrote to the medical school dean lamenting the substandard education being received by UCLA’s nursing students. The nursing students

are not learning adequate bedside care . . . . They appear to be more concerned with the psychological aspects of case studies to which they are assigned rather than being concerned with learning the rudiments of nursing care . . . . They likewise are taught minimal, if any, responsibility to the physician.

For Stern, the decline in the quality of UCLA’s nursing education could be correlated with the elimination of the hospital-based diploma program and the now minimal role of the physician in training nurses.

Stern joined his colleagues in the Department of Surgery in calling for reform of nursing education at UCLA. Specifically, the surgeons wanted nursing students to return to the wards and operating rooms like the earlier diploma students, and for “nurse training” to be “implemented by a curriculum of which and in which the physician shares supervisions, consults, and participates.” As chair of UCLA’s department of surgery, William P. Longmire explained, the surgeons’ hostility to the nursing reforms was because “Many
of us felt that our school was not graduating the type of nurse who would then become involved in patient care.” Longmire took particular issue with the school’s new philosophy, “that the student nurses were actually to have no ward assignments; they were to come on the wards as observers, to study the patient’s case but not to actively participate in the patient’s care.”

The surgeons had the support of the medical school dean, who drew up a proposal to reorganize the nursing school and transfer the nursing curriculum to the School of Medicine. In this plan, the nursing faculty would be appointed “to the appropriate department of the Medical School as a division of nursing with such titles as are appropriate—that is, Professor of Nursing (Surgery), Professor of Nursing (Obstetrics), and so forth—as a division of the Department. Each Medical School department could sponsor the appropriate parts of the Nursing curriculum.” A nursing faculty member would be assigned oversight of the curriculum and hold the position of associate dean within the medical school.

This proposal circulated in the medical school and university administration for several years. But, as Dean Hassenplug recounted, in those years the nursing school had the “honest support” of the university chancellor and provost of health sciences. In 1960, however, when physician Franklin D. Murphy was appointed chancellor and the position of provost for the health sciences was eliminated, the institutional politics at UCLA shifted. With the considerable power of his office, Murphy joined the assault on the nursing school. In June 1968—in an attempt to “come to grips with the nursing question”—the chancellor’s office circulated a proposal that called for the termination of existing undergraduate and graduate nursing programs; the transfer of responsibility for undergraduate nursing education to an Office of Nursing Education located in the UCLA Hospital; and the discontinuation of the nursing school. The department of surgery, medical school dean, and hospital director fully endorsed Murphy’s proposal.

Faculty throughout the university, however, including members of the departments of medicine, pediatrics, and psychiatry, submitted a position paper “in vigorous opposition” to the proposed closing of the school. The university Committee on Educational Policy issued a report that concluded, “The administrative unit for the education of nurses at UCLA should be the School of Nursing.” Moreover, Dean Hassenplug mobilized a nationwide political campaign in support of the nursing school. On receiving the proposal on a Friday afternoon in late June, Hassenplug alerted “all the deans of university schools of nursing, the national nursing organizations, our friends in the federal government” about what was happening: “Our attack, I might say, was fast and furious, and it was supported at every step.” By Tuesday morning,
UCLA’s president, chancellor, and regents were being bombarded with phone calls, newspaper coverage, and letters demanding continuation of the nursing school. Soon thereafter, the chancellor and his allies abandoned their efforts to close the school.26

Professional Conflict at the University of Minnesota

Although UCLA’s nursing faculty confronted criticism from physicians, the example of the University of Minnesota is emblematic of the resistance the new generation of nurse educators faced from their colleagues within nursing. Since 1919, the School of Nursing at the University of Minnesota had offered a 5-year baccalaureate program that required nursing students to take 2 years of liberal arts education before beginning 3 years of hospital-based clinical education. In 1962, however, the school introduced a new “integrated” 4-year baccalaureate degree that incorporated liberal arts and nursing courses throughout the 4 years, eliminated the 30-hr a week clinical service requirement, and emphasized coursework in the behavioral and psychological aspects of nursing.27

Edna L. Fritz had been appointed director of the nursing school after the retirement of Katherine J. Densford in 1959 and oversaw the introduction of the new curriculum. Fritz had received her baccalaureate nursing degree from Russell Sage College in 1940 and her Master’s in Nursing Education from Columbia University Teachers’ College in 1942. When she arrived at Minnesota, she was completing a doctorate in education at Teachers’ College under the supervision of Mildred L. Montag; she received her doctorate in 1965.28 Prior to her arrival at Minnesota, Fritz had worked for the National League of Nursing (NLN), first serving as director of a demonstration project integrating specialized clinical instruction into the curriculum and then as assistant director of the NLN department of baccalaureate and higher degree programs.29 Prior to her work with the NLN, Fritz had served as a nursing instructor at Cornell University, New York Hospital (now New York-Presbyterian Hospital) and Boston University General Hospital. Fritz thus brought to Minnesota experience with and a commitment to curriculum development but little experience with university administration.

When Fritz arrived at Minnesota in 1959, the undergraduate nursing curriculum was already being developed by a small group of the faculty. According to retired faculty member Marilyn Sime, the reform group “had a new vision . . . for delivering nursing education.” The older 5-year
curriculum had been predicated on a “medical model” and the assumption that nursing care, at least within the hospital, would be delegated by the physician. In that curriculum, the emphasis had been on clinical instruction. The new curriculum considered nursing care as something separate from delegated medical care. It taught students to “study patient behaviors, and arrive at . . . a nursing diagnosis of the patient’s needs and develop[e] a nursing care plan around those concepts rather than around the medical conditions.” In this way, the curriculum reforms drew explicitly on the work of Esther Lucille Brown, Hildegard Peplau, and Virginia Henderson, who called for nursing education to be grounded in the physical, biological, psychological, and sociological sciences to prepare nurses for independent practice that would be oriented to the individual needs—physical, psychological, and emotional—of patients.

As Sime recalled, however, the new curriculum “wasn’t loved by all. There were faculty that felt that too much had been lost and not enough gained by this new approach.” As Florence Marks (another former faculty member) elaborated, the faculty were no longer “teaching the didactic medical things, what you would do with this medical situation, this clinical situation. All those things were not there” anymore. Instead, the students “were supposed to know enough theory that they could figure these out for each patient. It was not something they learned, you know, as A, B, or C.”

In 1961, Marie Manthey was completing her baccalaureate degree while the curriculum was in transition. As she described it, “The faculty was divided. I don’t think they really knew how to manage the transition without pretty much destroying each other.” Manthey recounted taking a clinical course taught by three faculty members, two of whom were leading the reforms. The third had been on the faculty since the 1930s and was “an extremely brilliant clinician with a lot of understanding of the medical sciences.” What Manthey “saw as a student was these teachers standing up in front of us, two of them humiliating the third one, and the third one was the only one talking about anything I was interested in, which had to do with dealing with patients who are sick.” Manthey went on to earn her Master’s in Nursing Administration from the university and from 1964 to 1971 served as associate director of nursing at Minnesota’s University Hospital.

Reflecting on this period of educational reform, Manthey noted that

The curriculum swung so far over to a non-clinical side that it was absolutely frightening. People were coming out of the school with an RN, if they passed their boards . . . [they] came out not having ever given an injection, never having seen a delivery.
As Manthey perceived it, nursing students were being discouraged from doing physical care for the patients. So they were interviewing patients. They would come back and they would write down every single word that was said by the patient . . . analyze and, then, decide whether to admit [the patient] or not. People told me that if they so much as gave a patient a drink of water, they would be marked down by the faculty for engaging in nursing care activity.35

In essence, the nursing curriculum reforms reflected a growing tension among nurse educators about the fundamental principles of nursing and the appropriate balance between theory and practice in undergraduate nursing education. The difficulty of integrating theoretical and practical knowledge into the curriculum reflected an explicit tension built into the structure of nursing education. Whereas in medical schools, the teaching faculty held both faculty positions in the medical school and clinical positions in the teaching hospital, in nursing schools during this period, including the University of Minnesota’s, they rarely held clinical positions in the teaching hospital’s nursing service. Thus, faculty clinical practice was not integrated into the structure of academic nursing. At Minnesota, this led to conflict and divisions between the nursing faculty and members of the University Hospital nursing service. During those years, the faculty would hear from the nursing service, “You’ll never make a good nurse. You don’t get enough experience. Some things, you have to learn just by practice.” In response, the faculty would say, “You get the foundational theory. Eventually, you get the practice.”36

Minnesota’s nurse educators also faced resistance to the educational reforms from university administrators and regents. As part of the reforms, the nursing school eliminated its Practical Nursing Program in 1967. This program, launched 20 years earlier, had provided 1 year of technical training to prepare practical nurses for licensure (these were the class of nurses who now assumed responsibility for the lower skill bed and body work of the traditional diploma-trained nurse). When the school began the practical nursing program in 1947, it was only one of four such programs in the state. By the mid-1960s, however, there were 25 practical nursing programs in Minnesota.37 When the school revised the baccalaureate curriculum, it eliminated the practical nursing program so as to better utilize the faculty’s resources, and delegated the preparation of practical nurses to the state’s junior colleges. School Director Edna Fritz wrote to the university vice president for academic affairs in April 1966, With the resources available to us, the greatest contribution the University can make to the nurse supply of the state and region is through efforts to expand enrollments in Masters programs that prepare faculty to serve the many schools that exist, thus permitting expanded enrollments in them.38
Indeed, in 1966, 85 nursing schools in the upper Midwest reported 109 faculty vacancies and a need for 41 additional faculty positions.39 As Fritz saw it, the university nursing school’s priority was to train advanced degree nurse educators who could fill these positions.

The closing of the practical nursing program, however, provoked “some very grave resistance by a few people,” not least the university regents. Powerful regent Charles Mayo (of Mayo Clinic fame) was particularly upset because he viewed the university’s practical nursing program “as the one sound program” the nursing school had. Mayo was a physician wedded to the traditional diploma-school model of nursing education.40 The directors of the university hospital and its nursing service also worried that without the guaranteed supply of practical nurses graduating from the nursing school, the university hospital would be forced to compete with other local hospitals and clinics for the practical nurses trained by other, perhaps lower quality programs.41

The educational reformers at Minnesota, however, clashed most significantly with school Director Edna Fritz. In 1967, the reformers wrote to Robert Howard, dean of the College of Medical Sciences (which had authority over the nursing school), demanding action to rectify “what we perceive to be the major problem in the school, namely administrative interference with faculty functioning . . . . We feel that the relationship between the faculty and the director of the School of Nursing must be examined objectively.”42 Howard disagreed with their assessment and put his full support behind Fritz, which ultimately led many of the faculty to resign from the school. Unfortunately, little archival or oral history evidence is available to support this group’s contentions about Fritz’s leadership style (sadly, they have all since passed away).

The tension seems to have centered on a fundamental disagreement about the degree of clinical instruction in the new curriculum. Although Fritz supported curriculum reform in general, she wanted the faculty to be more engaged with clinical teaching. This approach followed from Fritz’s earlier work on an NLN-funded demonstration project, which had integrated concepts associated with specialized clinical areas into the basic nursing curriculum at Cornell University-New York Hospital School of Nursing.43 Fritz questioned the reformers’ decision to replace “clinical laboratory practice” hours in the curriculum with “classroom laboratory” hours, noting “It is this practice that has so minimized the opportunities of students to apply their learnings in reality situations.”44

Fritz also advocated a faculty practice model, championed by Dorothy Smith at the University of Florida, in which responsibility for clinical education would be shared by the faculty and nursing service. This diverged significantly from the practice during Katherine Densford’s tenure as director, when the hospital
nursing service had primary responsibility for clinical instruction. By pushing the faculty “to doll up in a uniform and a white cap and go back into the clinical areas,” Fritz ostracized some of the school’s most senior faculty who had not worked on the wards since their training in the 1920s and 1930s. In doing so, Fritz contributed to a generational and philosophical divide that already existed among the faculty and between the faculty and nursing service.45 This divide foreshadowed the conflict that emerged during the creation of nurse practitioner programs in the 1960s and 1970s. As Julie Fairman has described, although an older generation of nurse educators often saw nurse practitioners as physician wannabes, a younger generation—grounded in second-wave feminism—saw a unique role for nurse practitioners thoroughly distinct from that of physicians.46

Building the State’s Nursing Workforce

The efforts to reform nursing education at Minnesota and UCLA coincided with growing regional and national concerns among health care leaders and policymakers about impending shortages of health care workers, including nurses. Several studies of the nursing shortage conducted in the early 1950s predicted that between 50,000 and 75,000 new graduate nurses were needed each year.47 In 1963, the Surgeon General’s Consultant Group on Nursing (on which Hassenplug served) declared that the “Nation’s supply of nurses today has great inadequacies, both in numbers and in educational preparation.” By 1970, the group concluded, the country would need 850,000 professional nurses, with 200,000 of them having at least a baccalaureate degree, and another 100,000 having graduate preparation to meet the critical need for nurses prepared for teaching and leadership positions. This translated into schools needing to graduate 53,000 new nurses each year by 1970.48

The degree of nursing shortage varied across states and regions.47 In January 1957, for example, the University of California issued a report that projected that unless enrollment in the UCLA and University of California—San Francisco (UCSF) Schools of Nursing expanded, by 1965 the Western United States would face a shortage of more than 18,000 nurses. Within that shortage, the committees predicted deficits of 8,000 baccalaureate-trained nurses and 5,980 nurses with master’s degrees or higher.49 In Minnesota, nursing shortages were less severe. In 1966, the Upper Midwest Nursing Study reported that Minnesota’s rate of nurse graduates from all nursing programs was nearly twice that of the country and, moreover, the upper Midwest region served as “an important source for nursing personnel.”50
As a result of California’s shortages, the authors of the University of California report proposed a statewide plan for nursing education in which the UCLA and UCSF Schools of Nursing would retain their undergraduate curricula but would also “put special emphasis on graduate education, particularly the preparation of nursing educators.” Furthermore, “no other collegiate programs should be established on other campuses of the University of California.” Because only UCLA and UCSF had adequate facilities in medical education, the report’s authors contended that only these schools were equipped to provide nursing students “the quality of general and professional education now required for competence in the expanding fields of nursing.” Following the recommendations of the Ginzberg report of 1948 and the Bridgman report of 1953, the University of California report called for the abandonment of hospital schools of nursing and for 2-year curricula (leading to an associate degree) to be established at the state’s junior colleges, and 4-year curricula (leading to baccalaureates) at the state’s other 4-year institutions.52 Graduate nursing education should remain the province of UCLA and UCSF. The expectation, of course, was that many of these advanced graduate nurses would join the faculty at the junior and state colleges to boost their undergraduate curricula. Ultimately then, the report proposed a statewide division of educational labor in the university, state college, and junior college system.53

In response to these concerns, nurse educators framed their calls for educational reform as necessary for resolving the impending crisis in nursing supply and fulfilling the university’s obligation to the state. Since the late 1940s, state legislators had looked increasingly to academic health institutions receiving state funds to expand educational opportunities and better coordinate the production and distribution of the state’s health workforce. In March 1949, for example, at a meeting of the Finance Committee of the California Senate, Senator Bradford S. Crittenden offered his support for the budget of the University of California but warned

that he and other members of the committee and the Senate would be influenced in their enthusiasm by the present attitude and future planning of the University toward the problem of training enough professional people concerned with health and related problems to meet the needs of the State.

Crittenden felt the committee’s support was contingent, in particular, on the university addressing why the state had a shortage of doctors, dentists, nurses, pharmacists, and veterinarians.54

The nursing education reforms of the 1950s and 1960s were thus situated squarely within the politics of state health education and workforce policies.
To this end, the nursing faculty at UCLA warned administrators who wanted to shut down the school and reestablish nursing education as either a hospital-based program or a department within the medical school, that they would violate the mandates set by the California Master Plan for Higher Education. In 1959, the California state legislature had asked the University of California and the California Board of Education to investigate the problems raised by exploding student population growth and mounting financial competition between the state's public universities and colleges, and develop a plan that would allow the state to continue to support higher education within its limited fiscal resources. The resulting Master Plan for Higher Education, codified in the Donahoe Higher Education Act of 1960, described a functional division of educational labor (consistent with the one already proposed for nursing education) between the University of California, the California state colleges, and the junior colleges.55

In April 1962, UCLA's ad hoc committee on nursing, which had been appointed by Chancellor Murphy to review the organization of the nursing school in light of the medical school's complaints, concluded, “Clearly the University has an obligation . . . to continue a program in Nursing directed at alleviating” the shortages of nurses, nurse administrators, researchers, and educators, “at least until such a time as the State Colleges may take over some . . . of these functions.” As such, the committee was thoroughly opposed to merging nursing into the medical school:

the prime function of nursing education at UCLA should not, in the long run, be an attempt to contribute significantly to the direct production of practicing nurses, but rather to provide nursing faculty, highly trained nursing specialists, and scholars in allied areas interested in applying this knowledge to problems of Nursing. Jurisdictionally, it would seem unwise and improper to incorporate a Department of Nursing in the School of Medicine [emphasis added].56

Meanwhile, at the University of Minnesota, the nursing faculty addressed the concerns raised by the hospital's nursing service, the regents, and administrators that the school's new academic orientation would lead to further decline in clinical nurses. As Director Fritz wrote to the Committee on Long Range Planning in the Health Sciences in September 1966, the School had “identified the most useful contributions that we might make to an augmented supply of nurses for our state and region.” Based on data—including current and projected shortages—about the state of nursing in Minnesota, the Dakotas, and Montana, Fritz noted, "the greatest block to expanding student enrollments in nursing programs of all types is the serious shortage of qualified
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[that is, baccalaureate and graduate level-prepared] teachers.” Although there were several institutions in the region with practical nursing and basic professional programs, the University of Minnesota’s nursing school “is the only institution in a four-state area presently able to provide preparatory programs for teachers of nursing to make possible improvement and expansion of the many other schools of nursing in this region.” Fritz thus argued that the school’s priority should be preparing the next generation of nursing educators and advanced clinical specialists.57 The nursing school promised, however, to provide other nursing programs in the state, particularly at the junior colleges, with “consultant services and continuing educational opportunities” to help them expand and establish practical nursing and associate degree programs.58

The faculty of both schools thus argued for the coordination of nursing educational hierarchies across the state to ensure a sufficient supply of nurses for the state and region, with university schools of nursing at the center. In this coordinated planning, the state’s community colleges would be responsible for preparing associate degree nurses, the 4-year universities and colleges would prepare baccalaureate nurses, and university programs would prepare advanced degree clinical specialists, researchers, and educators. As UCLA’s nursing dean, Lulu Hassenplug recalled it was the nursing school’s responsibility to set up a network of nursing education throughout the state:

The state university exists for that. We were in the community as much as we were in the university. . . . [W]e thought we ought to be doing something like this to facilitate the growth of the baccalaureate and higher degree programs. We ought to be helping the whole region.

As early as 1956, nursing leaders from the Western states were working with the Western Interstate Commission on Higher Education to undertake regional planning for nursing.59

At Minnesota, the nursing faculty became increasingly involved in regional planning in the mid-1960s after the initiation of the Upper Midwest Nursing Study. This project, funded by the Hill Family Foundation, described and analyzed the quantitative and qualitative supply of nurses and projected future demand for nurses in Minnesota, Montana, North Dakota, South Dakota, the Upper Peninsula of Michigan, and the Northwestern portion of Wisconsin. With these data, the study group sought to tackle nursing shortages by better using the region’s existing supply of nurses.60 Early in 1971, the School of Nursing joined the Minnesota Nurses Association (MNA) and other state nursing schools in the upper Midwest and applied for federal funding to initiate a regional planning project. They did so in response to the
recommendations of the National Commission for the Study of Nursing and Nursing Education, which urged states to develop master plans for nursing and nursing education.61

By 1971, all University of Minnesota health science schools were under pressure from the university administration and state legislature to take the lead in health workforce planning. That May, for example, the university vice president for legislative affairs, Stanley Wenberg, wrote to his colleagues in the university’s central administration to warn that state legislator Verne Long was looking to the university to help resolve a current problem in nursing education. Wenberg asked his colleagues:

Is there some way we can get an answer to [representative Long] that responds to his concern that the University ought to give a little leadership in trying to multiply approaches to better utilization and training of health manpower particularly in para-medical fields [such as nursing]?

Long held considerable political and financial leverage at the university as chair of the Minnesota House’s higher education committee and vice-chair of the appropriations committee. His attention to the problem of nursing education was in part a response to the “many letters, calls, and visits” he had received since the beginning of the legislative session from nurses who were troubled by the difficulties they had faced in their efforts to attain advanced training. In making his request to Wenberg, Long reminded him that

several times in the past weeks you have pointed out specific needs and asked us, as legislators, to address and appropriate dollars to specific programs. I would now like to ask you to direct your immediate attention to the problems [with nursing education]. . . . If, in fact, the solution to these problems can be found . . . then I want to say in the most forceful manner I know how—let’s have the answers forthcoming soon.62

By placing their educational reforms in the context of state and regional health needs, nursing educators were able to secure their institutional objectives. Chancellor Murphy’s efforts to discontinue UCLA’s School of Nursing failed, and after several years of conflict, both schools regarded their educational reforms a success. Unfortunately for Fritz, however, by 1968 the practical implications of the nursing curriculum’s shift away from clinical education were placed in stark relief. At the NLN evaluation team’s site visit that March, the team noted the “serious imbalance” in the undergraduate program whereby the curriculum placed “disproportionate emphasis on the psychosocial dimensions of nursing, to the serious detriment of the biophysical aspects of nursing.”63
Their findings confirmed reports that William Shepherd, vice president for academic affairs, had received in recent years from “students in the program about the adequacy of preparation in the biophysical aspects of nursing.” Shepherd had also received reports from supervisors of the school’s graduates who “regard them as poorly prepared for beginning nursing practice.” That fall, 25% of the graduating class failed their state licensing exams. Although the curriculum’s defenders, including Marilyn Sime, asserted the state exams were not “measuring the new approach to nursing care. It was measuring knowledge from the old model,” the failure provoked broad-based concern among the university administration and regents and led to Fritz being fired.

Conclusions

The 1950s and 1960s were thus decades of change for the American nursing profession. A new generation of nurse educators sought to create greater professional autonomy for the nurse by introducing new models of education that emphasized science-based learning over technical skills and bedside care. They also sought to create new clinical roles for the nurse, based on advanced graduate education. Because they did so, these educators confronted resistance from an older generation of nurses who feared becoming “second class citizens” in increasingly academic nursing schools and from academic health institutions all-too-comfortable with the gendered hierarchies of the health professions on which the traditional model of hospital-based nursing education was predicated.

The politics of nursing education reform played out quite differently at UCLA and the University of Minnesota. These differences were based in local institutional history, politics and culture, and the personalities of those involved. The institutional status of each nursing school within the university was particularly significant. Indeed, the changes in nursing education occurred at the same time that many American academic health institutions were being conceptualized or reconfigured as academic health centers (AHCs). AHCs are institutional umbrellas that combine all of a university’s health science schools, biomedical research institutes, and affiliated teaching hospitals and clinics. AHCs emerged as a new organizational form in the United States in the 1950s, replacing the traditional academic medical center model, which typically included an administrative alliance between the university’s medical school, hospital, and medical staff. With each health science school theoretically granted equal administrative status, AHCs were designed to dismantle the disciplinary silos that had
previously characterized the health sciences, where the educational needs of nursing and public health were routinely subordinated to those of medicine. AHCs were intended to promote interdisciplinarity in research and education, and a team approach to clinical practice by integrating nursing, medical, dental, pharmacy, public health, and allied health care. By the late 1970s, AHCs had emerged as a dominant institution in American health care.67

UCLA’s Center for the Health Sciences was one of the first AHCs to be organized in the 1950s. It was initially established as a traditional medical center when the regents of the University of California authorized a medical school at UCLA in 1945. However, it was quickly reconceived as an AHC following the establishment of a professional nursing school in 1949 and the initiation of plans to establish schools of dentistry and public health in 1960 and 1961. In 1970, the University of Minnesota reorganized its health science schools and hospitals into an AHC. In contrast to UCLA, the development of Minnesota’s AHC required administrative, intellectual, and physical reorganization of schools and colleges of the health sciences that dated back to the late 19th century when the schools of medicine, dentistry, and pharmacy were founded. Minnesota’s nursing school was established in 1909 as the first university-based school of nursing in the country, whereas the School of Public Health and College of Veterinary Medicine were established in the 1940s.

These institutional differences help explain the different politics encountered by the nursing education reformers in California and Minnesota in the 1950s and 1960s. At UCLA, the School of Nursing was an autonomous administrative unit within the university in which the dean had the same administrative authority as all the other UCLA deans, including the dean of the medical school. Lulu Hassenplug was a formidable leader by all accounts who brought to UCLA 10 years of curriculum development experience from her tenure as associate professor of nursing education at Vanderbilt University. As dean, Hassenplug had a direct line of authority to the university’s central administration. The school was only ever under serious threat when Franklin Murphy, a physician wedded to the diploma-school model of nursing education became chancellor. As Hassenplug reflected, “When you get somebody [in charge] who is not supportive, you have grave problems.”68

At Minnesota, in contrast, the School of Nursing was under the administrative authority of the dean of the College of Medical Sciences. The head of the nursing school had the position of director, not dean, and thus held substantially less administrative authority in the university. When Fritz was appointed director in 1959, she replaced the indomitable Katherine J. Densford, who, for 30 years, had commanded great respect and authority from those inside and outside the school. Densford’s retirement created an opportunity for the
younger faculty—particularly those who took the lead in the curriculum revisions—to assert their professional interests and identities on the school. Indeed, when Fritz arrived at Minnesota, the curriculum revisions were already underway. As Florence Marks reflected, Fritz’s Achilles heel [sic] was that she didn’t rein in the faculty when it should have been done. . . . I think that she had to just say, “Okay, you have to have enough [clinical instruction] in there that they can pass the state boards,” and that didn’t happen. So that was a fatal error, you might say.69

Fritz’s difficulties managing the faculty may in part have stemmed from her relative lack of experience as a faculty member before arriving at Minnesota. Her most immediate experience, after all, had been directing various educational projects at the National League for Nursing. Not only would this have presented Fritz with limited experiences of managing academic personalities, it may also have imbued some of the school’s faculty with a lack of respect for Fritz’s leadership credentials.

In spite of the differences, these case studies point to broader themes in recent nursing history, not least the highly contested nature of nursing education reform. During the 1950s and 1960s, a new generation of nurse educators confronted generational conflicts in schools of nursing from older faculty and clinical instructors who feared becoming “second-class citizens” in increasingly academic nursing schools. And they faced resistance from academic health care institutions comfortable with the gendered hierarchy of the health professions on which the traditional model of nursing education was predicted. These examples also reveal the ways state-supported academic health institutions—like the UCLA and the University of Minnesota Schools of Nursing—have, since the 1950s, played an increasingly critical role in coordinating the supply and distribution of health care professionals in a region. And in so doing, academic health institutions have served as instruments of state health policymaking.

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Notes

2. A. Marilyn Sime to Edna Fritz, 20 May 1968, University of Minnesota Archives, Office of Vice President for Academic Affairs, Box 30, folder: School of Nursing Review of Program 1967–1968.
5. This resonates with Susan Reverby’s assertion that nurses’ efforts to professionalize in the first half of the 20th century were “fractured both by patriarchal constraints from above and differences among women from within.” Susan M. Reverby, Ordered to Care: The Dilemma of American Nursing, 1850–1945 (New York: Cambridge University Press, 1987), 2.
6. Fairman, Making Room in the Clinic; Lynaugh, “Academic Nursing Practice”; and Lynaugh and Brush, American Nursing.
9. Ibid., 67.


16. Lulu Wolf Hassenplug, UCLA School of Nursing's Founding Dean, oral history interview conducted by Judi Goodfriend (Los Angeles: Oral History Program, University of California, Los Angeles, 1989).

17. Ibid., 243.

18. W. Eugene Stern to Stafford L. Warren, memorandum, 8 February 1957, in The role of the student nurse and the nursing school curriculum with respect to patient care, UCLA Archives, Collection RS300, Box 178, folder: Departments—Nursing 1957.


22. Hassenplug, UCLA School of Nursing’s Founding Dean, 249–50.


26. Hassenplug, UCLA School of Nursing’s Founding Dean, 337–42.

27. For a comprehensive history of the University of Minnesota School of Nursing see Laurie K. Glass, Leading the Way: The University of Minnesota School of Nursing, 1909–2009 (Minneapolis: University of Minnesota School of Nursing, 2009).

29. On the demonstration project see Edna Fritz, Toward Better Nursing Care of Patients with Long-Term Illness (New York: Division of Education, National League of Nursing, 1956).

30. Oral History Interview with A. Marilyn Sime, interview by Dominique A. Tobbell, April 15, 2010, University of Minnesota AHC Oral History Project, 6. The University of Minnesota Archives permits the use of excerpts from the oral histories that are part of the University of Minnesota Academic Health Center Oral History Project.

31. Brown, Nursing for the Future; Peplau, Interpersonal Relations in Nursing; Peplau, “Interpersonal Techniques”; Henderson, “The Nature of Nursing”; J. Arthur Myers, Masters of Medicine: An Historical Sketch of the College of Medical Sciences, University of Minnesota 1888–1966 (St. Louis: Warren H. Green, 1968), 541–44, which explicitly acknowledges that the reforms were based on Brown’s work.

32. Sime interview with Tobbell, 11.

33. Oral History Interview with Florence Marks, interview by Dominique A. Tobbell, April 13, 2010, University of Minnesota AHC Oral History Project, 41.

34. Oral History Interview with Marie Manthey, interview by Dominique A. Tobbell, October 12, 2010, University of Minnesota AHC Oral History Project, 5–6.

35. Ibid., 12–16.

36. Oral History Interview with Ruth Weise, interview by Dominique A. Tobbell, July 28, 2010, University of Minnesota AHC Oral History Project, 15. Some of the medical faculty expressed similar concerns about the inadequate clinical preparation of nursing students; see, for example, Oral History Interview with John P. Delaney conducted by Dominique A. Tobbell on 27 March 2012, University of Minnesota AHC Oral History Project, 16.

37. See, for example, “Recommendation for Establishing Consultative Support and Continuing Education Services from the U of MN for the Furtherance of Practical Nursing Education and for Development of Programs in Nursing Leading to an Associate Degree in the State of MN, Concurrent with Disestablishment of the University’s Program in Practical Nursing,” ca. 1966 or 1967, University of Minnesota Archives, Office of the Vice President of Academic Administration, Box 22, Folder: Medical Sciences—Programs 1966–1967.

38. Edna Fritz to William G. Shepherd, 18 April 1966, University of Minnesota Archives, Office of the Vice President for Academic Affairs Papers, Box 23, Folder: Medical Sciences Nursing Programs 1966–1967.


41. Edna Fritz to Robert Howard, memorandum, 19 February 1965, in Discontinuance of the Practical Nursing Program, University of Minnesota Archives, Office of the Vice President for Academic Affairs Papers, Box 23, folder: Medical Sciences Nursing Programs 1966–1967.


43. Fritz, Toward Better Nursing Care of Patients with Long-Term Illness.

44. Marks interview with Tobbell; quotation from Edna Fritz to William Shepherd, 25 March 1968, Office of Vice President for Academic Affairs, Box 30, folder: School of Nursing Review of Program 1967–1968.
45. Marks interview with Tobbell, 46.
46. Fairman, “Context and Contingency.”
47. For a summary of these studies see, Lynaugh and Brush, American Nursing, 8–9.
48. Toward Quality in Nursing.
49. For a study of health workforce needs, including nurses, in Minnesota see Oler L. Peterson and Ivan J. Fahs (Health Manpower Study Commission), Health Manpower for the Upper Midwest: A Study of the Needs for Physicians and Dentists in Minnesota, North Dakota, South Dakota, and Montana (St. Paul, MN: Hill Family Foundation, 1966).
50. “A Report on Nursing Education in the University of California as Related to the Needs of California and the West,” 7 January 1957, UCLA Archives, #RS300, Box 178, folder: Departments—Nursing 1957.
52. Brown, Nursing for the Future; Ginzberg, A Program for the Nursing Profession; and Margaret Bridgman, Collegiate Education for Nursing (New York: Russell Sage, 1953).
53. “A Report on Nursing Education in the University of California.”
54. George A. Pettitt to deans, memorandum, 23 March 1949, UCLA Archives, #RS300, Box 47, folder: Medical Education in California 1949–1955.
57. Edna Fritz to Elmer Learn, 1 September 1966, University of Minnesota Archives, President’s Office, collection 841, Box 231, folder: Medical School, School of Nursing, 1960–1969.
58. Edna Fritz to O. Meredith Wilson, 30 September 1966, President’s Office, collection 841, Box 231, folder: Medical School, School of Nursing, 1960–1969; “Recommendation for Establishing Consultative Support and Continuing Education Services.” The first two associate degree programs in Minnesota were established in 1964 at Hibbing Junior College in Hibbing and St. Mary’s Junior College in Minneapolis; by 1969 there were four associate degree programs in the state. See Fahs and Barchas, Nursing in the Upper Midwest, 5.
59. Hassenplug, UCLA School of Nursing’s Founding Dean, 277–79. WICHE was enacted in 1953 by the Western states of New Mexico, Montana, Arizona, Utah, Oregon, Wyoming, and Colorado as a way of efficiently coordinating and sharing resources among the states’ higher education systems. WICHE was focused in particular on ensuring that the states without their own health science schools could work with their Western colleagues to ensure that enough health care professionals would be produced for the entire region. California joined the compact in 1955.
60. Fahs and Barchas, Nursing in the Upper Midwest.
62. Stanley J. Wenberg to Lyle French et al., 7 May 1971; and Verne E. Long to Stanley J. Wenberg, 29 April 29, University of Minnesota Archives, President's Office, collection 841, Box 231, folder: Medical School, School of Nursing, 1971–1980.
63. William G. Shepherd, Statement to the School of Nursing Faculty, 22 March 1968, Office of Vice President for Academic Affairs, Box 30, folder: School of Nursing Review of Program 1967–1968.
64. Ibid.
65. Sime interview with Tobbell, 16.
66. Weise interview with Tobbell, 21.
67. For a fuller description of the emergence of AHCs, particularly at the University of Florida and the University of Rochester, see Fairman, “Context and Contingency,” 54–85.
68. Hassenplug, UCLA School of Nursing’s Founding Dean, 332.
69. Marks interview with Tobbell, 43.

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