PURPOSES, ACTIVITIES, AND COLLABORATIVE EFFORTS OF THE DEPARTMENT OF NURSING AND THE COMMITTEE ON NURSING OF THE AMERICAN MEDICAL ASSOCIATION: 1961-1980

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We hereby recommend that the thesis prepared under our supervision by Karen Anne Bufton entitled Purposes, Activities, and Collaborative Efforts of the Department of Nursing and the Committee on Nursing of the American Medical Association: 1961-1980

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Dedicated to my Lord

and

to my parents, Kenneth and Jacqueline Bufton

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CHAPTER 1

INTRODUCTION

The struggle of American nursing to reach full professionalization has been hindered in numerous ways throughout its history. Perhaps the greatest obstacle to the attainment of this goal has been nursing's inability to adequately control the education and practice of all members of nursing. Various groups outside of nursing have concerned themselves with nursing education and practice and this external involvement has not always benefited nursing.

Since the appearance of the trained nurse, the medical profession has been one group that has maintained a strong interest in nursing. This interest persisted after the formation of the American Medical Association (AMA) as evidenced by the existence over the years of numerous committees that have been solely concerned with nursing. This continued interest in nursing by the AMA culminated in the formation of the Department of Nursing in 1961. The department was established to provide the Committee for Liaison with National Nursing Organizations with the personnel and

facilities to enhance the ability of the committee to engage in liaison activities. The underlying purpose of these activities was to improve interprofessional relationships. The formation of this committee was indicative that the AMA formally recognized the need for improved communication with nursing.

In the early 1960s, nursing was seeking improved relations with medicine in order that a mutual understanding could be reached. Nursing leaders recognized that a collaborative relationship would be necessary if nursing were to reach a professional standing. The American Nurses' Association (ANA), therefore, became engaged in activities with the AMA's Department of Nursing that were aimed at the establishment of a collaborative relationship.

In order to gain an understanding of the present situation, nursing must understand the past. An analysis of the activities of the AMA regarding nursing and the actions directed toward collaboration may provide additional insight into the existing factors that hinder collaboration and, thereby, impede the attainment of a full professional status.

Problem of the Study

The problem of this study was to identify the factors that led to the development of the Department of Nursing and the Committee on Nursing of the American Medical Association, the goals and activities of the department and committee, and to determine the extent of formal collaboration undertaken by the department and committee with nursing.

Justification of the Problem

Few nurses practice in an environment void of some degree of collaboration with members of the medical profession on either a formal or informal basis. Nursing and medicine have not, however, reached a level of collaboration and collegiality that is believed to be essential in order to provide the highest quality of health care to the consumer.

> Nursing and medicine, as the two major health professions, have the greatest potential to improve the quality and the quantity of the health care delivered in this country through their collaborative efforts. That potential, however, is not being realized. Collaboration between the two professions and collegial relationships, as colleagues, among their members are proposed by innovative, idealistic educators, administrators, and organizers in nursing. There are precious few supporters of this line of thinking in medicine or, indeed, among the rank and

> file of nurses. In order to understand why this is so, we must understand past and present interrelationships between the two professions. We need to define the problems that exist. Then perhaps we can determine whether solutions can be found to those problems so that collaboration and collegiality can occur. (Hoekelman, 1978, p. 330)

Sporadic attempts at collaboration have been made by nursing and medicine since the early 1960s; however, for the most part, these efforts have resulted in failure. This failure to establish a mutually beneficial interprofessional relationship has implications for nursing. At a time when nurses are well prepared to serve clients in expanded roles, physicians continue to view nursing as an adjunct to medicine. Physicians visualize expanded roles assumed by nurses as medical roles rather than nursing roles and persist in their efforts to set the parameters within which nurses will practice.

The AMA published a Position Statement in 1970, which dealt in part with expansion of nursing roles:

> The AMA recognizes the need for and will facilitate the expansion of the role of the nurse in providing patient care. Professional nurses, by the nature of their education, are equipped to assume greater medical service responsibility under the supervision of physicians. . . . The addition of nurses . . . would provide much-needed services to the consumer, enhance nursing

> as a profession, and extend the hands of the physician. ("Medicine and Nursing in the 1970s: A Position Statement," 1970, p. 1881)

An interesting dichotomy becomes apparent when comparing the above statement with Conley's preface to the "Objectives and Program of the AMA Committee on Nursing," (1962):

> The continued achievment of the high standards of patient care in the preventive, curative, and restorative aspects of illness depends upon a harmonious, collaborative relationship between medicine and nursing. In an effort to protect and foster an enduring alliance of understanding and cooperation between these two major health professions, the Committee on Nursing has instituted a continuing program of liaison, communication, education, and research. (p. 430)

True collaboration between nursing and medicine in order to provide the quality of care desired cannot be realized until medicine views nurses as colleagues rather than an extension of the medical discipline.

Nursing indeed falls short of full professionalization if, as stated by Bixler and Bixler (1966), a "profession functions autonomously in the formulation of professional policy and in the control of professional activity thereby" (p. 69). To gain full professionalization, nursing must set its own parameters of practice. The failure of nursing and medicine to reach a collaborative relationship has retarded the

growth of nursing towards the realization of that goal.

An analysis of the formal structure of the AMA as it relates to nursing will, if viewed within the historical context, provide nursing with a new perspective in regard to nursing's relationship with medicine. The factors that brought about the formation of the Department of Nursing, the goals and activities of the department, and the extent to which collaborative efforts were undertaken were, therefore, examined to provide a historical perspective in which to understand the status of current interprofessional relationships and to prepare for future efforts in that direction.

Assumptions

This study was based on the following assumptions:

1. Knowledge of history provides a broader perspective and insight.

2. The American health care delivery system would benefit from effective communication and collaboration between nursing and medicine.

3. Effective collaboration between nursing and medicine would facilitate nursing's realization of full professionalization.

Research Questions

This research study was undertaken to answer the following questions:

1. What factors influenced the formation of the Department of Nursing and the Committee on Nursing within the American Medical Association?

2. What were the formal goals of the Department of Nursing and the Committee on Nursing?

3. What were the activities undertaken by the Department of Nursing and the Committee on Nursing to meet their stated goals?

4. What were the issues related to nursing with which the Department of Nursing and the Committee on Nursing concerned themselves?

5. To what extent did the Department of Nursing and the Committee on Nursing collaborate with the American Nurses' Association?

Definitions of Terms

For the purpose of this study, the following terms were defined:

1. Department of Nursing--department formed in 1961 within the AMA to provide the Committee for Liaison

with National Nursing Organizations with the

> personnel and facilities to pursue on a broader scale those activities which it has utilized in the past in its efforts to improve intra-professional relationships. ("Committee for Liaison with National Nursing Organizations," 1961, p. 154)

2. Committee on Nursing--committee formed by the AMA in 1961 with four main concerns related to nursing (liaison, education, consultation, and research) and originally named the Committee for Liaison with National Nursing Organizations; the name of the committee was changed in 1962 to the Committee on Nursing.

3. Development of the Department of Nursing and the Committee on Nursing--historical events and factors leading up to their formation; issues external to nursing and medicine that contributed to medicine's interest in nursing.

4. Goals of the Department of Nursing and the Committee on Nursing--formal statements of goals by the department and/or committee.

5. Activities of the Department of Nursing and the Committee on Nursing--areas of action taken by these groups, particularly in relation to nursing, as determined from reports issued by the groups.

6. Extent of formal collaboration--the number of activities undertaken jointly by medicine and nursing; specific role functions of nurses and doctors who participated in joint efforts as determined by personal accounts and statements issued by collaborative groups.

Limitations

This study was limited by the availability of primary and secondary sources that were restricted by geography and limited access by the nurse researcher.

Procedure for Collection and Treatment of Data

The historical method of research was utilized in the analysis of the stated problem. Relevant data related to the problem was obtained by means of primary and secondary sources. Permission to conduct this investigation was received from the Human Research Review Committee of Texas Woman's University (Appendix A) and from the graduate school (Appendix B).

Data related to the formation of the Department of Nursing and the Committee on Nursing were obtained from the official organ of the AMA, the Journal of the

American Medical Association, and its official newsletter, the Medical News. The nursing literature including the official organ of the ANA, the American Journal of Nursing, its official newsletter, the American Nurse, and other selected sources were also examined to identify trends in nursing that may have contributed to the development of the department and the committee.

The formal goals and the activities carried out by the AMA were determined from that organization's official organ and newsletter. The issues with which the department and committee were concerned were also identified in this manner. Other medical literature was also utilized as necessary to isolate concerns of the AMA. Nursing literature was also considered in the manner in which nursing responded to the activities, goals, and issues related to the department and the committee.

The extent of collaboration between medicine and nursing was examined by use of selected journals and monographs dealing with these efforts. Nurses and physicians involved in the collaborative efforts were asked to contribute personal accounts.

Data collection was limited to materials produced during or relating to the time frame including 1961 to 1980, with consideration of factors that may have existed prior to this time period. The data were then organized as it related to the development, goals, and activities of the Department of Nursing and the Committee on Nursing of the AMA as it related to collaborative efforts undertaken by nursing and medicine.

Summary

Interprofessional relationships between nurses and physicians have not historically been beneficial to either discipline or to society in general. With the expanding demands placed on the health care system, these health care providers must work together effectively in joint efforts. A productive interprofessional relationship is mandatory if utilization of both groups of care providers is to be maximized. A historical analysis of the past efforts of nurses and physicians to develop and maintain collaboration would provide valuable insights to guide future efforts in this direction.

CHAPTER 2

AMERICAN MEDICAL ASSOCIATION COMMITTEES ON NURSING: HISTORICAL OVERVIEW

The formation in 1961 of the Department of Nursing within the formal structure of the American Medical Association (AMA) was not an isolated event but was, rather, the culmination of a century of committees that had been organized by the AMA for the purpose of examining, evaluating, and making recommendations about nursing education and nursing practice. In order to fully understand the implications and the impact of the Department of Nursing, it is necessary to examine the long historical involvement of the AMA in issues related directly to nursing. In response to the initial research question, "What factors influenced the formation of the Department of Nursing and the Committee on Nursing within the American Medical Association?" the many committees concerned with nursing issues formed within the medical organization were identified, examined, and analyzed in relationship to the purposes, activities, and efforts, if any, to

collaborate with organized nursing. As early as 1868, Dr. Samuel Gross, then president of that body, proposed to the AMA that a committee be appointed to examine the feasibility of training women in the United States to be nurses. This proposal resulted in the establishment of the first AMA committee on nursing consisting of three physician members: Samuel Gross, Elisha Harris, and Charles Lee ("Report of the Committee on the Training of Nurses," 1868).

Committee on the Training of Nurses

The establishment of the Committee on the Training of Nurses in 1868 was largely in response to social changes that had occurred during the previous two decades. The Crimean War, ending in 1856, had a revolutionary impact on society. Not only was it the first war in which war correspondents were present, it was the theater in which Florence Nightingale so altered the care of the sick and the wounded that she earned her immortality.

Prior to the arrival of Nightingale and the 38 women accompanying her to Scutari, the English soldiers embattled in Crimea were receiving little or no care.

The conditions within the Barrack Hospital at Scutari were horrible and undeniably in need of severe reformation despite the presence of medical officers. Within this setting, Nightingale dramatically demonstrated the positive effects of nursing on the mortality and morbidity rates among England's soldiers and on the entire milieu in which these men were confined. This decrease in mortality and the general improvements brought about by Nightingale's efforts were publicized around the world (Kalisch & Kalisch, 1978; Kelly, 1981).

The gratitude of the people of England was demonstrated by their donation of a large sum of money to Nightingale after her arrival in England following the end of the war in Crimea. With these funds, she established the first school solely for the purpose of training women to be nurses outside of religious orders (Dock & Nutting, 1935). This endeavor by Nightingale proved to be successful. Because of her work in the Crimea and at St. Thomas Hospital in London and her published writings, Nightingale's achievements were internationally recognized. Awareness and acceptance of Nightingale's work in England led to the realization on the part of the general public as well as many

physicians that the same type of changes needed to be effected in the United States.

The Civil War vividly demonstrated the lack of adequate nursing care in America. When the war commenced in 1861, there was no organized method of caring for the sick and wounded (Kelly, 1981). Within a matter of weeks, various groups of women were mobilized toward providing nursing care to the sick and wounded. Several thousand women served the North and the South in the capacity of nurses, but very few had any type of formal training. Kelly (1981) attributed the state of nursing during the Civil War and the fame of Nightingale as being the impetus for the arousal of American public interest in nursing and the subsequent interest demonstrated by the AMA. In addition, conditions in American hospitals were deplorable. Hospitals of the era were literally unfit for human inhabitation. Filth was abundant, infection was rampant, and mortality rates were astronomical.

The nursing care that was available in these institutions was primarily in the hands of unskilled and uneducated women, many of whom were of questionable character not unlike Dickens' (1910) fictitious

character, Sairy Gamp. Kalisch and Kalisch (1978) described the nursing care of the 1860s in the following way:

> During the 1860s the nursing service at most hospitals was haphazard and disorganized. While some women developed an aptitude for nursing and achieved positive results in caring for the sick, the majority of nurses at that time were uneducated and often morally unfit to assume responsibility for patient care. This was especially true in large city hospitals, where nurses were often recruited among the poor who had sought shelter in almshouses.
>
> At Bellevue Hospital in New York the wards were staffed by former inmates of the workhouses on Blackwell's Island called "ten-day women." Arrested for public drunkenness or disorderly conduct and sentenced to 10 days in the workhouse, they were paroled as soon as they had recovered sufficiently to be of service, provided that they agreed to undertake nursing in the Bellevue wards. (p. 79)

It was within this social context that Gross' Committee on the Training of Nurses presented its report to the AMA. The report of the Committee presented historical descriptions of nursing service in Europe and theorized that the successful experiments made in that vein would be equally successful in America. The Committee reflected on Nightingale's accomplishments, and on her training methods at St. Thomas Hospital. The Committee's evaluation of the effect of trained nursing on health care in England and other countries in Europe was positive:

> Another factor determined by the experience of the last ten years is that there is not only a marked diminution of mortality in those hospitals in which nursing is performed by trained women, but a decided diminution in their expenditure, and a great improvement in the moral condition of the inmates. ("Report of the Committee on the Training of Nurses," 1869, p. 171)

The report of the Committee focused on the need for trained nurses in the United States and supported the concept that training schools should be established to prepare women to nurse the sick. As the report stated:

> Nursing in its more exalted sense, is as much of an art and a science as medicine. The educated physician is sought far and wide; his skill is in constant requisition; day and night he is at the bedside of the sick and dying; at every visit he makes his prescription and leaves his instruction; he literally wars with disease and death; he necessarily from causes which no human agency can control, loses many patients; and many also who could be saved if his efforts were properly seconded by efficient nursing. The commander of an army cannot be victorious if he is not properly aided by his subordinates, the lieutenants, whose duty it is to carry out his orders and the minor details of the campaign. In private life there is hardly one really good, intelligent, or accomplished nurse in a hundred who exercise the functions of that office, one who is perfectly familiar with all the duties and requirements of the sick-room; and what is true of private society is still more true of the hospitals, almshouses, infirmaries, asylums, jails, workhouses, and similar institutions in the United States. It is a mistake to suppose, as is so often done, that any and every individual, whether male or female, is fitted for such an

> occupation, as if nursing, like poetry, were a gift of nature. ("Report of the Committee on the Training of Nurses," 1869, pp. 162-163)

The report of the Committee clearly recognized the valuable contributions that could be made by the use of a trained nurse in the sickroom and made a strong argument in support of the establishment of training schools in the United States. However, the report also made the assumption that it was the responsibility of the physician to determine the boundaries of nursing practice. The nurse's contribution to the care of the sick was certainly limited in the minds of Committee members. She was envisioned as being of value to the medical practitioner by serving as an appendage; that is, she would follow orders and manage minor details. It is of interest to note that this attitude was conveyed publicly by members of the medical profession 4 years prior to the formation of the first training schools in America based on the Nightingale system.

At the conclusion of the report, the following recommendations regarding the provision of trained nurses to meet the need of medicine and society were set forth:

> To afford the proper facilities for carrying out this grand design, the Committee are of the

> opinion:
> 1st. That every large and well-organized hospital should have a school for the training of nurses, not only for the supply of its own necessities, but for private families, the teaching to be furnished by its own medical staff, assisted by the resident physicians.
> 2dly. That, while it is not at all essential to combine religious exercises with nursing, it is believed that such a union would be eminently conducive to the welfare of the sick in all institutions; and the Committee therefore earnestly recommend the establishment of nurses' homes, to be under the immediate supervision and direction of deaconesses, or lady superintendents, an arrangement which works so well in the nurses' homes at London, Liverpool, Dublin, and other cities in Europe, and at the Bishop Potter Memorial House in Philadelphia.
> 3dly. That in order to give thorough scope and efficiency to this scheme, district schools should be formed, and placed under the guardianship of the county medical societies in every State and Territory in the Union, the members of which should make it their business to impart, at such time and place as may be most convenient, instruction in the art and science of nursing, including the elements of hygiene, and every other species of information necessary to qualify the students for the important, onerous, and responsible duties of the sick-room. The Committee would further suggest the importance of forming in every convenient place nurses' societies, the regular members of which should, in all cases, other things being equal, have the preference, as it respects the recommendations of the practitioner over the ordinary ignorant or uneducated nurse. ("Report of the Committee on the Training of Nurses," 1869, pp. 172-173)

The conviction held by the Committee that trained nurses could improve the care of the sick in America was wholly justifiable in view of their analysis of

the positive effects of the employment of these women in European institutions. The "Grand Design" of the Committee, however, presented some invalid conclusions. The role of the nurse was very narrowly defined within the parameters of assuming delegated responsibility. Members of the Committee failed dramatically in identifying the unique contributions of nursing. They visualized the trained nurse as subordinate rather than complimentary to the physician.

Nightingale had clearly delineated in her written works the differences between nursing and medical practice. In her Notes on Nursing: What It Is and What It Is Not, Nightingale (1891) made the following differentiation between nursing and medical practice:

> Pathology teaches the harm that disease has done. But it teaches nothing more. We know nothing of the principle of health, the positive of which pathology is the negative, except from observation and experience. . . . Surgery removes the bullet out of the limb, which is an obstruction to cure, but nature heals the wound. So it is with medicine; the function of an organ becomes obstructed; medicine, so far as we know, assists nature to remove the obstruction, but does nothing more. And what nursing has to do in either case, is to put the patient in the best condition for nature to act upon him. (p. 133)

In their analysis of Nightingale's achievements, the Committee remained totally ignorant of what nursing was

and what nursing could achieve outside the confines of medical practice. They failed to realize that, in achieving an unprecedented reduction in mortality rates in the Crimea, Nightingale had not practiced solely as an extension of the physician. With medical officers in attendance, the mortality rate was 60%. The methods employed by Nightingale decreased the mortality rate to 1%. By meeting the basic physiological and psychological needs of individuals and by employing simple hygienic methods, Nightingale had maximized the intrinsic ability of the body to heal itself.

The statements made in the Committee's report reflected three major beliefs held by many physicians that have persisted to the present day. First of all, Gross expressed the attitude that physicians must assume the role of guardianship over nurses and that, in fact, physicians had an obligation to do so. This attitude has gone unquestioned by many physicians throughout the century following the presentation of the report. In an editorial comment in the Journal of the American Medical Association (JAMA) in 1899, this attitude was stated:

> We have had experience enough to know that nurses, estimable and indispensable as they are, are not

> impeccable angels but mortal women with various feminine and epicine failings that call for eternal vigilance on the part of professional employers. These remarks are not intended as disparaging to the class, but simply as a wholesome reminder of these human imperfections and the constant need that they should be met and as far as possible overcome. ("The Nurse's Responsibility," 1899, p. 1556)

Even as recently as 1970, the AMA continued to advocate the belief that the nurse could only function under the supervision of a physician ("Medicine and Nursing in the 1970s: A Position Statement," 1970). The pervasiveness of this belief can be attributed to the enduring myth of male supremacy.

Since the appearance of the trained nurse in America, members of the medical profession have devalued the contributions of nursing. The paternalistic attitude of medicine toward nursing is inextricably tied to the attitude of society towards women in general.

> Throughout American history the medical profession has cultivated and maintained a male-dominant position over women. Historical data reveal the medical profession's preoccupation with profits, male privileges, and control over others. Much of the supremacy, power, control, and privilege the medical profession seeks to create for itself stems from the notion that the physician is a "man among men." The manifest sexism of the medical profession is not incidental, nor is its sexism merely the reflection of the sexist attitudes of society in general. The medical profession has gone one step further.

> It is a citadel historically designed to control women and to keep them "in their place." (Lovell, 1982, p. 215)

Because of women's perceived inferiority, nursing has traditionally been viewed by medicine, the public, and a number of nurses as a dependent occupation. Physicians have actively sought to limit and control the education and practice of nurses in order to maintain their superiority. Little recognition has been given to the unique functions of the nurse in the provision of care. The devaluation of the nurse's role is resultant of the myth of the nurse's being subservient to the physician and the social system that places a higher value on work performed by men than on the work performed by women (Passau-Buck, 1982).

The second enduring belief of the Committee was that physicians should control nursing practice by reason of the nurse's subservient, dependent role. The desire on the part of many physicians to determine the parameters of nursing practice can be traced to current times. "Medicine and Nursing in the 1970s: A Position Statement" (1970) indicated that in order to expand the role of the nurse, "certain medical services could be translated into nursing functions" (p. 1881). The idea

that the nurse's role could be expanded by absorbing discarded "medical services" reflected the assumption that nursing is not a unique profession in its own right with services to offer to the public that are distinct and separate from medical care. The belief that medicine must control and define the limits of the practice of nursing is based primarily on this assumption.

Finally, even before the establishment of training schools in this country, physicians were astutely aware of the benefit of nursing to medicine and medical practice. In a presentation by Gross (cited in "Report of the Committee on the Training of Nurses," 1869), this speaker commented on the projected decrease in mortality rates that could be achieved with the utilization of trained nurses at the bedside of the sick. The report indicated an eagerness on the part of physicians to capitalize on Nightingale's methods used in the sick-room, not only because it would enhance the credibility as well as the image of the physician with the public, but also because there was growing evidence that the cost of care could be reduced by having trained women nurse the sick.

The AMA of the present is as aware of the benefits of having nursing aligned with the practice of medicine

as Gross was 100 years before. The 1970 Position Statement reported that the increased utilization of nurses could improve the quality of medical care. The Position Statement gave several examples of ways in which nurses could be of benefit to physicians. The list of benefits to the physician included the following:

> 1. the physician can move toward the expanded role of planner and manager of a program for comprehensive care of his patients;
> 2. the physician is allowed to concentrate on those matters demanding his skill;
> 3. basic service procedures can be increased and amplified because the nurse associate will be prepared to give patients more time and attention;
> 4. the release of more time to the practicing physician will permit his greater participation in programs of continuing education. ("Medicine and Nursing in the 1970s: A Position Paper, 1970, p. 1881)

Following the presentation of the Report of the Committee on the Training of Nurses in 1869, the AMA's interest in nursing was not evident. The recommendations of the Committee were not directly acted upon even though attitudes expressed in the report tenaciously persisted. The lack of an immediate response on the part of the organization's membership to the Committee's recommendations can be partially attributed to the fact

that the AMA had not yet reached a position of social and economic power and was largely ineffective on the state and local levels (Bordley & Harvey, 1976). The membership's interest in nursing became overshadowed by their concern over the lack of quality in medical education, which became the focal point of the AMA interest and activity until 1923.

Council of Medical Education and Hospitals

Goldmark Study

During the 54-year time span between 1869 and 1923, nurses were also engaged in activities aimed at the establishment of nursing as a profession in its own right. Nursing schools based on the Nightingale model were established in 1873 and, during the years following, the number of nursing schools proliferated. By the turn of the century, nursing leaders became visible. Nurses had begun to organize and to identify problems that were unique to their occupation. One of the most glaring problems was the inadequacy of nursing education.

Nursing leaders like Nutting, Robb, and Fenwick were communicating the need for improvement in education.

As the number of schools had grown, they had done so without controls. Nutting, along with other nurses, realized that reform in the training of nurses was of paramount importance if nurses were to achieve a professional status. Areas in need of reformation were delineated by Isabel Stewart in 1927.

> The low standards of admission to many schools, the long hours of student service, the circumscribed curriculum, the lack of teachers and supervisors, and many other unfortunate conditions can be traced to this system [of the economic dependence of the schools on the hospitals]. (Stewart, cited in Hughes, 1978, p. 64)

The lack of uniformity in curriculum and the deficits apparent in the apprenticeship system provided the focus of nursing's interest in the years ahead (Kalisch & Kalisch, 1978, Kelly, 1981).

Following the publication of the Flexner Report in 1910, nursing sought funding so that a similar study aimed at upgrading the educational preparation of nurses could be conducted. After failing to obtain funds through the Carnegie Foundation, which had financially backed the Flexner Report, nursing was able to secure funding for a study of nursing education through the Rockefeller Foundation (Kalisch & Kalisch, 1978).

The original plan of the Rockefeller Foundation was to fund a study of public health nursing. It quickly became apparent, however, that the lack of adequately prepared nurses to meet the public health needs of society had its roots in the basic education of the nurse. Awareness of this fact resulted in a broadening of the original study to include an investigation into nursing education in general ("From the Report of the Committee on Nursing Education," 1922). The Foundation appointed the Committee for the Study of Nursing Education in January 1919, and the results of the study and the Committee's recommendations were published in 1923 (Kelly, 1981).

The Committee consisted of 6 nurses, 10 physicians (2 of whom were hospital superintendents), and 2 laymen. The goals of the Committee on Nursing Education were:

> to survey the entire field occupied by the nurse and other workers of related type; to form a conception of the tasks to be performed and the qualifications necessary for their execution; and on the basis of such a study of function to establish sound minimum educational standards for each type of nursing service for which there appears to be a vital social need. ("From the Report of the Committee on Nursing Education," 1922, p. 882)

The activities of the Committee undertaken to accomplish their goals were to study 23 hospital schools of nursing, representing all types, and to gather opinions of leading nursing educators (Kelly, 1981). The results of the study were published under the title of Nursing and Nursing Education in the United States, but the report is more commonly referred to as the Goldmark Report in honor of the chief investigator, Josephine Goldmark.

The major conclusion of the Goldmark Report was that the existing apprenticeship training was not adequate to prepare women for nursing. The Committee arrived at the conclusion that all nurses needed a basic standardized education and that the education of nurses should be directed by individuals who were qualified and committed to that goal. Lack of independent financial support for nursing education was identified as the major obstacle facing the nursing field in its attempts to provide quality nursing education.

The Committee made the following recommendations in view of their conclusions:

1. Specific educational standards should be established and maintained in all training schools for nurses.

2. A subsidiary grade of nurses should be legally recognized. These nurses should receive a shortened training course (approximately 8 or 9 months) and should be employed to care for the less critically ill or convalescent patient.

3. By eliminating the noneducational and unessential tasks required of student nurses, the training period for the nurse could be reduced to 28 months.

4. Superintendents, supervisors, teachers, and public health nurses should receive training beyond the basic nursing course.

5. Nursing leaders should be educated in university schools of nursing.

6. The completion of high school or its equivalent should be required for all applicants to training schools.

7. Nursing should secure funding for endowments of nursing education in the university setting. ("From the Report of the Committee on Nursing Education," 1922).

Committee on Trained Nursing

in 1922, the same year that the general findings of the Goldmark Report were released and 1 year prior to its official publication, the Council on Medical Education and Hospitals of the AMA created the Committee on Trained Nursing. The Council on Medical Education had originally been formed in 1904 and was concerned only with the education of the physician. In the early 1920s, the Council expanded its scope to include nursing education by renaming itself the Council on Medical Education and Hospitals. Ashley (1976) asserted that the renaming of the Council was an action aimed at providing official sanction for the AMA to become more actively involved in hospital and nursing affairs. Since nursing education was so intimately tied to hospitals, physicians assumed they had a right and an obligation to involve themselves in matters concerning nursing education and practice.

The newly created Committee on Trained Nursing was appointed to investigate the problems of nursing education and to recommend appropriate solutions. The creation of the Committee was completed in November 1922, and the investigation took approximately 4 months. The

Committee was composed of five physicians and two hospital administrators, who were also physicians. The stated purpose of the Committee was to "make a preliminary investigation of the problems of nurse education and to recommend what should be done ("Nurse Training," 1923, p. 1932).

The manner in which the Committee approached the accumulation of information is of extreme interest. According to the Minutes of the House of Delegates of the American Medical Association, the Committee was provided with a copy of the recently completed Goldmark Report and this provided the basis of their report. The methodology of the Committee was reported in the following manner:

> An extensive exchange of ideas by correspondence was carried on, and the chairman held numerous conferences with groups of physicians, leaders in nursing education, and such members of the committee as were in the eastern part of the country. No complete survey was either possible or necessary, since the detailed report of the recent extensive survey made under the auspices of the Rockefeller Foundation was placed at the service of the committee. ("Nurse Training," 1923, pp. 1932-1933)

Despite the publicly stated purpose of the activities of the Committee, the Committee's major function was to read the Goldmark Report, which was the result of

nursing's efforts to solve its own problems. The Committee on Trained Nursing then made its own recommendations for how the problems of nursing education could be solved.

Since the focus of the Committee's efforts was the study of the Goldmark Report, it is not surprising that their conclusions were remarkably similar to the findings of the Committee for the Study of Nursing Education. The Committee on Trained Nursing identified the following deficiencies in nursing education:

> 1. The course, on the whole, is unsystemized, unstandardized, and far from uniform.
> 2. There is too little systematic instruction in practical work and too much theory, and certainly a lack of correlation between the two elements.
> 3. Too many of the teachers are poorly qualified.
> 4. There is too much waste of the pupil nurses' time in uneducational routine work.
> 5. Many schools are connected with hospitals having utterly inadequate clinical facilities. ("Nurse Training," 1923, p. 1933)

The major discrepancy between the findings of the two committees was in relation to the amount of theory instruction provided for student nurses. The Committee on Trained Nursing expressed the belief that there was "too much theory," whereas the Goldmark Report commented on the sparcity of theory instruction in many training

schools. The attitude held by many physicians that nursing was an occupation dependent on medical guardianship and direction provided the basis, in large part, for this discrepancy in the findings of the two committees.

Physicians demonstrated a marked interest in the level of education required for nurses beginning shortly after the introduction of the trained nurse in America. Ingles (1976) documented this interest by historically reviewing physicians' arguments for and against levels of nursing education in the medical journals. Ashley (1976) addressed the attitude of physicians during the early 1920s:

> After the First World War . . . physicians increasingly expressed their disapproval of and their animosity toward nurses. They argued that the nurse should remain "a true physician's assistant" and should continue as a "household helper" in the homes of the sick. "For her own good," they wanted her to "be a little more human" rather than seek higher standards and legal protection. All she needed to know was how "to write, to read, to reason." In 1923, the House of Delegates of the American Medical Association concluded that the nursing problem had become a "vexed question" and that the nurse should "remain a trained lieutenant of the physician." Their increasing hostility toward nurses in the 1920s was a reaction to the registration efforts and higher recommended standards set forth by the National League for Nursing Education. (p. 119)

The disagreement over the amount of theory to be included in educational programs for nurses that began at the turn of the century was only the beginning of many such controversies.

The proposed solutions to the problems identified by the Committee on Trained Nursing and the Committee which prepared the Goldmark Report were also similar. Both committees recommended university education for superintendents and instructors in nursing schools, the establishment and maintenance of minimum educational standards for training schools, the development of a subsidiary type of worker in nursing, the shortening of the hospital training period to 28 months with the elimination of nonessential, repetitive tasks, and the 4-year high school education as a prerequisite for nurse training.

The Committee on Trained Nursing went beyond the Goldmark Report by making additional recommendations. They suggested that a committee be formed composed of:

> (a) physicians who are competent clinical teachers, (b) representative nurses, and (c) at least one educator who is neither a physician nor a nurse; that this committee be arranged for by the American Medical Association in conjunction with the National League of Nursing Education, each having equal representation and

> appointing its own representatives, and that the educator be selected by the other members of the committee when appointed. ("Nurse Training," 1923, p. 1934)

The goals and activities of this proposed new committee were not identified within the recommendation. The Committee on Trained Nursing also recommended that a classification system be established whereby only those schools which met a certain standard would be considered acceptable. As a result of this interest in a classification system for schools of nursing, the Committee became aligned with nursing organizations in such an endeavor in 1925.

Although nurses and physicians had served on committees together previously, this proposed committee, which became a reality in 1923, would be the first the AMA had initiated as a joint endeavor. It is comprehensible that this gesture on the part of the AMA was aimed at the development of a method of influencing the trajectory of the course upon which nursing was set. Nursing was struggling to elevate standards of education and to gain legislative control over practice.

At the time the Preliminary Report of the Committee on Trained Nursing to the Council on Medical Education

and Hospitals of the American Medical Association was presented formally at the Annual Congress on Medical Education, Medical Licensure, Public Health and Hospitals, there was a minority of physicians present who were not convinced that it was the right or the obligation of the AMA to attempt to solve nursing problems. In the Minority Report of the Committee on Trained Nursing, Dr. Richard Olding Beard stated:

> The proposal of the majority of your committee that the American Medical Association should, at this late day, initiate a new movement of its own for the futile repetition of an already fulfilled purpose, the formulation of a model curriculum, will be unwelcome to the profession of nursing. Even were it a necessary or desirable thing to do, the work to be studied is nursing and not medicine, and concerning the greatly major part of its medical opinion would obviously be of little service. It is neither necessary nor desirable. About the last thing that nursing education needs is the multiplication of model curriculums. What it does need is a broad educational policy which may be brought to bear on the schools of nursing through the mechanism of their classification, to the higher levels of which they will then strive, in the interests of their own survival to reach. The majority's proposal to preempt an equal representation with the nursing profession on a working committee is doubtfully politic. The medical profession of today must realize that it may fitly offer, while the profession of nursing may fitly accept, its friendly counsel in matters of nursing education, but it is no longer in a position, if it ever possessed the right, to dictate its conditions or to determine its limits. Its assumption of that right cannot fail of resistance

> from the profession of nursing. ("Minority Report of Committee on Trained Nursing," 1923, p. 852)

Despite Beard's cogent comments to the Committee, the AMA continued to maintain the position of self-appointed guardianship over nursing. The vast majority of nurses, too, failed to see the possible consequences inherent in such an alliance with the medical establishment despite the analysis of the medical attitude toward nursing made by Isabel M. Stewart (1922).

> Our older brothers, particularly the medical ones, are inclined to be rather superior and early-Victorian in their attitude. They don't like any of these new feminist notions about education and independent careers for women. They prefer the real "womanly" woman who is perfectly satisfied to let her male friends and relatives manage all her affairs for her, while she busies herself in waiting on them and doing as they tell her. They assure her that she is much happier and more useful without education. Education of course is essential for men, particularly for medical men, but it ruins nurses, makes them unpractical and independent, takes away their simple-minded devotion, and makes them dissatisfied with their humble duties. Besides it takes them from their practical work and that can't be tolerated for a moment. If there must be any education at all, let it be as innocuous as possible and under the control of medical men who will see that it doesn't do any harm.
>
> There is a more aggressive type of older brother who has been making himself rather conspicuous lately by announcing loudly in the public press that this aspiring young profession of nursing is not a profession at all--certainly no relation to the eminent and

> respectable profession of medicine--simply a little Cinderella who lives in the Medical family, waits on others, and helps them with a few odd jobs. It is inferred that she is scarcely worth her keep, but not a bad sort if kept in her place. (p. 423)

Stewart and other enlightened nurses could envision the difficulties inherent in allowing physicians to exert their ideas and opinions on nursing education and practice. Despite scattered warnings, the majority of nurses accepted, even welcomed, what they saw as help and guidance from medical practitioners. Nurses of the time were largely products of an era of Victorian ideals and were conditioned to assume a secondary role in society with deference to men. Many nurses not only welcomed, but requested, assistance from their male associates in medicine and hospital administration in seeking solutions for problems within the ranks of nursing. These nurses were aware of the symbiotic relationship between nursing and medicine and naturally accepted the persistent interest in nursing held by the medical profession. Physicians had fulfilled prominent roles as teachers in schools of nursing since the establishment of the first schools. Within this context, nursing's receptive attitude toward medical

opinions and recommendations is understandable (Hughes, 1978).

Joint Committee on Nurse Education and Service

Acting upon the recommendation that a joint committee be formed consisting of physician-teachers, nurses, and one educator, the Committee on Trained Nursing created the Joint Committee on Nurse Education and Service in conjunction with the National League of Nursing Education (NLNE) in 1923. The Committee existed 2 years without sufficient funding to carry out the surveys it desired, and, therefore, in 1925, made the decision to expand the Joint Committee which would hopefully involve enough organizations to enable the Committee to procure adequate monies.

On March 4, 1925, the Joint Committee met in New York City and decided to establish a committee of 12 delegates. These delegates would be representatives of the AMA, the American Hospital Association (AHA), the American College of Surgeons, and two each from three national nursing organizations ("Nurse Education," 1925).

Committee on the Grading of Schools

The recommendation made by the Committee on Trained Nursing that a classification of nurse training schools be established coincided with a previously conceived project anticipated by nursing organizations that was aimed at studying "nursing education, especially as it related to the need for qualitative grading of schools" (Kalisch & Kalisch, 1978, p. 435). The Joint Committee on Nurse Education and Service was absorbed into the Committee on the Grading of Schools which was created in 1926 by agreement among major nursing organizations.

Dr. William Darrach, AMA representative to the Joint Committee on Nurse Education and Service, was named the chairman of the Committee on the Grading of Schools. Dr. May Ayres Burgess, a trained educator and statistician, was appointed to direct the activities of the Committee. The Committee was composed of representatives from the following organizations: American Nurses' Association (ANA), National Organization of Public Health Nursing, AMA, American Public Health Association, and AHA. In addition, representatives from

higher education and the general public were also included on the Committee (Kalisch & Kalisch, 1978; Kelly, 1981).

According to Burgess (1927), the Grading Committee was formed in response to

> the failure of medical and hospital workers to secure nursing service of a type and quality they need for their patients, and, on the other, the inability of nurses to secure satisfactory conditions of employment. (p. 20)

The Committee actually carried out three projects: the study of supply and demand related to nursing, job analysis of nursing and nurse teaching, and the actual grading of schools (Burgess, 1927). In 1928, Burgess further defined the purposes of the Grading Committee in the following ways:

> to assist hospital trustees and administrators to recognize the difference between nursing service and nursing education, and to decide what their responsibility is towards each and . . . to interpret modern nursing problems to the members of the medical profession, helping them to supplant unreliable opinions with definitely ascertained facts, and making it possible for nurses and doctors to discuss plans for the future, frankly and constructively, on a friendly professional basis of mutual understanding. (p. 25)

The work of the Committee took 7 years and three separate reports were published. Nurses, Patients, and

Pocketbooks appeared in 1928 and provided the findings of the Committee in relation to the economic status of nurses. The second report of the Committee was published in 1934 and was entitled An Activity Analysis of Nursing. This report provided discussion of specific nursing functions and focused on specific educational needs of student nurses. The final report entitled Nursing Schools Today and Tomorrow was also published in 1934 and was the actual report of the grading of schools of nursing.

The findings of the Grading Committee were widely publicized. One of the major consequences that resulted from the work of the Grading Committee was the closure of many small and inferior training schools for nurses. The Committee demonstrated how expensive it was to maintain a training school that could meet educational standards. As a result of this economic realization, and in conjunction with the Depression, many smaller training schools were forced to close.

Committee on Nurses and Nursing Education

During the period from April 1926, when Dr. May Ayres Burgess was appointed director of the Committee

on the Grading of Nursing Schools, to 1934, when the final report of the findings was published, the attitude of the AMA did not alter. In 1926, Dr. E. Eliot Harris presented a resolution to the Reference Committee on Medical Education at the last session of the House of Delegates. As a result of the proposal made by Harris, another committee concerned with nursing was appointed which was entitled the Committee on Nurses and Nursing Education.

The goal of this new Committee was to

> investigate and report to the next House of Delegates the results of its investigation and constructive thought on the nursing question and especially on the subject of increasing the number of bedside nurses throughout the several states. ("Report of Committee on Nurses and Nursing Education," 1927, p. 1175)

Members of the Committee distributed a questionnaire in order to collect

> a large body of opinion and historical fact which may be of valuable assistance in guiding the evolution of the nursing service into channels of orderly, practical usefulness to the patient, who is our chief concern and to the physician, who is responsible for the care of the patient. ("Report of Committee on Nurses and Nursing Education," 1927, pp. 1175-1176)

The questionnaire submitted to practicing physicians sought to determine the availability of nurses and the

retention of graduate nurses in the specific geographic area where the physician practiced. Information about the monetary value attributed to the labors of student nurses was also obtained by the questionnaire. The major focus of the questionnaire, however, was aimed at securing physician attitudes about the training of nurses. Specific questions were asked about the training schools within the area in which the answering physician practiced. The physicians were also asked to express their thoughts and opinions about minimum requirements for entry into training schools, curriculum content, ratio of theory and practical experience in the training schools, and the length of training offered by the schools.

Upon analysis of their survey of physician opinion, the Committee on Nurses and Nursing Education set forth the following recommendations:

> 1. That the business law relating to nurses' registries in all the states be amended in a manner to conform to the new law in the State of New York.
> 2. Recognizing the county as the most practical field unit, that official nurses' registries be established in every county of every state.
> 3. That every county society develop plans for the official approval of registries which meet satisfactory standards to be erected by the county society.

> 4. Sincere efforts toward the coordination of all nursing services.
> 5. Endorsement and encouragement of visiting nursing services.
> 6. Thorough trial by members of the American Medical Association of hourly or part-time nursing with broad publicity of its methods and possibilities.
> 7. Group nursing in hospitals.
> 8. That the period of training be twenty-eight months, the first four months to be devoted to concentrated study of fundamental anatomy, bacteriology, chemistry and dietetics, and that the succeeding two years be devoted as far as possible to teaching the art of nursing by demonstration, participation and practice. ("Report of the Committee on Nurses and Nursing Education," 1927, p. 1180)

The motivating factor underlying the formation of the Committee on Nurses and Nursing Education and the Committee on the Grading of Schools was basically the same. During the 1920s, nurses were severely criticized by the public and the medical profession because of their inaccessability and high cost. Both committees sought to identify the reasons behind this social problem.

The Committee on Grading determined that there was an oversupply of inadequately prepared nurses. There was, in addition, an overabundance of substandard training schools in existence that produced nurses who were not qualified to meet the health needs of society.

The Grading Committee clearly documented that private duty nursing was an economically infeasible method for the delivery of nursing care. Private duty nursing required the patient to absorb the entire cost of nursing care over a 24-hour period. In order to be utilized at all, the private duty nurse was forced to place a self-imposed ceiling on her salary. As a result, the private duty nurse could scarcely make a living and the public could hardly afford her. The Grading Committee recommended that the number of graduates be reduced, that the smaller and inferior schools be closed, and that hospitals should employ graduate nurses to staff the nursing service department, rather than using students.

Despite the assertion by the Grading Committee that far too many graduates were inadequately prepared, the Committee on Nurses and Nursing Education proposed a 4-month period of basic knowledge instruction to be followed by 2 years of practical experience. Burgess (1932) elaborated specifically on the practical training that students received.

> Even with our enormous overproduction of nurses in this country, it still remains true that there is a shortage of good nurses. The reason

> is that there are many schools which because of a shortage of competent graduate nurses in the wards, are allowing their students to spend three years in practicing poor nursing. (p. 1049)

The proposal of the Committee on Nurses and Nursing Education that less of the nursing students' time be spent in the classroom and more time be devoted to practical experience on the wards was based on the following attitude:

> It is true that some physicians feel that too much education diverts the nurse's attention from the personal needs of the patient and causes her to upsurp the physician's perogatives; but is this not a matter of the individual reaction of a particular nurse? Someone has said that nurses are not overtrained, but overeducated. A better social adjustment might be promoted by a constant insistence throughout the course on teaching the art of nursing by demonstration while less attention is paid to the purely didactic side. ("Report of Committee on Nurses and Nursing Education," 1927, p. 1180)

The insistence of the Committee on Nurses and Nursing Education that students undergo a minimum of 2 years of practical training with only a short course in basic foundational areas reflected the belief held by many physicians that the inaccessibility and high cost of nursing care was a direct result of overeducation of the nurse. This very premise was expressed clearly in a committee report to the House of Delegates

of the Michigan State Medical Society in 1928. The committee report stated:

> Nurses are overeducated. Whether it is the amount of learning or the manner in which it is required, it is more difficult to get the desired service from the higher trained nurses. The higher entrance requirements and the elaborate training given have helped to increase the cost of nursing to a point at which it is higher than the patient can afford. The committee recognizes the following principles for endorsement by the state medical society: 1) Nurses are helpers and agents of physicians, not co-workers or colleagues; 2) physicians should have a part in the direction of the training of nurses and in its limitations as should the hospitals which give the training; 3) the training of nurses should be simplified and the time of undergraduate training reduced to not more than two years; 4) the cost of nursing can be reduced by the introduction of instruction in simple nursing technic [sic] in our public schools . . . by shortening the present training course, by the establishment of more hospitals and by more frequent use of group and hourly nursing. The committee believes that the power to license nurses should be in the hands of a nonpolitical board of educators with an advisory group of physicians. ("Committee's Report on Nursing Service," 1928, p. 1296)

The recommendations of the Committee on Nurses and Nursing Education regarding visiting nursing, group nursing, and hourly nursing were viable options for solving the economic dilemma in nursing. These options were being considered and discussed among nursing leaders as well as workable alternatives to private

duty nursing. Each of these options made the nurse responsible for the care of several patients and, thereby, the cost of nursing care could be distributed among several clients.

The study and the recommendations of the Committee on Nurses and Nursing Education were conducted independently and without any recognition of the strides made by nurses since 1873. The committee also chose to disregard contemporary efforts to study the problems in nursing education and practice. In fact, the committee replicated much of the work already being done by the Grading Committee in which the AMA was already participating. Physicians in the AMA still did not perceive nursing as capable of charting its own future or resolving its own problems without guidance and direction. Therefore, members of the medical profession continued to engage in activities aimed at influencing nursing education.

The persistent involvement of the AMA in nursing issues in no way implies that the AMA was oblivious to nursing's activities aimed at the establishment of nursing as a profession. In the month following the presentation of the recommendations of the

Committee on Nurses and Nursing Education to the Annual Session of the AMA, the Speaker verbalized recognition of the fact that there were two committees within the AMA that were "considering the same subject, but working at somewhat cross-purposes and submitting two reports for your consideration" ("Survey of Nursing Education and Services," 1927, p. 1642). The Committee on Trained Nursing had not been reporting to the Trustees or to the House of Delegates and, thus, in its haste to identify and solve the problems within nursing, the Council on Medical Education and Hospitals had appointed the Committee on Nurses and Nursing Education. When the realization of the fact that two committees existed with essentially the same purpose, to study the nursing problem, became apparent, it was left to the reference committee to define further strategy. In his closing comments, the Speaker reiterated the position of the AMA in regards to nursing.

> Your Speaker recommends anew that, in dealing with this problem, all surveys, studies and recommendations shall emanate from the American Medical Association and not from any newly constituted independent organization. The problem of nursing education and service is a vital one to the public and to every physician. It is a problem in which we should exert and evidence opinions and recommendations

> and accomplish their institution. It is a service we owe to the public, to hospitals, to training schools, and to our fellow members. The American Medical Association should, yea, must, undertake its solution and formulate the resultant principles when they are announced. We become negligent and shirk our responsibilities and forfeit guiding direction if we delegate the task to others. ("Survey of Nursing Education and Services," 1927, p. 1643)

This dogmatic statement leaves absolutely no question as to the stance of the AMA in 1927. Physicians' historical assumption of guardianship over nursing prevailed. It was the duty of the medical establishment to govern all aspects of nursing and it was a duty that was not to be taken lightly in its application. Physicians had long recognized the value of nursing to medical practice and were, in fact, dependent on nurses. Ashley (1973) illustrated the point of physician dependence on nurses by stating,

> a surgeon could successfully perform an operation, but without skilled nursing care patients could, and very often did, die of infection. Diet, rest, and "fever sponges" saved more patients with typhoid fever than the medical therapies then available. In lowering mortality rates, nurses were not performing the discarded functions of physicians; they were practicing their own profession and, in doing so, preserving life. . . . nursing encompassed a great deal more than assisting the physician and the essential components of the nursing process were carried out without any medical guidance or supervision. (p. 639)

This dependence on nursing led medicine to seek control of nursing and to vehemently ascertain the privilege, duty, right, and obligation to define the scope of nursing practice.

Following the AMA's realization in 1927 that two separate committees on nursing existed with the same goals and purposes, the official organ of the AMA fails to present any further reports on the activities of either of these committees or reports on any efforts to consolidate the two separate committees. It is probable that both committees disbanded since no documented reports from either committee were formally presented to the AMA after 1927.

Despite the fact that the Committee on Trained Nursing apparently disbanded along with the Committee on Nurses and Nursing Education, its collaborative efforts with nursing were not insignificant. Through the Grading Committee, the AMA aligned itself successfully with nursing in an effort to study nursing education and practice.

The report of the Grading Committee had a tremendous and lasting influence on nursing. The establishment of specific and uniform standards for nursing

education was a direct outgrowth of the activities of the Grading Committee. The influence of the Grading Committee continues as the National League for Nursing functions as the accrediting body for institutions involved in the educational preparation of nurses.

Prior to this historical undertaking between medicine and nursing, the efforts of both groups failed to produce a demonstrable influence on any aspect of nursing. An analysis of past AMA committees on nursing demonstrated that both nurses and physicians were able to agree on the problems facing nursing. Each group, however, worked independently of the other in attempting to resolve identical problems. Rather than working in unison in a collaborative manner, they duplicated work and replicated effort. Time would further isolate the AMA's involvement with the Grading Committee as a hallmark in collaboration and cooperative effort between nursing and medicine.

Committee on Nursing Problems

The 20-year time span between 1927 and 1947 was characterized by a lack of formalized effort on the part of the AMA to establish committees on nursing.

The organization was engaged wholeheartedly in a battle to sustain its control over the practice of medicine. Efforts on the part of the federal government and laymen to develop prepaid and compulsory insurance plans met with vehement opposition on the part of the AMA. From the mid-1920s to the beginning of World War II, the AMA funneled its political and economic resources into its battle against what it termed "socialized medicine" (Fishbein, 1969).

Nurses were concurrently involved in ongoing studies by the Committee on the Grading of Schools. The formation of committees concerned with nursing within the AMA was primarily in response to activities undertaken to establish or improve nursing. Despite the lack of formal involvement in nursing, physicians continued to maintain an interest in nurses and their practice. The involvement of the United States in World War II, for example, created a tremendous demand for nurse manpower and provided justification for many physicians to advocate a shortening of the training course for nurses and to recommend that ancillary workers be employed to subsidize the delivery of nursing care to the civilian public (Hughes, 1978).

At the Annual Session of the House of Delegates in 1945, the AMA reiterated its stance in relation to nursing, perpetuating the long-standing belief that physicians had a rightful and an obligatory guardianship role to assume concerning nursing education and nursing practice. This tenacious attitude was conveyed in the following manner:

> The problem is so definitely one of multiple jurisdictional interest and responsibility in which the medical profession as well as hospital management have a major part and obligation to the public to use the weight of their experience and authority in assisting to bring about the most perfect program possible in the nursing field. ("Resolutions on Appointment of Committee for the Study of Nursing Problems and Education," 1945, p. 1191)

Two years following this address before the House of Delegates, the AMA used "their experience and authority" to form yet another committee to study and speculate about nursing issues. The Committee on Nursing Problems was formed in 1947, reportedly in response to the shortage of nurses that occurred following World War II. The expectation that nurses returning from overseas military duty would return to civilian practice in the nation's hospitals proved to be unrealistic. These returning nurses had enjoyed well-deserved public prestige as a result of their

valiant and, often, heroic contributions to the American war effort. This prestige, coupled with the increased autonomy experienced by many military nurses, made the idea of returning to traditional nursing practice unattractive to many of these nurses. Salaries in most of the nation's hospitals were not competitive with other occupations, Social Security benefits were not provided for nurses, staffing was inadequate, and job satisfaction was often minimal. These factors served to dissuade scores of nurses who chose to pursue other types of employment or to focus their energies on marriage and homemaking (Hughes, 1978; Kalisch & Kalisch, 1978; Kelly, 1981).

In addition, many women who had worked in the nation's hospitals during the war had lost their patriotic incentive and, therefore, chose to leave nursing and return to their homes after the war. By the middle of 1947, the American Hospital Association estimated that 33,000 existing hospital beds were not in use because of lack of nursing personnel (Hughes, 1978). It was in July of that same year that the Committee on Nursing Problems was established by the AMA. In proposing the formation of the committee, Dr.

E. L. Bortz, president-elect of the AMA, told his colleagues that

> Long hours, irregular employment, lack of any pension or security program and indifference on the part of groups which should be cognizant of the nurses' needs has caused a serious shortage in one of the noblest of the nation's professions. It is high time physicians study the various ramifications of these issues and exert their influence in support of the objectives which the members of the nursing profession are now striving to attain. ("The Nursing Crisis," 1947, p. 705)

Bortz further elaborated that the Committee on Nursing Problems, consisting of five physician members, would

> investigate the present objectives of the nursing profession, the standards of education, the time involved in training, the various curriculums, the supply of nurses and quality of services rendered, remuneration, participation in the determination of administrative policies and the question of security benefits. This committee would further act as a liaison with the various nursing organizations and would obtain information of significance to serve as a basis of a report to the House of Delegates at its next meeting. This Association should be able to make a definite contribution in behalf of its close allies--the nurses. ("The Nursing Crisis," 1947, p. 705)

Following the establishment of the Committee on Nursing Problems in July of 1947, an organizational meeting was held in New York in September of that same year. This organizational meeting resulted in the

formation of a subcommittee which met with nursing representatives from the American Nurses' Association and various other nursing organizations. On the day following this meeting, the subcommittee met with representatives of the AHA and the American College of Surgeons. Based upon these discussions, Thomas P. Murdock, M.D., Chairman of the Committee on Nursing Problems, outlined to the House of Delegates of the AMA the areas that were to be considered by the Committee. Murdock reported that the study was to be conducted along three lines:

> (1) immediate relief [of the nursing shortage]; (2) the future training courses to be recommended for various grades of nurses; (3) the economic conditions [of nursing]. ("Report of Committee on Nursing Problems," 1948, p. 878)

In his report, Murdock presented plans that had been suggested to deal with the problems. The proposed plans consisted of three elements: (a) the employment and training of as many practical nurses as possible, (b) doctors' recruitment of nurses on the local levels, and (c) obtaining coverage of nurses by the Social Security Act ("Report of Committee on Nursing Problems," 1948).

The major activity of the Committee was to stimulate round-table discussions about the issues relevant to nursing and to propose recommendations that could be implemented on a practical level. The Committee on Nursing Problems presented its recommendations to the AMA in 1948.

In order to at least partially alleviate the acute shortage of nurses, the Committee recommended that retired and married nurses be actively recruited. To this end, the National Broadcasting Company and the Advertising Council were engaged to promote this solution to the public in order to stir a sense of duty in the hearts of nonpracticing nurses. State and county medical journals urged physicians at the local levels to recruit retired nurses to resume practice and to aid in the recruitment of student nurses ("Report of Committee on Nursing Problems," 1948).

In addressing the economic conditions of nurses, the Committee proposed two recommendations. First of all, they recommended that steps be undertaken that would assure all nurses of participation in Social Security and retirement plans. They felt that hospitals should be urged to adjust benefits

such as salary, working hours, sick leave, and vacation time to a level comparable with other occupations for women that required approximately the same level of preparation. Secondly, the Committee recommended that essential nursing services to the patient be covered by prepayment insurance plans.

The recommendations regarding the future training courses for various grades of nurses suggested two main classes of nurses, the professional nurse and the trained practical nurse. The professional nurses were further divided in two groups, nurse educators and clinical nurses. Nurse educators, or those with college level preparation, would fulfill the roles of directors of nursing schools, teachers, department and clinical supervisors, public health nurses, and other roles which the Committee left undefined. According to the Committee, these roles were not restricted to those professional nurses who had collegiate preparation, but they could also be filled by any clinical nurse, regardless of her educational preparation, if she showed an aptitude for the work.

The second group of professional nurses, clinical nurses, were comparable to nurses who functioned in

general duty or private duty capacities. Despite the fact that the clinical nurse was seen as capable of performing broader functions than the trained practical nurse, the Committee recommended, surprisingly enough, that the training course for the clinical nurse be reduced to 2 years. It is notable that the Committee felt that a 2-year training course in addition to "aptitude" would qualify clinical nurses to assume "subordinate teaching positions" ("Report of Committee on Nursing Problems," 1948, p. 878).

The Committee envisioned that trained practical nurses would perform the bulk of the routine bedside care of patients under the supervision of professional nurses and physicians. The Committee expressed the belief that the delivery of nursing care could be made more economical and more efficient through the use of trained practical nurses. The Committee recommended a 1-year training course for trained practical nurses consisting of 3 months of theory instruction and 9 months of practical instruction. The Committee also recommended that provisions be made that would allow trained practical nurses to advance to the grade of clinical nurses.

In addition to the recommendations submitted to the AMA in 1948, the Committee on Nursing Problems went on record in opposition to nurses utilizing collective bargaining as a tool for improving their economic situation. The opposition expressed by this Committee was a direct result of actions taken by the American Nurses' Association, the National League for Nursing Education, and the National Organization for Public Health Nursing at their joint convention held in Atlantic City in 1946. At that convention, nurses adopted a 10-point economic security program. One of the points included in this program was the identification of each individual state nurses' association as the rightful and qualified collective bargaining agent for their membership.

Nurses themselves were acutely and painfully aware of the same economic and employment issues that had been identified and addressed by the Committee on Nursing Problems. The nurses participating in the 1946 convention, however, differed drastically from the Committee on Nursing Problems in terms of the manner in which the economic problems in nursing could be resolved. The Report of Committee on Nursing

Problems (1948) flatly stated that nurses had "innocently erred" when they adopted the provision allowing state nurses' associations to act as nurses' bargaining agent. The opposition of the Committee was justified in the following way:

> They are members of a noble profession. They do not need bargaining agents. The term bargaining agent carries with it the implication to strike even though it is true that they have never gone on strike. Medical men, nurses, and other hospital employees have not the right to strike anywhere, any time. They are dealing with the most priceless possession--life itself. It is hoped that the nurses will correct this in the near future. ("Report of Committee on Nursing Problems," 1948, p. 879)

At the 1946 convention, 2 years prior to the making of this statement, nurses had themselves voluntarily relinquished the use of striking as an economic tool, believing such action would be unethical and unprofessional.

Statements made by Bortz and Murdock and reports issued by the Committee on Nursing Problems reflected the concern of organized medicine related to the education and supply of nurses ("Report of Committee on Nursing Problems," 1948; "The Nursing Crisis," 1947). Medicine's support of the 1946 Economic Security Program should not be mistaken as an altruistic gesture.

It was rather another instance where medicine sought to assume guardianship over a group it felt was incapable of caring for itself. This committee, like its predecessors, felt the necessity of pointing out errors in judgment by nursing leaders and set itself in the role of authority in matters related to the educational preparation of nurses. Lovell (1982) analyzed this type of medical interest.

> Physicians' motivation to "guide" nursing education in the "right direction" was based on their fear of competition by nurses. Prior to the turn of the century nursing was openly recognized as a branch of applied science that promised to be as important to the health of society as the medical profession. Fearing that nursing knowledge would undermine medical stature and authority as well as threaten their jobs, medical professionals tried to dupe nurses into believing that they were an ignorant group who needed the advice and guidance of the "superior" male profession. This paternal exploitation of nurses is riddled with deception. (p. 217)

The Committee on Nursing Problems rendered its final report to the Association in 1949. The previous year the Committee had organized a permanent Conference Committee consisting of representatives of the AMA, the AHA, and the ANA. With the implementation of this new group, the Committee on Nursing Problems was discharged ("Report of Committee on Nursing Problems,"

1949). This permanent Conference Committee was designated as the Joint Commission for the Improvement of the Care of the Patient (JCICP) and maintained existence for the next 4 years.

Jcint Commission for Improvement of the Care of the Patient

The JCICP, established in 1949, was composed of six physicians representing the AMA, six hospital administrators representing the AHA (four of whom were also physicians), and six nurses representing the ANA and the NLNE. The reported purpose of the JCICP was "to bring about better understanding of each profession's point of view, especially in relation to nursing" ("Report of Joint Commission for Improvement of the Care of the Patient," 1953, p. 824). During its 4 years of existence, the Joint Commission identified and studied four major nursing needs that were felt to warrant immediate action. These needs were:

> (1) well-prepared nurses for faculty of schools and for administrative and supervisory services, (2) effective in-service education to improve workers on the job, (3) more practical nurses properly prepared, and (4) experimentation in nursing curriculums (two year program was specified). (p. 824)

The Joint Commission met twice a year over a 4-year period in an effort "to reach a mutually agreed on statement of steps which should be taken to meet nursing problems" (p. 824). In its final report to the AMA in 1953, the Commission concluded that providing comprehensive nursing care to the public was becoming more and more complex and that this required enlarging the group of practical nurses, nurses' aides, and volunteers who could participate in meeting the nursing needs of the public and providing additional training for those nurses who would assume a supervisory role over these various types of nursing personnel. The Commission generated several positive recommendations to combat the continuing nursing shortage and to facilitate the nurse's ability to work in an increasing complex health care delivery system. The report of the Commission included the following major recommendations:

1. Administrators, supervisors, consultants, and nursing faculty should have collegiate preparation to prepare them for the responsibilities of these roles. Postgraduate courses should be established for diploma nurses who wished to assume supervisory

roles over auxiliary nursing personnel or who wished to pursue a home health or health instruction role.

2. The recruitment of women for practical nursing programs should be increased. Career ladder programs should be developed for those practical nurses who wished to return to school to become registered nurses.

3. Non-trained ancillary workers in nursing should be provided with appropriate and comprehensive inservice programs to prepare them to function competently on the nursing team.

4. Appropriate inservice training should be developed and maintained for all categories of nursing personnel.

5. Experimentation into new types of nursing programs should be undertaken.

6. Recruitment efforts for all levels of nursing personnel be intensified. ("Report of Joint Commission for Improvement of the Care of the Patient," 1953).

Following the 1952 report, no further activity of the Joint Commission was recorded. The Commission assessed the current situation in nursing and presented some well-intentioned recommendations aimed at improving the nursing care available to the public.

Unfortunately, the Commission failed to stimulate any concrete or specific actions. In 1974, Edith P. Lewis, R.N., then editor of Nursing Outlook, commented that the JCIPC seemed to have "just faded away, as old commissions have a way of doing" (Lewis, 1974, p. 159).

Summary

For a period of 84 years, from 1869 to 1953, the AMA maintained an interest in nursing education and nursing service. These committees were historically examined in response to the first research question. The repeated formation of various committees on nursing was a direct manifestation of two basic assumptions. First of all, the AMA seemed convinced that nurses could not determine their own educational needs nor govern their own practice independently of physician guidance and direction. Secondly, the AMA was acutely aware that nursing services were essential for the effective delivery of medical care.

The AMA's efforts to dictate reforms in nursing education and practice were largely reactionary measures taken in response to actions initiated by nursing

or in response to a perceived crisis affecting the delivery of medical care. Each crisis concerned the supply of and demand for nurses. The interest in supply and demand was intimately tied to the educational preparation of nurses. The AMA consistently recommended a lower level of education for the nurse and/or stratification of nursing roles in order to mass produce nurses who were cheaper to educate and employ. Though this method might increase the production of nurses, it certainly would not facilitate the development of nursing as a true profession consisting of individuals capable of creativity and critical thinking. Individuals whose acquisition of knowledge is limited are easier to control and are less likely to question those in authority over them. This state is conducive to the furtherance of medical supremacy.

The AMA committees (Table 1) that were formed whose purposes, though covering a wide range of interests, dealt primarily with problems that were perceived to exist in the realm of nursing. For the most part, the AMA committees had no far-reaching effects on either nursing practice or education. Many

efforts were characterized by interaction between nursing and medicine, but only the cooperative alliance aimed at the Grading of Schools of Nursing had any real impact on nursing.

Table 1

Purposes of Committees Initiated by the American Medical Association: 1868-1953

Name	Purpose
Committee on the Training of Nurses: 1868-1869	1. Analyzed the impact of trained nurses on the health care institutions of Europe. 2. Presented plan to the members of the AMA for the establishment of schools of nursing under the guardianship of local medical societies and the formation of nursing societies.
Committee on Trained Nursing: 1922-1923	1. Investigated the problems of nursing education by means of correspondence and conferences with doctors, nurses, and committee members. 2. Read the recently compiled Goldmark Report and made recommendations concerning nursing education.

Table 1 (continued)

Name	Purpose
	3. Recommended the establishment of a committee composed of doctors, an educator, and nurses in conjunction with the NLNE. 4. Recommended that the schools of nursing be classified.
Joint Committee of Nurse Education and Service: 1923-1926	1. Existed two years without the funds to carry out surveys it desired. 2. First committee to include nurses. 3. Participated in the Grading of Schools of Nursing.
Committee on Nurses and Nursing Education: 1926-1927	1. Carried out a survey relating to the availability of nurses. 2. Made recommendations based on survey results that supported nurse registries, the coordination of nursing services, hourly nursing, visiting nursing, and group nursing in hospitals.

Table 1 (continued)

Name	Purpose
Committee on Nursing Problems: 1947-1949	1. Held discussions related to economic security for nurses and ways to deal with the shortage of nurses. 2. Supported coverage of nurses by Social Security and adjustments in salaries and benefits for nurses. 3. Supported the stratification of nursing into three levels: professional, clinical, and practical.
Joint Commission for the Improvement of the Care of the Patient: 1949-1953	1. Consisted of representatives of the AMA, AHA, and NLNE. 2. Supported higher level of education for administrators, supervisors, consultants, and nursing faculty. 3. Supported increasing number of practical nurses and untrained workers to function within the nursing services. 4. Supported the advent of new types of nurse training programs.

CHAPTER 3

DEPARTMENT OF NURSING AND THE COMMITTEE ON NURSING

Within the 7-year time span between 1953 and 1960, the JAMA alluded to the existence of several committees on nursing; however, formal reports of the goals and activities of these groups were not published. The decision to consolidate all existing committees into one, the Committee for Liaison with National Nursing Organizations, was made in 1960. The name of the Committee was changed to the Committee on Nursing in 1962 and remained active over a greater period of time than any of its predecessors. The formal goals and activities of the Committee and the issues with which the Committee concerned itself were examined in response to the second research question ("What were the formal goals of the Department of Nursing and the Committee on Nursing?"), the third research question ("What were the activities undertaken by the Department of Nursing and the Committee on Nursing to meet their stated goals?"), and the fourth research question ("What were the issues related to nursing with which the Department

of Nursing and the Committee on Nursing concerned themselves?"). Collaborative efforts made by the Committee during the 1960s were also examined in response to the fifth research question ("To what extent did the Department of Nursing and the Committee on Nursing collaborate with the American Nurses' Association?").

Committee on Nursing

The House of Delegates of the AMA which met in Atlantic City in June 1959, formally recognized the need for the establishment of an effective liaison with nursing organizations and related the desire that physicians at the local levels participate in this endeavor. In a June 1960, JAMA editorial, physicians were presented with a synopsis of several issues related to nursing in order to provide them with background information to facilitate their participation in local liaison activities. The editor of the JAMA informed his colleagues that their understanding of these issues was imperative if effective liaison between physicians and nurses was to be achieved. These eight issues covered the following broad topics: current

supply of registered nurses, the increased responsibilities of nurses as a result of performing tasks formerly within the medical domain and the assumption of managerial roles, the transition of nursing education, the need for graduate programs, the three levels of nursing educational preparation for entry into practice, the utilization of increased practical nurses, the training of auxiliary workers to aid in nursing, and the dissatisfaction of doctors, nurses, and patients with the frequent necessity of delegating nursing tasks to unprepared and unqualified workers ("The Nurse and the Doctor," 1960).

In a direct response to the JAMA editorial, the editor of the AJN stated:

> The constructive tone of the editorial is highly commendable. It offers to physicians some facts which account for many of the problems nursing faces today, not the least among them the increased delegation of medical responsibilities to professional nurses.
>
> In particular, we would like to commend our medical colleagues for giving such direct public recognition to the fact that there can be and are legitimate differences of opinion between physicians and nurses. The resolution seems to signify the beginning of the end of the traditional concept held by many that the nurse is merely the handmaiden of the physician.
>
> As a self-determining profession, nursing has to set its own goals. But it needs the understanding and the assistance of the public--

> and especially of physicians--if it is to achieve them. ("Doctors and Nurses," 1960, p. 1095)

With the publication of these remarks which exposed a mutual desire for increased communication, organized medicine and organized nursing jointly set the stage for the beginning of a realignment of their separate and distinct disciplines. The goals and activities of the AMA's Committee for Liaison with National Nursing Organizations were aimed toward the achievement of improved interprofessional relationships.

The seriousness with which the AMA undertook to effect activities of liaison is evidenced by the establishment in 1961 of the Department of Nursing. The establishment of the Department was a major structural change within the organization and was, reportedly, the result of the desire of the AMA to establish improved liaison activities with nursing organizations and to increase the scope of their activities ("Committee for Liaison with National Nursing Organizations," 1961). The Committee for Liaison with National Nursing Organizations maintained its existence after the formation of the Department and, in fact, came under the aegis of the Department.

By August 4, 1962, the Committee changed its title to the Committee on Nursing and presented its objectives and program to the medical community at large. The program was based on the following assumptions:

> (1) that nurses have a separate and distinct professional status and their contributions are those of co-workers; (2) that nursing should expect the medical profession to support and endorse high standards of nursing education and service; and (3) that each of the various levels of academic and technical accomplishment in nursing makes its own unique contribution to the total health care of the public. ("Objectives and Program of the AMA Committee on Nursing," 1962, p. 430)

In nearly a century of various committees on nursing, this was the first time that nursing was recognized as a separate and unique discipline within the health care delivery system and it was the first time that nurses were formally termed co-workers of the physicians.

In addition to delineating the assumptions upon which their program was based, the Committee on Nursing set forth six major objectives.

> 1. To expand and strengthen liaison activities between organizations representing the medical and nursing professions at the national, state, and local levels.
> 2. To study and report to the medical profession on current practices and trends in nursing and on development among nursing auxiliary personnel.

> 3. To stimulate, initiate, and where feasible, support research in areas pertinent to the nurse-physician relationship in professional practice.
> 4. To offer advisory support and assistance to both professions in impersonal matters.
> 5. To provide support and assistance to the nursing profession and its nonprofessional matters.
> 6. To encourage physicians to accept invitations to serve on nursing school faculties. ("Objectives and Program of the AMA Committee on Nursing," 1962, p. 430)

The Committee envisioned its activities as focusing on four main areas: liaison, education, consultation, and research ("Committee for Liaison with National Nursing Organizations," 1961).

The aims of the Committee were not unlike those of past committees, but the social context in which the concerns were expressed was altered by the gradual emergence of the hospital as the primary entry point into the health care system. An increased use of hospitals demanded an increased availability of nurses. The post-World War II nursing shortage remained a reality over 15 years after the conflict ceased. Although working conditions had improved to a certain extent and the actual number of nurses was greater than at any previous time, the demand for nurses exceeded the available supply.

Health Services in the 1960s

Several factors contributed to the increased use of hospitals and the existing shortage of nurses to staff them. An increase in life span and in the number of births following the War resulted in a growing population. The availability of prepaid insurance plans and the tremendous technological advances resulted in a rising dependence on hospitals by the public and physicians. The health care delivery system became more complex, and, thus, the demand for nursing care became more profound (Kalisch & Kalisch, 1978; Kelly, 1981).

The increase in demand for nurses and the resulting shortage of professional and vocational nurses were often met by employment of nursing aides. Many of these aides were poorly trained although they provided the bulk of direct nursing care to the patient (Kalisch & Kalisch, 1978). This increasing stratification of nursing personnel displaced the professional nurse from the bedside of the patient and into a position of management. The nurse found herself supervising ever-increasing numbers of health workers. The

health care industry grew along with the dissatisfaction of nurses, physicians, and patients.

Federal Government Intervention

Contemporary to the AMA's formation of the Department of Nursing was the appointment of the Consultant Group on Nursing by the Surgeon General of the U.S. Public Health Service. The 25-member panel consisted of representatives of nursing, medicine, hospital administration, the public, and other health services. When appointed in 1961, the Consultant Group assumed the task of evaluating the nursing needs of the nation and advising the Surgeon General of the role the federal government should take in the meeting of those needs.

The report of the Consultant Group, Toward Quality in Nursing: Needs and Goals, was issued in February 1963. The report cited the following areas of concern in relation to the nursing profession: shortages of nursing personnel, weaknesses in the educational preparation of nurses, recruitment needs, need for improvement in nursing administration, and the need for augmentation and support of nursing research. The Consultant Group

recommended areas that would benefit from federal assistance and urged nursing to begin a study of the existing system of nursing education funded by federal and private monies (Kalisch & Kalisch, 1978; Kelly, 1981). As a direct outgrowth of the report, the Nurse Training Act of 1964 was enacted and provided grants for the construction of facilities, grants for traineeships for graduate students in nursing, and funds to provide student loans.

With problems arising from the complexity of the health care system becoming increasingly apparent and a growing awareness of the need for a re-examination of nursing, the conditions existed for a realignment of traditional relationships between medicine and nursing. Nursing was dedicated to the achievement of professionalization. The formation of the AMA Department of Nursing demonstrated that medicine was concerned over the direction of nursing efforts in that area.

Activities of the Committee on Nursing

The Committee on Nursing defined its functions to encompass the areas of education, research, consultation,

and liaison. In reality, all activities undertaken by the Committee held the potential for improving mutual understanding between practitioners of nursing and medicine.

Research and Consultation

The research activities of the Committee consisted of surveying state and local medical societies to determine the extent of activities on the local level aimed at liaison with nurses. In 1961, the group surveyed state societies to determine the existence of standing or ad hoc committees concerned with interdisciplinary relationships. This survey was immediately followed by another that attempted to ascertain if national organizations of medical interest sponsored programs for professional nurses ("Committee for Liaison with National Nursing Organizations," 1961). The results of these surveys were not published in the JAMA.

State societies were surveyed again in 1963, and the results were published in May 1964. Questionnaires were prepared and distributed to 52 state societies.

> Fifty (96%) of the scoieties responded. Forty-one of the 50 respondents (82%) presently

> maintain liaison with the nursing profession in their state. It is important to note that nine states, including several with a high percentage of nurse and physician population, evidently have no forum for the exchange of ideas or for joint effort. ("Nursing Liaison Activities in State Medical Societies, 1964, p. 692)

In addition, the survey revealed that local groups involved in ongoing dialogue with nurses were concerned with "nursing education, and the shortage of nurses" (Nursing Liaison Activities in State Medical Societies, 1964, p. 692). The respondents also suggested that joint educational meetings would be a feasible method of improving interprofessional relationships.

The Committee on Nursing desired to serve in the role of consultant to state and local societies. In order to achieve this goal, the Committee was to assist state societies in organizing liaison activities with nursing and to distribute information describing existing state programs for liaison. The Committee would also maintain methods of communication with state groups to keep them informed of trends and problems in nursing education and service. The most significant activity would be national level meetings between representatives

of medicine and nursing. This function was suggested by state societies as a means of enhancing communication between the two major elements within health care delivery.

Liaison Activities

Between 1964 and 1967, three national conferences were held by members of the AMA and ANA. During 1963, members of the committee on Nursing and staff members of the ANA met to complete plans for the first such conference scheduled for February 13-15, 1964, in Williamsburg, Virginia. The Conference was entitled "Medical and Nursing Practice in a Changing World." An equal number of physicians and nurses attended.

The outcome of the 3 days was described in the JAMA.

> participants agreed on the value of the Conference and the need for a continuing dialogue between the members of the two professions. The Conference did not result in specific recommendations, but it served to open new channels of communication, to identify new interdependent areas for joint exploration in the practice of medicine and nursing, and to lay the basis for a stronger relationship between the two professions. ("Committee on Nursing, 1964, p. 323)

Prior to this conference, any problem existing within the system of health care delivery had been redefined as a "nursing problem" and approached from that viewpoint. A remarkable diversion from that premise was expressed during a conference in Virginia. Sheps (a physician) and Bachar (M.S., Hyg.) (1964) presented a paper entitled "Changing Patterns of Practice--Nursing and Medical" in which they described the evolution of hospitals and the advances realized in the delivery of health care. They specifically addressed the issue of attributing shortcomings in health care to nursing.

> It might be thought that the problems we are discussing would disappear completely if more nurses were available--in other words, that the difficulties arise simply and directly from the shortage of nursing personnel. While there can be no question that the relative scarcity of nurses aggravates the problems, we believe that other important changes have taken place in the framework of medical care which call for modification of the roles and responsibilities of doctors and nurses. (Sheps & Bachar, 1964, p. 1)

Sheps and Bachar delineated the increasing complexity of health care and the subsequent requirement of a realignment of professional responsibilities. These authors then posed a valid and appropriate question.

> For the nursing profession, these changes seem to call for more advanced educational preparation, both liberal and scientific, and greater independence of judgement. The need for the latter extends far beyond the patient's bedside. The question is, must the impetus for each modification of the scope and responsibility of nursing filter through the medical profession, or should much of it represent a farily (sic) direct utilization by nursing of the developments emerging from research and demonstrations? The latter process is indeed taking place, but its reality and import is not adequately recognized by either profession. For the medical profession, it calls for a greater measure of cooperative endeavor based upon joint function, as distinguished from a kind of territorial segregation of tasks which, though mutually supportive, do not overlap. (Sheps & Bachar, 1964, p. 2)

The second national conference took place in Denver from September 30 to October 2, 1965. The program was entitled "Nurse-Physician Collaboration." The idea of collaboration between the two disciplines was again discussed at great length; however, no long-reaching results became apparent.

Representatives of the ANA and the AMA met for the third and final conference in Coronado, California, from February 23 to 25, 1967. The topic under discussion at this time was "The Sick Person Needs . . . ." In summarizing the events that had taken place, a physician participant stated:

> As these two professions grappled with a problem of patient care, both groups recognized clearly the needs, a system which delegated and relegated responsibility, and a system which was built on mutual respect as well as responsibility. . . .
>
> From the discussion here today I feel there is a significant group of leaders ready to move out of an authoritarian system, give up paroled play, and assume a mature adult relationship, not paternalistic, but productive. (Martin, 1967, p. 41)

Although the ideas espoused and supported by the representatives at the Third National Conference for Professional Nurses and Physicians were certainly desirable and noteworthy, they were not widely acted upon by the majority of practicing nurses or physicians. Without a doubt, the viewpoint expressed by the participants of the three national conferences could hardly be considered representative of the entire community of nurses and physicians. Voluntary attendance and participation at the conferences would indicate an interest in and support of improved relationships between physicians and nurses. The goals of the participants could not, therefore, be held to be representative of attitudes of all nurses and all physicians. The inability of the participants to initiate changes within traditional relationships should be considered also in view of

previous, contemporary, and future policies expressed by the AMA.

The structure of the AMA is vastly complex and, in practice, this structure often precludes any effective action on recommendations emanating from any committee within the organizational structure. Committees within the AMA, such as the Committee on Nursing, held no actual power to initiate changes but rather assumed a consultative function by making recommendations to the Board of Trustees. The final authority to act upon any recommendation put forth by any committee rested solely and finally with the Board. According to Hyde (1954) the AMA Board of Trustees functions the majority of the time without the guidance of member input. In describing the bureaucratic structure of the AMA, Hyde (1954) concluded that:

> In theory, the policy-making function of the American Medical Association is vested in the House of Delegates. However, since the House meets semi-annually, many administrative and policy decisions are necessarily left to the Board of Trustees. Although it is responsible to the House of Delegates, the Board functions with little supervision when the House is not in session. (p. 943)

The composition of the AMA membership and of the employees contributes significantly to the organization's

policy formation and resultant activities. The physicians who serve as officials within the organization are employees of the AMA, not practicing physicians, and are virtually dedicated to the maintenance of AMA authority and autonomy over health care matters. According to Capuzzi (1980), the employed officials of the AMA are generally conservative in attitude, representative primarily of urban areas, and were predominantly specialists rather than generalists in their prior practice of medicine. As a result, the leadership of the AMA rests in the hands of a small group of physicians who are not necessarily representative of the entire membership. Capuzzi (1980) further identified that this elite group of employed officials hold all of the significant power and authority over the direction and type of activity engaged in by the AMA.

> leadership resides in AMA's Board of Directors, with little direction from other governing bodies. The board can spend as it desires, nominates members to key committees, appoints editors for the journals, and determines the editorial policies. (Capuzzi, 1980, p. 480)

The failure of the ideas generated in the three national conferences between doctors and nurses to

produce specific recommendations or to result in definite action by the AMA must be examined within the context of the basic purpose for the existence of the AMA. Hyde (1954) delineated four broad functions of the AMA; promotion of quality medical services; establishment of standards for medical practicioners, both qualitatively and quantitatively; determinations of conditions for practice and payment; and the monitoring and shaping of government health policies. Recognizing these four broad functions, it is apparent that positions on certain issues by the Committee on Nursing would receive less than high priority among the broad range of medical interests. The formation of the Department of Nursing and the Committee on Nursing certainly validated the assumption that organized medicine was concerned with nursing issues and that the AMA felt medical input into nursing was appropriate. Lack of formal action by the AMA on the furtherance of the progressive ideas supported by the Committee on Nursing may indicate the issues were contrary to the traditional views of the AMA or that they were simply not considered important enough to gain promotion to the membership by the Board of Trustees.

Education

The remaining function identified by the Committee on Nursing was that of education. The primary objective of the Committee in this area was to educate physicians about issues and trends that were specific to nursing. In order to meet this objective, the Committee authorized the preparation of various reports dealing with the following specific issues in nursing: the role of the nurse, the education of the nurse, the shortage of available nursing personnel, the licensure requirements for nurses, and lastly, inadequate communication between nurses and physicians. The dissemination of the information provided in these reports was achieved by oral presentations during annual AMA conventions, by selective publication of some of the reports in the JAMA, and by distribution of the reports to nursing leaders in education and service, state medical society executives, chairmen of local committees on nursing, executive directors of nursing organizations, editors of specific journals, and others ("Committee on Nursing," 1965).

Several reports were prepared which specifically addressed the role of the nurse within an increasingly

complex health care system. Each of these reports acquainted physicians with non-traditional and expanded roles assumed by nurses. Specifically, physicians were informed about the potential utilization of nurses in the following roles: school nursing, pediatric practitioner roles, public health nursing, and primary health provision for the chronically ill in neighborhood clinic settings. The tone of the reports was consistently positive in their description and evaluation of nurses serving in these expanded roles. The articles were supportive of nurses' functioning in non-traditional ways. Recognition was given to the fact that health care could be given more efficiently and more economically through the utilization of nurses in these roles. The reports conveyed to the physician that a major advantage to the use of nurses would be more appropriate utilization of physician time and talent (Ohlson, 1966; Runyan, Phillips, Herring, & Campbell, 1970; Silver, Ford, & Day, 1968; Silver, 1971).

In two reports published in the JAMA, physicians were provided with a description of the different educational programs available in nursing. An article printed in 1963 provided physicians with data on programs

on nursing education ranging from practical nurse programs to doctoral programs ("Educational Programs in Nursing and Related Career Opportunities," 1963). A 1968 article authored by three nurses described for physicians the differences in the three types of educational programs which prepared individuals for licensure as registered nurses (DeChow, Malmstrom, & Ogden, 1968). Both of these articles were descriptive in nature and neither of them actually endorsed any one type program over others. The Committee on Nursing felt that in order for physicians to understand nursing and its problems they should be cognizant of the vastly diverse educational programs that existed as well as the variety of career opportunities available to nurses.

In 1968, the Committee on Nursing reiterated the long-standing concern of the AMA about the shortage of nursing personnel. To partially alleviate the shortage, the Committee on Nursing suggested that inactive nurses be encouraged to resume practice at least on a part-time basis. In order to facilitate the re-entry of these nurses into practice, refresher courses were suggested ("285,000 Inactive Registered Nurses Could Turn the Tide," 1967).

The issue of mandatory licensure was one in which the Committee on Nursing chose to state a definite position. An analysis of the advantages and disadvantages of permissive and mandatory licensure of nurses was prepared at the request of the Committee on Nursing. This analysis was prepared by Florence Alexander, Ph.D., R.N. A summary of the analysis was printed in the JAMA in 1966; it reflected support for mandatory licensure of nurses (Alexander, 1966).

The issue of inadequate communication between physicians and nurses resulted in the publication of two reports in the JAMA under the aegis of the Committee on Nursing. Both reports elaborated on the complexities in health care and on the resultant need for effective planning of patient care. This type of planning dictated enhanced communication between nurses and physicians. Neither report offered conclusive suggestions to facilitate the type of communication that was obviously needed (Quint, 1966; Reader & Schwartz, 1967).

Summary

The decade of 1960 to 1970 was witness to unprecedented advances and increased complexity in the delivery

of health care. This brought the need for alterations in the method of care delivery into sharp focus. The establishment of the Department of Nursing and the resultant formation of the Committee on Nursing provided the AMA with a vehicle to examine the impact of the changing health care system on nurses and physicians and on their joint relationship in providing care during a time of great change. This chapter examined the goals and activities of the Committee and their collaborative efforts during the 1960s in response to the second, third, fourth, and fifth research questions.

For the first time, an AMA committee gave verbal recognition of nursing as a separate profession from medicine. Some liaison activities were undertaken as a result of the efforts of the AMA Committee on Nursing. Widepsread change in the relationship between physicians and nurses was not, however, forthcoming. From a historical perspective, most of the issues identified and potential solutions suggested were simply repetitive of past efforts of various committees established by the AMA.

CHAPTER 4

NATIONAL JOINT PRACTICE COMMISSION

The Committee on Nursing maintained its existence into the 1970s although it came under the aegis of the Department of Health Manpower (Kelly, 1975). During this period, the Committee undertook activities with nursing aimed at collaboration. These collaborative efforts were examined in response to the fifth research question, "To what extent did the Department of Nursing and the Committee on Nursing collaborate with the American Nurses' Association?"

The major impact of the Committee was realized in 1970. At the AMA convention in June 1970, the Board of Trustees and the House of Delegates adopted a position statement submitted by the Committee on Nursing. The position statement entitled Medicine and Nursing in the 1970s delineated specific objectives which would guide AMA activities in the area of nurse-physician relationships. In nearly 10 years of existence, this position statement was the most controversial action taken by the committee.

Medicine and Nursing in the 1970s: A Position Statement

A 2,500 word document, the position statement identified six major areas related to nursing education and nursing practice in which the AMA held interest. The Committee on Nursing stated six objectives in relation to those interests:

Objective 1. "The American Medical Association recognizes and will support efforts to increase the number of nurses."

Objective 2. "The AMA recognizes the need for and will facilitate the expansion of the role of the nurse in providing patient care."

Objective 3. The AMA encourages and supports all levels of nurse education."

Objective 4. "The AMA will promote and influence the development of a hospital nursing service aimed at increased involvement in direct medical care of the patient."

Objective 5. Delivery of medical care is, by its nature, a team operation."

Objective 6. "To implement these objectives, constructive collaboration of medicine with the various

elements of the nursing profession is essential" ("Medicine and Nursing in the 1970s: A Position Statement," 1970, pp. 1881-1883).

The position statement elucidated on each of the stated objectives and those comments provided extensive insight into the AMA's attitude toward nurses and nursing practice. Indeed, it was the attitude inferred by these comments that resulted in protest by members of the nursing profession.

The position statement's elaboration on the expansion of the role of the nurse provided the most telling insight into the medical attitudes about nursing practice. While recognizing that nurses were capable of functioning beyond the traditional parameters in expanded roles, it was the stated interpretation of expanded roles that was controversial. The position statement reported that:

> Professional nurses, by the nature of their education, are equipped to assume greater medical service responsibility under the supervision of physicians. . . . The addition of nurses especially prepared by short periods of intensive training would provide much-needed services to the consumer, enhance nursing as a profession, and extend the hands of the physician.
>
> This objective builds on a history of translating certain medical services into nursing functions. . . .

> Increased utilization of the nurse [in an expanded role] will significantly contribute to the quality of medical care. ("Medicine and Nursing in the 1970s: A Position Statement," 1970, p. 1881)

The comments made in the statement clearly indicated that the traditional view held by medicine and expressed as early as 1868 still prevailed. Once again, the medical establishment assumed the right to define the parameters of nursing practice as an extension of medical care, convinced that the use of nurses in this manner would enhance the quality of medical care. By refusing to see that nurses could offer something separate and distinct to patient care, the AMA defined the role of the nurse in a narrow and restricted way that would hardly maximize nursing potential in the area of health care.

Although espousing the need for nurses to expand traditional roles, the AMA presented a paradoxical argument in recommending and supporting the expansion of the associate degree and diploma levels of educational preparation as a solution to the problem of the nursing shortage. The rationale given to support these specific educational programs for nurses was that both of these programs out-produced the baccalaureate programs in terms of the number of graduates.

Responding to the shortage of health care personnel, the AMA seemed convinced that supporting and encouraging women to enter associate degree and diploma programs would provide the solution to the problem. The statement encouraged baccalaureate education primarily "for individuals who plan to make education or administration their work" ("Medicine and Nursing in the 1970s: A Position Statement," 1970, p. 1882). This AMA position was in direct contradiction to the position taken by the ANA 5 years previously. In 1965, the ANA adopted a position entry level requirement for professional nursing practice. It is apparent that the AMA did not regard the baccalaureate degree as essential preparation for bedside nursing practice. Part of the reason for this could lie in physicians' interpretation of the nurse-physician relationship in patient care.

While the position statement verbally supported the concept of the delivery of medical care as a team effort, comments made in relation to that statement indicated that the AMA remained unwilling to share authority and accountability for patient care with any other member of the team. The traditional view of

the physician as the "captain of the team" remained a fundamental truth in the minds of the medical establishment. Though supporting the improvement of nurse-physician relationships as a means to improve patient care, the statement said:

> The well-prepared and responsible physician possesses the degree of competence required to assume authoritative direction of the medical team. For the benefit of the patient, it is critical in the decision-making process that there is a known specific point of accountability and that the person having that responsibility also has commensurate authority. The physician, as the logical leader having definitive legal authority in matters of medical care, must accept this ultimate accountability to the patient. ("Medicine and Nursing in the 1970s: A Position Statement," 1970, p. 1883)

The position statement did offer several constructive suggestions for improvement in care delivery and for improvement in the collaborative relationship between nurses and physicians. The statement discussed the increasing lack of direct care performed by nurses at the bedside as a result of their assumption of administrative functions. In support of the idea that nurses should return to a position of direct care delivery, the statement recommended the development of new non-nursing personnel who would relieve the nurse of routine administrative duties. In the support

of improved physician-nurse collaboration, the statement suggested that nurses serve on medical committees which focused on patient care. In addition, the position statement concluded with comments supporting the need for effective communication between physicians and nurses. Although realizing that the membership of the national nursing organizations was not entirely representative of the total nursing community, the position statement did advocate continued collaboration between the AMA and the national nursing organizations. The statement did identify its ultimate goal as being the establishment of the productive communication with all nurses.

National Commission for the Study of Nursing and Nursing Education

The publication of the AMA position statement coincided with the publication of a report sponsored by the National Commission for the Study of Nursing and Nursing Education. The establishment of the National Commission for the Study of Nursing and Nursing Education was the result of the desire of nursing to act on a recommendation set forth in the 1963 report, Toward Quality in Nursing (Kalisch & Kalisch, 1978;

Kelly, 1981). The recommendation made by the Consultant Group on Nursing that nursing evaluate the system of educating nurses was acted upon shortly after the publication of the report. The ANA and the NLN formed a joint committee that would develop a method by which nursing could evaluate the current status of nursing education and the changing characteristics of nursing practice. In addition, the nursing organizations planned to collect data that would enable them to gain a perspective in regard to possible future demands on members of the nursing profession. Financial backing for the study was provided by the American Nurses' Foundation, Avalon Foundation, Kellogg Foundation, and an anonymous donor.

The planning committee determined that participants in the study group would constitute an autonomous agency, representing no interest group. Physicians and members of other related disciplines were invited to participate, but these individuals were independent of any organizational responsibilities. Twelve commissioners, headed by Jerome Lysaught, began the project in 1968 and published their report in mid-1970. Entitled <u>An Abstract for Action</u>, the report identified

four major areas for study: nurse supply and demand, nursing role and function, nursing educational needs, and nursing career opportunities (Kalisch & Kalisch, 1978, Kelly, 1981).

Over 50 recommendations were generated within the Lysaught Report (1970). The recommendations were broadly summarized in terms of four major priorities:

1. An increased emphasis on research into the area of nursing practice and nursing education.

2. Adjustments in the curricula of nursing educational programs based upon the results of the above research.

3. Increased financial support for nurses to ensure adequate career opportunities that would attract and retain the number of individuals required for quality health care.

4. Clarification of roles in practice cojointly with other health professions; specifically, the establishment of the National Joint Practice Commission (NJCP) between medicine and nursing. The Commission would be formed

> to discuss and make recommendations concerning the congruent roles of the physician and the nurse in providing quality health care, with

> particular attention to the use of the nurse clinician; the introduction of the physician's assistant; the increased activity of other professions and skills in areas long assumed to be the concern solely of the physician and/or the nurse. (Kelly, 1981, p. 78)

National Joint Practice Commission

The creation of the NJCP in September 1971, was in direct response to the recommendation by the National Commission for the Study of Nursing and Nursing Education. At the time of its inception, the NJPC held tremendous promise in terms of its potential for significantly improving physician-nurse collaboration. As Thelma Schorr (1972), then editor of the AJN, so cogently commented.

> These are subjects that are urgent in the total spectrum of health problems. A body such as the National Joint Practice Commission has enormous potential for coming up with some answers if it focuses joint thinking and open minds on health care goals and not just on nursing problems, and if it develops enough clout to effect the changes in both medical and nursing practice that those health care goals will undoubtedly require. (p. 459)

Formulated by joint action by the AMA, represented by the Committee on Nursing, and the ANA, the 16-member commission was composed of members who were all practitioners, engaging, at least 50% of their time, in

direct patient care activities. Funding for the NJPC was provided jointly by the AMA and the ANA, but the literature does not reveal in what proportions the funding was allocated (Kelly, 1981; Steel, 1981).

Purposes and Objectives

In proposing the formation of the NJPC, the following purposes and objectives were delineated:

> Discuss, study, and make recommendations on the congruent roles of the physician and the nurse in providing quality health care.
>
> Examine the roles and functions of both professions and recommend new or altered practices by both.
>
> Work cooperatively with state counterpart committees and specialty group task froces to develop statements on joint practice, proposals for model health practice acts, statements on licensure, and the like. ("Joint Practice Commission Slated by the ANA and AMA," 1971, p. 2075)

The initial meeting of the NJPC was held January 21, 1972. At that meeting, the members established the following guidelines to direct their activities:

> The Commission should initially concern itself with generating, rather than implementing, concepts. The Commission should represent the interests of the public rather than of medicine and nursing per se. Commission members should regard themselves as consultants on the problems of medicine and nursing, not as advocates for positions within their professions. (Kelly, 1981, p. 588)

In summarizing the results of that first meeting, Dr. Robert Hoekeleman, the elected chairman of the Commission, reported:

> Nursing has recognized the need for expanding its role, to function to fullest capacity. Medicine has recognized it must concentrate on its own best area of expertise, letting go some of what it does to other professions, especially nursing. Between these parallel desires . . . we should be able to develop better health care systems. ("ANA, AMA Form Council to Improve Health Care," 1972, p. 408)

Activities of the NJPC

In essence, the ultimate goals identified by the members of the NJPC were to examine and redefine the traditional roles of both medicine and nursing in an effort to determine areas where interdependent practice could be fostered and to suggest feasible and practical ways in which joint practice could be implemented. The activities undertaken by the NJPC to achieve these goals were directed toward two major tasks: informing physicians and nurses about the concept of collaborative joint practice and the means by which it could be implemented, and secondly, sponsoring a 3-year project demonstrating the successful implementation of joint practice in the institutional setting.

The educational goal of the NJPC was accomplished through several activities. The Commission sponsored several national conferences, attended by nurses, physicians, and administrators, addressing crucial issues related to joint practice and the manner in which collaborative practice could be implemented ("Joint Practice Conference Set for November," 1978; Kelly, 1981). In addition to this, the NJPC published a series of statements over a 3-year period addressing specific issues relevant to the concept of joint practice. These statements were published as an effort to facilitate clarification and enhance communication between all groups who would be involved in implementation of the concept of joint practice. By publishing these statements, the NJPC delineated guidelines and established a framework whereby joint practice could be actualized (Appendix C).

Lastly, the NJPC sponsored three publications addressing the concept of joint practice. A Selected Bibliography with abstracts on Joint Practice was the initial publication produced by the NJPC. Following this, a book entitled The Statutory Regulation of the Scope of Nursing Practice--A Critical Survey was

published in 1975. This book addressed the potential legal ramifications associated with the implementation of joint practice and offered suggestions which would facilitate amendment of state nursing and medical acts to encompass the concept of joint practice (Kelly, 1981). The final publication sponsored by the NJPC was titled Together: A Casebook of Joint Practice in Primary Care. The text provided 24 case reports of actual physicians and nurses functioning together in a joint practice relationship (Steel, 1981).

The most significant and lasting impact of the NJPC was the sponsorship of a project designed to demonstrate the implementation of joint practice in four separate hospitals across the United States. In establishing the demonstration project, the NJPC identified five major goals which each hospital would need to address in order to ensure successful implementation of joint practice. According to the NJPC, each of the demonstration hospitals would need to

> Introduce primary nursing, as contrasted to team nursing. . . .
> Encourage nurses' clinical decision-making, with both medical and nursing consultation "available on request" . . . .
> Integrate the patient record so that it reflects the observations, actions, and judgements of both RNs and MDs . . . .

> Conduct joint patient care record review as a supplement to separate medical and nursing audits . . . .
> Establish a joint practice committee, equally representing RNs and MCs, to continuously monitor nurse-physician interactions and recommend "appropriate" actions supporting joint practice. (Stone, 1978, p. 18)

The four hospitals chosen to demonstrate the implementation of joint practice were Hillcrest Medical Center, Tulsa, Oklahoma; Eskaton American River Healthcare Center, Carmichael, California; York Hospital, Yorktown, Maine; and Downstate Medical Center, Brooklyn, New York. These hospitals were chosen because they represented a cross-section in terms of size, use of medical house staff, and administrative organization. The hospitals differed in that some were affiliated with universities while others were community-based. In each of these demonstration hospitals, one nursing division was selected for the implementation of joint practice. Primary nursing was instituted on the nursing division and each hospital developed a nurse-physician joint practice committee. Each institution's joint practice committee established specific and individualized guidelines to facilitate the implementation of joint practice. Once joint

practice had been implemented, the committee functioned as a forum for the resolution of problems encountered by both nurses and physicians involved in the project. Additionally, each hospital derived a mechanism for keeping joint patient records and for evaluating the quality of patient care provided as a result of this new model of care delivery.

These projects were implemented primarily for demonstration and, unfortunately, no mechanism was established by the NJPC to gather specific statistical data as to nurse retention, possible patient care cost increases, or decreases in the number of hospital days per patient. The evaluation of the effectiveness of joint practice in these four settings was predominantly achieved by individual comments solicited from the participating nurses, physicians, administrators, and patients. As associate director of Chicago Associates for Social Research, Marilyn Notkin was chosen to coordinate the projects and, as a result, visited each of the hospitals involved on several occasions. According to comments made by Notkin, the predominant response to the introduction of joint practice in each of the hospitals was positive. In the March 5, 1982

issue of the American Medical News, Notkin's observations were summarized in the following way:

> Ms. Notkin said patient satisfaction and economic benefits showed up several ways in her informal surveys. Call lights went on less frequently. There were fewer requests for pain medicine, possibly because of lower stress levels. Lengths of stay might have dropped slightly. Patients "uniformly were ecstatic about their care," she said. (Carrell, 1982, p. 10)

Feedback from all four hospitals involved was remarkably consistent in terms of the positive aspects of joint practice as well as in terms of the problems encountered during the implementation. Generally speaking, each hospital was confronted with some difficulty in clearly delineating specific role definitions for both nurses and physicians in joint practice and determining which aspects of patient care management could be best addressed through a collaborative effort. This issue of role definition and role identification continued to be a difficulty as the project proceeded and it was left to each joint practice committee to negotiate workable solutions on an individual basis.

A corollary to this problem was that nurses involved in the project initially experienced difficulty in identifying the role of nursing outside of the

medical plan of care. Some nurses reacted anxiously to the increased responsibility and autonomy that was mandated by joint practice. The freedom to make independent nursing judgments and to implement nursing actions resulted in increased accountability for practice which some nurses were hesitant to assume.

The second major difficulty encountered by these hospitals was the development of a satisfactory patient record which would integrate and incorporate both physician and nurse input concerning the patient's progress and the patient's plan of care. Fear of the appearance of potentially conflicting data on one form resulted in physician concern over possible legal repercussions. Some nurses were hesitant to record their observations and their nursing orders on a dual nurse-physician record. This initial hesitancy on the part of some nurses could have been due to a lack of confidence in their ability to accurately record pertinent patient observations.

The introduction of joint practice in these four hospitals was proven to be beneficial in two major ways. Without question, the implementation of joint practice provided a positive framework for improvement

in the collaborative relationship between doctors and nurses. This project clearly demonstrated that joint practice was a successful vehicle for the improvement of nurse-physician communication and for enhanced collaboration. Feedback from each of the hospitals indicated that mutual trust between doctors and nurses developed as a result of joint practice efforts. Each group gained an insight into the problems that members of the other group faced. For years nurses and physicians had predicted that increased collaboration between the two groups would improve patient care. Indeed, the demonstration projects in these four hospitals demonstrated that prediction to be correct. Patient satisfaction increased with a resultant enhancement of nurses' and physicians' job satisfaction. Sarah Blackwood, R.N., project coordinator at Hillcrest Medical Center in Tulsa, reported the improvement in patient satisfaction in the following way:

> the use of sleeping pills and analgesics is going down . . . . This is because the nurse is more attuned to the patients' stress levels, coping mechanism, and is there to intervene in in the early stage of pain.
>
> Overall, she said, patients are going back to their physicians' offices "raving about the fantastic care they've gotten from both the MDs and the RNs. They've said things like

> they're going to this hospital rather than the other one because of the program's benefits to them--and thus indirectly it's helping physicians keep their patients." (Stone, 1978, p. 18)

It is significant that in each of the four hospitals included in the project, there were both nurses and physicians who were totally unwilling to have any involvement with the joint practice concept. According to collaborative practice proponents, some nurses lacked confidence in their ability to function with the increased responsibility and accountability mandated by the joint practice concept, while some physicians feared loss of autonomy over patient care and expressed concern for possible risks of increased liability as a result of engaging in joint practice with nurses (Carrell, 1982).

Summary

During the 1970s, the Committee on Nursing engaged with ANA representatives to establish the NJPC. The Commission issued several published statements which provided guidelines for the establishment and maintenance of joint practice in both primary and secondary health care settings. The collaborative efforts of the Committee and ANA representatives were analyzed in

response to the fifth research question, "To what extent did the Department of Nursing and the Committee on Nursing collaborate with the American Nurses' Association?"

In 1979, Barbara Nichols, then president of the ANA, identified the National Joint Practice Commission as a catalyst for stimulating interaction between the AMA and the ANA. She further commended the Commission for its successful efforts in providing guidance to both professions in their efforts to improve patient care through collaboration and joint practice. According to Nichols,

> We now face a maldistribution of facilities and manpower along with inflated costs. It is logical, therefore, that the American Nurses' Association and the American Medical Association take advantage of this climate to collaborate on the resolution of health problems. ("ANA, AMA Presidents Emphasize Harmony," 1979, p. 1)

Despite the "logical" and desirable benefits to be derived from continuation of the NJPC, the AMA Board of Trustees voted in June 1980 to withdraw financial support from the Commission, effective January 31, 1981 (Lee, 1980; Steel, 1981). Without this financial support, the demise of the NJPC was inevitable. In reporting the demise of the NJPC, the nursing journal

RN reported the following comment from Hubert Ritter, M.D., an AMA trustee.

> very headstrong nurses on the commission wanted to establish an extended practice of nurse practitioners totally unrelated to physicians . . . . This was the "most difficult issue the joint practice commission had to deal with . . . and it had nothing to do with joint practice." (Lee, 1980, p. 25)

Lee (1980) reported additional statements made by Ritter which disclosed the premise held by AMA officials that there were methods of liaison which could surpass those inherent in the Commission. Lee (1980) further quoted Ritter as stating that AMA and ANA representatives

> "thought there was a better way of liaison than the commission. It was understood that we would no longer support it and they had better things to do with their money too." (p. 25)

Roberta Thiry, a nurse member of the NJPC, disagreed with Ritter's inference that the withdrawing of funds was by mutual agreement and understanding. Thiry indicated the possibility of informal discussions between representatives of the organization having taken place, but she disclaimed the notion that the ANA supported dissolution of the NJPC at that time (Lee, 1980).

The actual reasons for the withdrawal of the AMA from the Commission are unclear. In order to gain further information relating to factors contributing to the termination of the NJPC, 16 questionnaires were mailed to former Commission members. Only five of the questionnaires were returned and none of those responses could be utilized to evaluate the conditions precipitating the dissolution of the NJPC.

Members of the nursing profession expressed surprise and disappointment in the action taken by the AMA. In the February 1981 issue of the American Nurse, Thiry was quoted:

> The commissioners had discussed the idea that the commission would not be self-perpetuating, but we had hoped to continue through the summer of 1981. ("NJPC Will Publish Practice Guidelines Based on Project," 1981, p. 12)

Lee (1980) reported the reaction of Nichols.

> "NJPC, in its nine years, has opened new worlds and opportunities for the creative involvement of nurses and physicians in practice-related concerns common to both professions. Now, of course, I am disappointed that it will cease to exist. (p. 25)

The impact of the NJPC on nurse-physician collaboration was not totally negated as a result of the dissolution of the Commission. The four hospitals involved in

the demonstration projects as well as other hospitals continued to refine the concept of joint practice in the patient care setting. The loss of the NJPC was, however, a psychological blow to the demonstration projects. In addition to this, the availability of the support and guidance formerly provided by the NJPC was lost to any groups wishing to follow the pattern of joint practice in the future. Continuing and future efforts in the area of joint practice will necessarily rely on utilization of local joint endeavors between medical societies and nursing organizations and endeavors between committed individuals of both disciplines.

CHAPTER 5

CONCLUSIONS AND ANALYSIS

Since 1868, the American Medical Assocition has formed numerous committees which have been concerned with issues related to nursing education and practice. During examination of the activities and concerns of these committees, the following conclusions were drawn:

1. From a historical perspective, the medical profession and the nursing profession have not communicated effectively in their efforts to address common concerns and issues related to health care delivery; instead, joint efforts have been characterized by the redefining of health care delivery problems into nursing problems.

2. Despite the recognition by members of the professions of medicine and nursing that traditional relationships are inadequate to better meet the nation's health care needs within the complexity of the present system, the two groups have not reached a level of collaboration conducive to the effecting of positive change.

3. Historically, physicians have assumed the right to influence the scope and function of nursing practice.

4. The posture of medicine toward nursing has prompted its interest in nursing education and nursing practice and into nursing's efforts to solve problems within the discipline, thus hampering the development of nursing into a self-determining profession.

5. The historical efforts of the AMA to establish effective liaison with national nursing organizations and with the nursing profession have been essentially nonproductive; however, positive results of collaboration between the two groups was demonstrated in the Grading of Schools and in the NJPC.

6. The AMA's efforts to recommend solutions to critical issues in nursing were consistently reactionary in nature, responding to perceived crisis in health care or to actions initiated by the nursing profession with the exception of their involvement in the NJPC.

7. Historically, the AMA has not acknowledged a distinction between nursing care and medical care.

8. Through numerous committee recommendations, the AMA repeatedly advocated stratification of the

nursing role and shortened educational preparation for nurses as the primary solutions to the shortage of nursing personnel.

9. Although individual members of the AMA demonstrated sincere dedication to the achievement of constructive interprofessional relationships, the bureaucratic structure of the organization effectively precluded any alteration in the status of the physician with the health care system.

Analysis

The AMA's repeated formation of various committees to study and recommend solutions to problems existing in the area of nursing education and nursing practice demonstrated that physicians traditionally assumed a role of guardianship over nursing. The assumption of the guardianship role was initiated by the first committee established by the AMA that was concerned with nursing and was sanctioned by its successors.

Ashley (1976) viewed this traditional relationship between nursing and medicine within the context of paternalism. In definition and in practice, paternalism assumes that one person (or group) has the right and,

in fact, the obligation to guide and direct another person (or group). The obvious assumption underlying paternalism is that the person (or group) to be led is inherently unable to direct his (or their) own activities and determine future courses or actions independently. Adherence to a paternalistic attitude directly indicates a belief in the inequality of the two persons (or groups) involved. The person (or group) who guides and directs the actions of another is obviously far superior to and more powerful than the one being led.

The paternalistic posture of medicine toward nursing, although sporadic in nature, has survived for over a century and has been characterized by multiple efforts to establish a positive and productive relationship between the two disciplines. The efforts of the AMA have been largely reactionary in nature, as opposed to being innovative or constructive. Although individual members of committees established within the AMA may have been totally committed to the establishment of collaborative relationships, bureaucracies tend to be conservative and resistant to change. The ability to alter traditional and restricted relationships may

necessarily reside at a lower level. Benner (1981) suggested that the development of collaborative relationships must be approached on a personal and individual basis.

The AMA organization remains totally committed to maintaining its control over health care delivery and over the roles assumed within that structure by members of other health occupations. The stated intention of the AMA to advance nursing as a profession has not been congruent with their persistent support of lesser levels of educational preparation for nurses or with their failure to envision nursing outside the medical model. Extreme stratification in nursing has created disunity within the discipline and has decreased the power of nursing to effect changes. Consequently, physician dominance over health care has been encouraged and facilitated.

Historically, nurses have sought the sanction and the assistance of the medical profession to achieve its goals and solve its problems. If considered within the context of Friere's (1970) conceptualization of the relationship between the oppressor and the oppressed, nursing's acceptance of medical paternalism is comprehensible.

> The oppressed, having internalized the image of the oppressor and adopted his guidelines, are fearful of freedom. Freedom would require them to eject this image and replace it with autonomy and responsibility. Freedom is acquired by conquest, not by gift. It must be pursued constantly and responsibly. Freedom is not an ideal located outside man; nor is it an idea which becomes a myth. It is rather the indispensable condition for the quest of human completion. (Friere, 1970, p. 31)

Although the dichotomy between medicine's paternalistic attitude and nursing's acceptance and nurturance of that attitude has been delineated to members of the nursing profession for several years, nurses have not unitedly formulated a strategy to combat the paternalism that has historically impeded its growth and development into a full profession. Nurses have been hesitant to accept the responsibility and accountability that is inherent to the practicing of a profession. Without subscribing to these fundamental attributes of professional behavior, nursing will not advance past the parameters imposed by paternalism nor will it realize its fullest potential in the continuing effort to gain and maintain a healthy society.

Paternalism is the antithesis of collaboration. The concept of collaboration assumes that both groups involved in the process can participate meaningfully and

equally. The persistent assumption of a paternalistic attitude by the medical profession over nursing effectively precluded the possibility of any meaningful collaboration between the two groups. Undoubtedly, it was this basic premise that has led to the failure of the two groups to establish and maintain a mutually satisfactory and enduring collaborative relationship despite repeated attempts throughout history.

The demonstration projects initiated by the NJPC, the most recent effort in collaboration, may well indicate that a change in traditional relationships is possible. The furtherance of this type of change can occur only in an atmosphere void of paternalistic attitudes and characterized instead by mutual respect, mutual appreciation of role responsibilities, and effective communication. These elements are mandatory if medicine and nursing are to reach a level of collaboration that will benefit both groups and the public they serve.

Implications for Nursing

This study has implications for nursing practice and nursing education.

Nursing Practice

1. In order to alter the health care system in a constructive way, the collaborative efforts of nursing and medicine should address relevant health care issues rather than focusing primarily on nursing problems.

2. Nursing must systematically delineate its scope of practice and its role in health care and effectively communicate its role functions to the public and to the medical profession at large.

3. Nursing should assume the responsibility for monitoring activities of the AMA that are directed toward any issues affecting nursing.

Nursing Education

1. A course in nursing history should be included in the curriculum of all schools of nursing. By understanding history, members of the group may avoid repeating past mistakes and duplicating past unsuccessful endeavors.

2. Joint courses between nursing and medical students on effective communication should be included in the curriculum of nursing and medical schools in

order to facilitate mutual understanding between the two groups.

3. In order to facilitate the movement of nursing past the parameters imposed by medical paternalism, students of nursing should be socialized into positive professional role functions to better prepare them to assume professional role behaviors upon entering practice.

Recommendations for Further Study

1. A historical study be conducted to examine the American Hospital Association's involvement in nursing education and nursing practice.

2. An empirical study be conducted to evaluate the impact of joint practice between nursing and medicine on nurse retention, number of hospital days per patient, and the economics of care.

3. A historical study be conducted to more closely examine the impact of social ideologies about women upon the growth and development of nursing toward professionalization.

4. A historical study be conducted to more closely examine and evaluate the development of external

controls over nursing and the resultant impact on the development of nursing autonomy and professionalization.

APPENDIX A

TEXAS WOMAN'S UNIVERSITY
Box 23717, TWU Station
Denton, Texas 76204

1810 Inwood Road
Dallas Inwood Campus

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Karen Anne Bufton Center: Dallas

Address: 203 Bon-Aire Drive Date: 6/11/81

Dallas, Texas 75218

Dear Ms. Bufton:

Your study entitled Purposes, Activities, and Collaborative Efforts of the Department of Nursing and the Committee on Nursing of the American Medical Association: 1961-1980.

has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

_____ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

_____ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

_____The filing of signatures of subjects with the Human Subjects Review Committee is not required.

_____Other:

__X__No special provisions apply.

Sincerely,

Estelle D. Kurtz

Chairman, Human Subjects
Review Committee

at Dallas

PK/smu/3/7/80

APPENDIX B

TEXAS WOMAN'S UNIVERSITY
DENTON, TEXAS 76204

THE GRADUATE SCHOOL

July 20, 1981

Ms. Karen Anne Bufton
203 Bon-Aire Drive
Dallas, Texas 75218

Dear Ms. Bufton:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Robert S. Pawlowski
Provost

RP:dl

cc Dr. Estelle Kurtz
Dr. Anne Gudmundsen
Graduate Office

APPENDIX C

Statement on Certification of Nurses and Physicians

The National Joint Practice Commission has been charged to promote collaborative efforts between medicine and nursing to improve patient care. Within this context we wish to promote continued interprofessional preparation and continuing education. Should certification of any group within a profession be deemed necessary, the process should be accomplished by that profession. Consultation with other professionals may be desirable in the certification process. (February 8, 1974)

Statement on Medical and Nurse Practice Acts

The accumulation of knowledge and the expansion of techniques and skills able to be utilized in the care of individuals and in the prevention, treatment, and cure of disease has necessitated or resulted in a realignment and readjustment of nurse and physician roles.

In view of their growing interdependence, it becomes increasingly evident that successful or effective delivery of health care cannot be achieved through unilateral determination of functions by either medicine or nursing.

Practice acts which now serve as conditions for licensure and continuing licensure in each profession must be examined to ensure the legality of these realignments and readjustments for the protection of both the public and the professionals involved.

It is the recommendation of the National Joint Practice Commission that:

1. Practice acts which are broad enough to permit flexibility within the confines of licensure be left as they are and that statements addressing themselves to the issues of role realignment and adjustments be initiated by State joint practice committees or other joint bodies of medicine and nursing.

2. That practice acts of medicine or nursing which are so defined and constrained that they do not allow for flexibility within the limits of legality be restated to permit breadth and flexibility, neither delineating nor contraindicating specific functions within the role. State joint practice committees, joint bodies, or members of both professions acting jointly will then be free to issue statements relating to role changes and role realignments without recourse to further legislation.

Recognizing that priority health problems may vary and differ dependent on State and local situations, the National Joint Practice Commission is prepared to advise State joint practice committees and others who are reviewing options within existing medical and nurse practice acts or possible routes and models for the formulation of new acts to achieve the necessary freedom to provide the consumers with needed care in their respective states. (February 8, 1974)

Nursing Staffs in Hospitals

The primary goal of the National Joint Practice Commission is to promote collaborative efforts between medicine and nursing for the improvement of patient care. The Commission believes such collaboration is essential for defining and meeting the complex health care needs of the public. In hospitals, it requires effective communication between medicine, nursing, and hospital administration.

Effective communication has been impeded because nursing frequently does not have the position of the opportunity for input in the decision-making of the hospital organization. Nursing has established its

autonomy as a profession. In order for free and full collaboration between medicine and nursing to exist, nursing must have responsibility for the quality of nursing care it provides to patients and accountability for its ethical conduct and professional practices.

The National Joint Practice Commission therefore recommends that organized professional nursing staffs of hospitals exercise responsibility for the quality of nursing care provided to patients, and for the ethical conduct and professional practices of its members, and be accountable to the governing board of the hospital.

The Commission calls upon the American Medical Association, the American Nurses' Association, the American Hospital Association, the Joint Commission on Accreditation of Hospitals, and other medical and nursing associations and individual hospitals to endorse and implement this recommendation. (September 1977)

Joint Practice in Primary Care: Definition and Guidelines

The purpose of the National Joint Practice Commission is to promote collaborative effort between

medicine and nursing for the improvement of patient care. The Commission believes that such collaboration is necessary to define and meet the complex health care needs of the public and that comprehensive primary care must be an integral part of the health care delivery system. Comprehensive primary care means the provision of all services needed to respond to the wide range of presenting health problems of individuals in their community setting.

The Commission defines joint primary care practice as having all the following characteristics:

a. An initial and continuing relationship between patients in need of care and the providers of that care.

b. Continuity of care for patient populations of all ages and in all states of health and illness.

c. Responsibility by the providers for a continuum of comprehensive care which includes maintenance and promotion of health, evaluation and management of disease, restoration of health, and coordination of all necessary services and agencies.

d. Accessibility, which is defined as attainable services that are continuously available.

e. Acceptability to patients.

Furthermore, patients should understand the services they receive, the reasons for those services, their role in their own health care, and should actively participate in that care.

A commitment to the ideal of providing "primary care" in the full sense of the term establishes a framework within which the skills and perspectives of both medicine and nursing can most successfully be brought to bear on the health needs of patients and communities.

Neither the nurse nor the physician alone is prepared to address adequately the broad range of health, medical, and nursing concerns of patients encountered in a primary care setting: each professional has a clear identity, each is licensed in his or her own right, and each is in command of a separate body of knowledge, although there is a shared scientific base of preparation and considerable overlap in many functions. Thus, each professional brings different information and expertise to the setting that the other

professional recognizes, values, and is unable to provide alone.

The National Joint Practice Commission believes the provision of primary care to the public is best accomplished by the joint efforts of specially educated nurses and physicians, and that the relationship should be that of colleagues in professional practice, regardless of individual employment status.

Nurses and physicians cooperate to synchronize medical and nursing efforts aimed at achieving optimum patient outcomes. Nurses and physicians monitor patients' health status, provide advice and guidance, detect early signs of potential health problems, and assist patients to comply with prescribed regimens. Both professionals participate as auditors in periodic reviews of the primary health care rendered to patients.

Although both nurses and physicians concern themselves with diagnosis, treatment, disease prevention, and the maintenance of health, physicians tend to bring a diagnostic and therapeutic perspective to the medical needs of patients, while nurses tend increasingly to bring health-oriented and educational perspectives to the physical, emotional, and social needs of patients.

The Commission recommends that nurses and physicians engaging in primary care joint practice subscribe to the following guidelines for their practice:

a. The scope of practice of the nurse and the physician should be jointly determined to their mutual satisfaction. Their practice should remain flexible and should be viewed and changed as necessary.

b. The performance of tasks by nurses that are not commonly accepted nursing practice should be mutually agreed upon by the nurse and the physician.

c. The delineation of tasks should be determined on the basis of the practice situation, the capabilities of the nurse and the physician, and the needs of the patient.

d. The medical and nursing services of the joint practice must be available to all patients.

e. The joint practice relationship should be explained to all patients.

f. The business relationship of the nurse and the physician should be negotiated between them and stated in writing. (September 1977)

The Definition of Joint or Collaborative Practice in Hospitals

The elements of the nurse-physician relationship which constitute joint practice in the hospital include:

a. The nurses and physicians serve the same population of patients.

b. A joint practice committee exists equally representing practicing nurses and physicians, which continuously redefines the scope of medical and nursing practice in the light of experience and patient care needs. The committee's recommendations are ratified by the medical and nursing staffs and, when appropriate, by the administration and the governing body of the hospital.

c. A formal communication process exists, in addition to informal processes, for continuously integrating the medical and nursing observations, diagnoses, and regimens for care for each patient. Informal communication between nurses and physicians, and between them and their patients, is well developed. Formal communication by means of

consultations and conferences is frequent; and the patient care record is integrated in some variant of the problem-oriented patient record.

d. A formal process exists for jointly evaluating patient care and for maintaining jointly established standards of care.

e. There is joint determination of administrative and non-clinical actions bearing on patient care by nurses, physicians, and the hospital administration.

f. There is acceptance by nurses and physicians of each other's clinical judgement in their respective professional fields. Both are subject to clinical challenge in the patient's interest. Conflicting judgments are resolved on clinical grounds.

g. There is provision for medical, nursing, and joint continuing education.

h. Nurses and physicians judge themselves satisfied with their roles in the hospital. Patients are satisfied with the care they receive.

i. Patient care and medical and nursing services meet recognized standards of quality

established by the Joint Commission on Accreditation of Hospitals.

j. The hospital administration actively supports all the above actions and activities.

k. In addition, the NJPC believes that, when necessary preparations have been made, nursing will be compensated according to the nature and duration of its services to patients; and further, that organized professional medical and nursing staffs of hospitals will exercise overall responsibility for the ethical conduct and professional practices of their members, and be accountable to the governing board of the hospital. (September, 1977)

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