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Short report

American Nursing Education Since World War II: History and Perspective

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Abstract

After World War II, American nursing began innovations that continue to the present. A brief, chronological review is presented of developments in the profession during the approximately 50-year interval. The discussion covers the evolution of registered nurse education as it shifted from predominantly hospital-based, diploma training to academic degree programs. Also reported is the influence of important studies on the profession through the years. The article concludes with reflections on the future. At the threshold of the 21^{st} century, nursing is re-examining its role in society to meet the challenges of the newly established *managed health care* system and an increasingly informed, health-oriented public.

Introduction

American nursing developed relatively recently in comparison to its European and British counterparts. History tells us that in 1839 the Nurse Society of Philadelphia under Joseph Worthington, MD, made the first attempt at an organized nursing school. He taught mostly medical students but included some nurses and gave them "certificates of approbation" on completion of training. The hospital-based, training school concept is what took root. The New England Hospital for Women & Children's training school graduated Linda Richards as its first professional nurse in 1873 (Doheny, Cook & Stopper, 1997). Without minimizing the historical importance of many significant events during the intervening years, it is the period following World War II that profoundly changed American nursing. Therefore, the overview of nursing education that follows will focus on the post WWII era.

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Licensed Practical/Vocational Nurses

The war changed nursing and nursing curriculums. Programs were improved, faculties were better prepared, and the work week was reduced to 48 hours and within another decade to 40 hours. Any historical review must note the advent of licensed practical or vocational nurses (LPN/LVN), which was a response to the severe nursing shortages following WWII. Individual states started training technical nurses, who received brief bedside nursing experience and were licensed beginning 1947. From that year to 1954, LPN schools increased from 36 to more than 260 providing over 50% non-professional nurses. By the 1990s, there were more than 1,100 LPN programs (Doheny, Cook, & Stopper, 1997).

The 1948 Brown Report

University nursing education had begun well before WWII. Between 1923 to 1925, Western Reserve University, Yale University and University of Chicago opened undergraduate programs. However, professional nursing was greatly influenced by a seminal document popularly called the "Brown Report." Esther Lucille Brown, a sociologist with Carnegie Foundation funding, conducted a study that was published formally in 1948 as *Nursing for the Future*, which focussed on what was best for society, not necessarily for the profession. Brown found nursing education needed two types of preparation. The first type should provide a foundation that permitted continuing growth in many areas (positive health and integration of personality; insight into personal motivation, behavior of others and cultural patterns; spoken and written language; skill in analyzing problems; perspective developed through historical and anthropological records; understanding the rights and responsibilities of citizenship; and membership in a profession). The second type of preparation needed was broader technical skills than those taught in hospital training schools. She believed that universities and colleges could best provide the foundation that was required. Regarding nursing service, Brown recommended mandatory licensure, expansion of in-service education with focus on interpersonal relationships, improved salaries and career opportunities, development of clinical specialists and increased research for nursing practice. The recommendations in the Brown Report influenced professional nursing to the present time (Brown, 1948).

Developments in the 1950s: Associate Degree in Nursing Programs and Clinical Nurse Specialists

The next decade produced two important developments: the two-year associate degree nurse (ADN) and the master's degree clinical nurse specialist (CNS). In 1952, Mildred Montag at Teachers College, Columbia University began the ADN program to fill the nursing shortage. She proposed that these programs be established in local community colleges, that graduates

be "technical RNs" with supervised clinical experience in hospitals, and that the ADN be a terminal degree. They were more broadly prepared than LPNs yet more limited than traditional professional RNs. By the mid-1960s, ADNs flourished and became the largest source of RNs in America (National League for Nursing, 1993). Contrary to Montag's intention, ADNs were regarded as professional RNs rather than technical nurses. The degree began to articulate with selected baccalaureate programs, the so-called second step or BSN-completion curriculums.

In 1955, Hildegard Peplau at Rutgers University, School of Nursing started the first psychiatric clinical nurse specialists (CNS) two-year program with an academic master's degree. Although at that time most graduates were recruited into school of nursing faculties, master's students learned to give expert, direct nursing care to patients with psychiatric diagnoses. Eventually, almost all other clinical nursing areas developed master's CNS programs.

1964 U.S. Nurse Training Act

The decade of the 1960s saw the focus expand from nurses to include improvements in quality of patient care, which meant more knowledge about science and humanities. The role of higher education was re-emphasized. The federal government's Nurse Training Act of 1964 provided generous funding to assist schools of nursing and to support individual students. Monies were available for nurse training grants including developing master's nursing specialties, research studies, and student stipends. Federal funds clearly propelled nursing education forward during the 1960s.

1965 American Nurses' Association (ANA) Position Paper

The ANA recognized that nursing needed to keep pace with the rapid scientific and technical advances that were impacting health care delivery. The 1965 ANA Position Paper stated that nursing education should occur in the general system of higher education. Also, it asserted that minimum preparation for entry into professional practice is the baccalaureate degree and the associate degree for technical practice. This caused serious, ongoing controversy because hospital-trained RNs, who represented the largest segment, felt their professional credentials were discredited . By the 1990s, however, there has been noticeable progress in meeting the recommendations(American Nurses Association, 1966).

Nurse Practitioners

Multiple factors gave rise to the role of the nurse practitioner (NP). After WWII, physicians preferred becoming specialists rather than general practitioners (primary care), and they liked working in urban and suburban areas rather than the under-served rural and inner cities. Maldistribution of doctors was a major problem throughout America. However, nurses were willing

to practice in rural areas and the inner cities. In 1965, a new, relatively autonomous nurse practitioner role was begun initially as post-bachelor's training and later incorporated into master's nursing programs. Their functions were to provide general health assessment of adults and children, treat common illnesses and chronic illness, prescribe routine medications and provide health education. Ill patients, who need medical attention, are routinely referred to physicians. The NP role developed parallel to the CNS and thrives to this day.

1970 Lysaught Report and 1973 Abstract into Action

In 1970, Joseph Lysaught chaired the *National Commission for Study of Nursing and Nursing Education*, which focussed on providing quality patient care. Composed of both nurses and non-nurses, the commission studied the following issues: supply and demand, roles and functions, education, and careers. The report had 58 recommendations but basically four major ones: 1) that research funds be used to study nursing's impact on health care and nursing education, 2) that nursing education take place in colleges and universities, 3) that each state form a committee to ensure that nursing education occurs within mainstream of American education, and 4) that government funding be secured for education and research. The Commission's outcome recommendations were published in the 1973 *Abstract into Action* and were implemented during the ensuing years (Lysaught, 1970).

1983 National Commission on Nursing and 1985 National Commission on Nursing Implementation Project

Composed of 31 persons from hospital and nursing administrations, nursing education, and other related organizations, the 1983 *National Commission on Nursing* studied nursing problems in health care, especially those concerning supply and demand and the extant nursing shortage. Among the issues reviewed, the Commission supported the trend to upgrade nursing education. In particular, it emphasized development of graduate education (master's and doctor's degrees) for nurses.

The 1985 *National Commission on Nursing Implementation Project* followed the 1983 Commission's study and focussed on 1) education and credentialing for beginning nursing practice, 2) models for nursing care delivery, and 3) development of the discipline of nursing (doctoral programs). The project was composed of four important nursing organizations: American Nurses' Association (ANA), American Association of Colleges of Nursing (AACN), National League for Nursing (NLN), and American Organization of Nurse Executives (AONE). This was another study whose recommendations for action greatly influenced nursing's direction. They published *Nursing's Vital Signs: Shaping the Profession for the 1990s*, which described approaches to education, management as well as practice research and development.

Nursing Education in the 1990s: Data and Assessment

More recently, the 1995 PEW Health Professions Commission reported on its task force's study on health care workforce's regulation. Their report, *Critical Challenges: Revitalizing the Health Professions for the Twenty-first Century*, looked at all health professions and recommended a "fundamental alteration of the health professional schools and the ways in which they organize, structure and frame their programs of education, research, and patient care." (PEW 1995, p. vii). The specific recommendations for nursing were:

- distinguish between practice responsibilities of the different levels of nursing, focussing associate preparation on entry-level hospital setting and nursing home practice; baccalaureate on hospital-based care management and community-based practice; and master's degree for specialty practice in the hospital and independent practice as a primary care provider.
- strengthen existing career ladder programs in order to make movement through these levels of nursing as easy as possible.
- reduce the size and number of (basic) nursing education programs by 10-20%. These closings should be in associate and diploma degree programs.
- expand the number of master's level nurse practitioner training programs by increasing the level of federal support for students.

Two decades of studies reveal that characteristics of nursing education have changed. In 1993, of 88,150 graduates, diploma schools provided 8% (they graduated 89% in 1955), associate degree 64%, and baccalaureate degree 28% (National League for Nursing, 1995). Graduate education in nursing, both master's and doctoral degrees, expanded rapidly in the last 20 years. This was due to the need for nurses in advanced practice (nurse practitioners, clinical specialists, midwives and nurse anesthetists), administrators, educators and researchers. In 1994, American Association of Colleges of Nursing (AACN) reported 328 master's programs with 6,770 graduates, an increase of 8.7% over the previous year. Also, doctoral programs have increased emphasizing development of nursing as a discipline with theoretical knowledge based on research. The AACN 1994 data showed 59 doctoral programs with 380 graduates (American Association of Colleges of Nursing, 1994).

Increasingly, nursing faculty in universities and colleges must have the doctoral degree to earn tenure. Doctoral graduates also become leaders in executive and policy-making positions related to health care and health care delivery. The various doctorates awarded are doctor of philosophy in nursing (PhD), doctor of nursing science (DNSc./DSN), and doctor of nursing education (DNEd).

The most recent development was publication of the 1996 *Essentials of Master's Education for Advanced Practice Nursing* (APN) by a prominent task force of the AACN. This might prove to be the latest landmark, national study. It established the framework for *the advanced practice nursing* role, which included CNS, NP, nurse midwives and nurse anesthetists. In preparing for nursing's increased primary care authority and responsibility, the AACN recognized the need to standardize the various curriculums. The study set forth recommendations for the

master's core curriculum for theory and practice including specific requirements for APN core content and clinical practice. The standardization served to inform not only nursing and other health professions but also the general public about the role and function of APNs (American Association of Colleges of Nursing, 1996).

Nursing Education for the 21^{st} Century

The American health care system now requires cost containment, access, and quality through a new delivery of care called managed health care. Nursing education must move quickly to provide adequate numbers of appropriately prepared nurses to function in the new system. Successful implementation will require the following :

1. Significant increases in the number of advanced practice nurses prepared to provide primary health care in communities and primary care services in group and interdisciplinary practices.
2. A shift in emphasis for all nursing education programs to ensure that all nurses—whatever their basic and graduate education and where they choose to practice—are prepared to function in a community-based, community-focussed health care system.
3. An increase in the number of community nursing centers and their increased use as model clinical sites for nursing students.
4. An increase in the number of nursing faculty prepared to teach for a community-based, community-focussed health care system.
5. A shift in emphasis for nursing research and an increase in the number of studies concerned with health promotion and disease prevention at the aggregate and community levels.
6. Targeted national initiatives to recruit and retain nurse providers, faculty, administrators and researchers from diverse racial, cultural and ethnic backgrounds (National League for Nursing, 1993).

Nursing needs to re-think its traditional relationship among teaching, research and community service in academia. They now must assume new forms in the public interest and a more direct relationship to the community rather than serving primarily academic interests. "The mission of nursing education turns increasingly not only to the promotion of quality care by educating qualified practitioners but to the creation of linkages that will allow the educational projects of its faculty and students to actually provide services. Both research and learning can be expected to focus more on community health needs than has been the case." (National League for Nursing, 1993, p.10)

Some nursing education will still occur in academic settings as well as hospitals, but more will occur where the people are—at homes, work sites, schools, ambulatory settings, long-term care facilities, shelters and community gathering places. Nursing curriculums will begin to look different from each other as they increasingly reflect the particular locale or community where the program is being taught. However, they all will need to educate for the macro-level of intervention rather than for micro-individual situations. Also education will need to teach nurses to assume greater professional authority and responsibility with less reliance on

institutional authority and policies (National League for Nursing, 1993).

The most important educational reform involves process. Technology has democratized information and has shifted access and control from the professional to the educated public. With the shift, the education focus moves from content to processes in

- critical thinking
- collaboration skills
- shared decision-making
- social epidemiological viewpoint
- analysis and intervention at the systems and aggregate levels

However, there is one issue that must be addressed before any changes can be made– faculty reform comes before curricular reform. Too few faculty know either by education, experience or research about a community-based primary health care system and even fewer are skilled educators for such a system. Existing community and public health programs were developed in an era with a different health system than the one currently being constructed. Faculty need to develop expertise about extra-institutional clinical sites, population-based care, cooperative relationships with consumers, principles and practice of public health, interdisciplinary collaboration and new relationships to knowledge and technology (American Association of Colleges of Nursing, 1996; National League for Nursing, 1993).

In varying degrees but a shared responsibility nevertheless, all programs and faculty must prepare nursing graduates for community-based care. This is America's vision of nursing education at the threshold of the 21^{st} century.

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