Nurses as Formal Leaders in United States Civilian Hospitals: 1891-1991

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Dedication

To my mother who first sparked in me the pursuit of learning and curiosity in history.

Acknowledgments

During my time as a leader within the hospital at the University of Virginia, I observed how senior leadership decisions significantly impacted the nurses' ability to practice effectively at the bedside. While observing the impact of the decisions I was fortunate enough to be mentored by my committee co-chair, Dr. Kenneth White, who encouraged me to ask questions about the role of leadership in nursing. He challenged me to think critically and with innovation about the importance of nursing's role in healthcare today, which led me to pursue my doctorate. I am grateful for his thoughtful guidance and enduring support over the last several years. I also want to recognize co-chair Dr. Barbra Mann Wall. Thank you for introducing me to the scholarship of nursing history and unlocking in me a fervent interest in nursing history. This dissertation would not have been possible without the collaborative and encouraging support of my wonderful co-chairs. I also want to thank the rest of my dissertation committee members. Dr. Elizabeth Gorman for challenging me to think critically about my research questions and nursing within organizations. Dr. Arlene Keeling, thank you for your wise counsel and patiently working with me to become a more focused and thoughtful writer. It has been an absolute privilege and honor to be guided by my committee members, to whom I am ever grateful.

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Chapter 1

Introduction, Historiography, and Methods

By examining the growth and evolution of nursing leaders in hospitals in the United States from 1891-1991, this research augments our understanding of the forces that supported, limited, or suppressed nurses' roles in formal senior hospital administrative or leadership positions. Understanding and interpreting the environmental forces and historical antecedents help examine the factors that influenced the cycle of prominence, obscurity, and resurgence of nurses at the helm of healthcare organizations. The dissertation adds to nursing history by enhancing our understanding of what factors may have limited or suppressed nurses' roles in hospital leadership and how nurses re-emerged in formal senior administrative leadership positions by 1991.[1]

Nurses had a prominent role in establishing and shaping US hospitals at the end of the nineteenth century. Yet, nurses became more insular in the middle twentieth century in order to define and establish nursing as a profession. By the latter part of the twentieth century, nurses re-emerged with a seat at the senior management table. Using the historical method, I argue that, over time, the nursing profession had to adapt and respond to both internal and external pressures to survive and solidify their leadership roles in American hospitals.

Purpose, Design and Research Questions

Using a historical lens, this dissertation describes and analyzes the experiences of nurses who were effective in their leadership roles in the period 1891–1991 and the adaptive tactics they employed to survive and maintain their leadership positions in hospitals. How nurses in hospital

senior leadership roles responded to religious, political, financial, and societal factors is the focus. The research examines factors that facilitated and stymied the evolution and strategic adaptation of formal nurse leaders in United States civilian hospitals by tracing the evolution of nursing leadership starting with nursing's efforts to professionalize in 1891 to the formalization of their role as nurse executives in the strategic governance of hospitals in 1991.[2]

In the late nineteenth and early twentieth century, most American hospitals were led by nurses who served in administrative roles as superintendents of the hospital and nursing training schools. Yet, as hospitals grew larger and more complex by the 1930s, nurses were replaced by men with apprentice training in hospital administration – especially in large, urban hospitals – thereby divesting nursing of this influential role.[3] The literature suggests that both White and Black women were edged out of leadership roles because of the demand for trained businessmen and administrators, to help manage the hospital transition from a charity to a more solvent financial business model.

For my research, the historical method provides the best approach for examining the roles American nursing leaders played in healthcare during the period 1891-1991. I use four case studies. The first will be that of a White woman: Isabel Hampton Robb, who successfully led two nursing training programs, established national nursing organizations, and became a visionary leader in standardizing nursing training programs to establish nursing as a respectable profession from 1891-1910. The second case study takes us to the height of the Black hospital movement between the 1920s and 1950s and will examine the leadership of Belva Overton, Superintendent of Nursing at the Chicago Provident Hospital from 1921-1946. The third case study focuses on Sister Mary Maurita Sengelaub and is an example of leadership when, in 1970, she became the first nurse and woman to become chief executive officer of the Catholic Hospital Association.

The fourth case study examines the leadership style of Anne Zimmerman who led state and national associations in the fight to improve nursing working conditions and wages from the 1960s to 1991.

The four case studies examine the impact or limitations nurses had on the emerging American healthcare system and nursing profession. The first discussion of Robb provides the context of the origins of nursing leadership at the dawn of modern hospitals in the late nineteenth and early twentieth centuries. Her role in positioning herself – and nursing – with hospital leadership demonstrates a successful jockeying of power within hospitals. In the second case study, Overton's life provides insight into the power and political struggle of a Black nursing superintendent in the Jim Crow era at a Black hospital buoyed by philanthropy. In the third case, Sengelaub is an example of the impact of a nurse and member of a Catholic religious community (Religious Sisters of Mercy) who demonstrated leadership in the Catholic hospital sector at a time when hospitals were transitioning from benevolent charitable free-standing institutions to more sophisticated multi-hospital system business corporations, vying for market share and maximizing financial reimbursement from government and private payers. Finally, Zimmerman provides a perspective into nursing leadership by leveraging the power of professional organizations.

By using the historical method, this research identifies the changing healthcare environment and the ways in which these four nursing leaders adapted and shaped responses, which resulted in successful and sometimes not so successful, nursing leadership structures. The historical method considers the social, political and economic context of the time period involved and allows the researcher to learn from the documented experiences and accounts of the nurses who were engaged in leadership positions in hospitals at that time. This method involves

collecting, verifying, and synthesizing evidence from the past to answer the research questions rather than following a restrictive, preconceived research hypothesis.

To examine this problem, this dissertation asks the following research questions: 1) How did nursing leadership in United States hospitals change from 1891 - 1991? 2) How did certain nurse leaders adapt to changes within the societal, political, and economic changes with in hospitals? 3) What strategies did nurses carry out to strengthen their leadership roles in hospitals?[4]

Literature Review

History of Nurses in Administrative Roles

The extant literature on nurses providing leadership to hospitals at local and national levels during the early 1900s is significant and provides interesting insight into today's modern healthcare system in the United States. Since 1658, hospitals have been organized in the US to meet he needs of the sick, but it was not until the early twentieth century did hospitals become an indispensable resource to all, regardless of socioeconomic background.[5] Starting with the late nineteenth century and into the twentieth century, superintendents – many of whom were nurses – played a significant role in providing leadership to hospitals through local and national organizations.[6] They supervised hospital operations and, in many cases, also ran the nursing school that provided the hospitals with the labor force needed to care for the patients. Though the superintendent's responsibilities varied in hospitals based on size, the superintendents managed the hospital finances, physical plant, oversight of the nurse training program, and the discipline of junior house officers and student nurses. They also served as the intermediary between the hospital's trustees, boards, and physicians. However, as hospitals began to increase in size,

Charles Rosenberg suggests that superintendents began to recognize a need for training to be effective in the role and define their authority in hospitals.[7] The exception to this disputed leadership role in hospitals was – as we will see in a later section of this examination – the Catholic hospitals through most of the mid-nineteenth and twentieth century.

Adelaide Nutting, Director of the Department of Nursing and Health at the Teachers College, recognized the need to expand the nursing curriculum to support nurses entering superintendent roles and created a topic in her nursing curriculum titled "Institutional Administration" with the purpose of:

> Organizing instruction in matters of household management, - of arranging and combining theory and practice in such a way as to provide adequate academic and practical preparation for women desiring to fill administrative posts in institutions.[8]

Nutting understood that graduate nurses had a role in not only leading student nurses to provide direct care to patients, but also in creating care environments in hospitals where nurses, doctors, and pharmacists could effectively provide care to their patients. With the augmentation of "Institutional Administration" in the nursing curriculum, the graduates of this program were recruited by hospitals to serve in hospital leadership roles. Significantly, ten out from the first graduating class of forty-five accepted jobs as hospital superintendents upon graduation.[9] Nutting's contribution was the beginning of formal education to prepare nurses for hospital leadership roles, which spread to other nursing schools throughout the country. However, there was resistance to Nutting's proposition that nurses were well-suited to run hospitals. The minutes of the 1911 meeting of the American Medical Association reflect signs of skepticism of nurses in any formalized role stating:

> The hospital… should be run by a physician hospital executive because the hospital was a 'first class hygienic machine.' Physician superintendents of hospitals had no desire to see nurses in positions of control over medical work. Nursing was 'only a differentiation of domestic duty,' and the nurse herself a 'half-baked social product, thrust unto the fulfillment of an uncertain social need.' Nurses were not reportedly interested in the comfort of the patients, but only in the order and symmetry of the ward.[10]

Despite the general tone of cynicism by physicians, nurses continued to take roles as superintendents and became active members of the American Hospital Association (AHA) in the early twentieth century. In 1912, the AHA had 922 members and of these 421 were nurses and 235 were doctors.[11]

Leaders like Adelaide Nutting, Isabel Hampton Robb, Annie Goodrich, and Lillian Wald all advocated in the early twentieth century that nursing schools needed to begin attracting educated students and called upon nursing leaders to standardization of nursing curricula to create a profession of nursing. In 1894, the American Society of Superintendents of Training Schools for Nurses – which in 1912 was renamed the National League for Nursing Education (NLNE) – was established at Columbia University Teachers College for the purpose of creating a universal standard for training nurses. [12]

It was not until 1923 when the Goldmark Report was published did nursing have a blueprint to create a standardized curriculum. The report recommended that graduates of nursing programs replace the student nurses working in hospitals to provide nursing students with the support to dedicate more time to education. This would have, in effect, created the foundations of a permanent professional nursing workforce who would have been trained to align the

burgeoning professional nurse with the nurse hospital superintendent, not just the physician in the direct care role. But, unlike the Flexner Report that transformed medical schools to adhere to a higher standard of education causing the closure of poorer quality medical schools, the Goldmark Report had a nominal effect on nursing schools – primarily due to the lack of autonomy nursing schools had from the sponsoring hospitals who benefited from student labor in their facilities. [13] The NLNE advocated for the use of graduate nurses at the bedside in hospitals, which, as Susan Reverby suggests, "would bring greater skills to the hospitals because she was older and more experienced, and greater loyalty because of her professionalism" as opposed to a student nurse workforce. But, driven by fears that higher standards of education would lead to the closure of smaller nursing schools from which they graduated many nurses loyal to their school than to a profession.[14]

The nursing education system and gender inequalities did not present the only challenge to nursing leadership in hospitals, but hospitals began to align its priorities to a more capitalistic and business focus in providing services to patients. With this change there was an increasing interest in replacing nursing hospital leaders with administrators trained in business. Rosemary Stevens argues that American hospitals prior to the twentieth century may have started as voluntary or community hospitals that met the needs of the poor or fulfilled religious outreach objectives, but toward the 1930s hospitals became more reliant on patient fees rather than on charity to keep the hospital operational. Hospitals subscribed to a "pay nexus" between services offered and how much a patient was willing to pay. They began to market themselves and compete with other hospitals with improved hospitals rooms, as opposed to wards, and new state-of-the-art technology including pathology laboratories, X-ray facilities, and surgical room capabilities. The new services also were used to recruit skilled physicians by offering privileges

to work at their hospitals. Stevens further argues that hospitals transitioned from voluntary hospitals to an "income-maximizing organization" focused on preserving a corporate business bureaucracy twentieth century.[15] With the establishment of the American College of Hospital Administrators (ACHA) coupled with the creation of new insurance programs – such as Blue Cross – the hospital leadership focused on generation of revenue and the management of labor, specifically nursing, which became a calculation in operating expenses. Nursing's influence over hospital operations reduced through the 1930s as hospitals became more complex and specialized, expanding bureaucratic divisions of labor to oversee multiple departments in large hospitals. The ACHA trained administrators were there to fill the leadership void, not nursing.[16] Joan Lynaugh and Barbara Brush suggest that hospital boards at this time perceived women's expertise and abilities innately lacking in the "financial management or institutional planning" of hospitals. This cultural perception of women as being subservient to male authority, placed administrators and physicians in positions of power over women working in nursing. [17] Instead of building on the experience of nursing administration, medical superintendents and other (largely male) administrators sought to establish themselves as a new profession, except for the nuns in the Catholic hospitals. [18]

Rosemary Stevens claims that nurses we "institutionally subsumed" because nursing training programs continued to teach Nightingale's philosophy for women in nursing as "traits of self-sacrifice, dedication to duty, and complete obedience to superiors"[19] Nursing appeared to be an "all-purpose female service workers" without a defined scientific skill set that could compete with physicians who embodied the specialized science of healing. [20] Patricia D'Antonio argues the similar point of a high standard for nursing morals by writing "while the public might tolerate the shortcomings of other 'professional' women, however, it would not tolerate them in nurses.

Nurses, most if not all leaders and educators believed, were and would be helped to a 'higher standard' of morality. They, and they alone, were privileged with duties of a much higher importance and ones that involved both 'the great problems of life and the mysteries of death and suffering."[21] This was in fact why many women chose nursing because of the "meaning and power" brought to the woman's family and community. Equipped with unique skills and education women thought were in control of their destinies and created opportunities that they would not have had otherwise.[22] Susan Reverby suggests that nursing leaders experienced a dichotomous predicament of advocating for better nursing wages, housing, working conditions with hospital administrators and physician leadership while respecting the training and ideology of discipline and sacrifice being taught nursing schools. In addition, fearful of a loss of a cheap labor force in nursing students, administrators and physician paternalism sought to control the nursing by suppressing their advocacy by emphasizing their role as "caring" versus the physician's role of "curing."[23]

This very brief review of early 1900s nursing leadership does expose gaps in the literature that I hope to address with my research. First, the literature does not go into great detail regarding the voice of nurses in hospital leadership positions in the early twentieth century. There is a significant body of research on the nursing leaders who were involved at the national level who promoted the professionalization of nursing, such as Adelaide Nutting, Isabel Hampton Robb, Annie Goodrich, and Lillian Wald, but the voice of nursing leadership in the hospitals was largely absent, especially during the 1930s when hospital administrators began to establish their profession. Eventually, the AHA supported the creation of the ACHA of which its leaders formalized the role of "hospital administrator" in the 1940s and this "new" profession. What was missing was the perspective of nursing leaders who were actively serving as hospital

administrators across the country during the transition from nurse-led superintendent (administrator) to non-nurse administrator?[24]

Second, how did nurse leaders survive in the hospital leadership roles through the first half of the twentieth century? My research examines the experiences of nurses who were effective in their leadership roles and tactics they employed to remain in their roles. Did the hospital boards and physicians, who were predominately male, actually want to remove women from leadership positions who were effective in the management of hospitals? The literature suggests that women were edged out of leadership roles because of the growing need for trained businessmen, or administrators, to help manage the hospital transition to a more solvent financial model. If women were perceived as inept in the management of hospital finances, how were the nurse leaders who were successful in leadership roles perceived? As we will see in the next section, the nuns of the Catholic hospitals proved that women absolutely could manage complex financial operations.

Role of Religion in Healthcare Administration

Guenter Risse writes that since Byzantine and Middle Ages, hospitals in Europe have "always been instruments of hope and pious benevolence" due to endowments and gifts from the community who supported the early hospitals due to a display of Christian faith and charity. In many ways donating to the Church was a form of penance. Moreover, it was recognized early by local and regional Church leaders that hospitals could be sources of political power. The hospitals in the beginning were organized from the early monastic models of discipline and a hierarchy to manage the finances to operate a hospital, which led to "power struggles between hospital sponsors and administrators" over patrons' endowments. Religion had a significant

impact on nursing as demonstrated by "medieval religious admission rituals included penance and the Eucharist, followed by purification ceremonies," which incorporated "washing of feet and issuance of new clothing." Much like the nursing duties of today that includes the changing of beds and hospital gowns and the nurse's responsibility for the patient's bathing and grooming. [25] Traditional nursing responsibilities became formalized with the establishment of Florence Nightingale's Training School for Nurses at St. Thomas' Hospital in London. In developing the school, Nightingale applied the lessons she learned while observing the Catholic Sisters of Charity in Paris and the Protestant Deaconess Institute in Kaiserswerth, Germany. She combined her observational experiences with her experience with the British Army in the Crimean war with to develop the prevailing school philosophy that "stressed the vocational aspects of nursing and trust in God's mystical providence" and "ritual, discipline and loyalty."[26]

In the mid-nineteenth and early twentieth centuries a variety of Protestant, Catholic, and Jewish hospitals began opening hospitals throughout the United States not only, as Charles Rosenberg writes, to provide charitable care to a community in need, but to provide care to groups people with similar ethnic backgrounds with physicians of familiar background, language, and ethnicity. Frequently, Protestant hospital superintendents or in some cases hospital Board members refused admission to patients with chronic conditions or patients who were not morally acceptable and sent them to almshouses, which eventually became government run organizations.[27] However, Protestant and Jewish hospitals began to lose strength in religious and ethnic affiliations because the local populations for which they were built moved, but the charitable donations continued, which sustained the hospitals' namesakes.[28] Paul Starr writes that denominational hospitals attempted to mirror the practice of other European countries to develop entire organizations to meet all social needs for a specific subset of cultural groups who did not

use the social services of the dominate cultural group. The Protestants in the United States did not have the urgency to define and did not feel they had to "define their institutions on religious lines."[29]

In contrast to Protestant and Jewish hospitals leadership was the Catholic hospitals that were run and managed by vowed Catholic religious women or men. In defining a key difference between the hospital denominations Barbra Mann Wall argues during the American Civil War Protestant women saw nursing as an opportunity to gain "new roles for women," but conversely the Catholic nuns (also referred to as "Sisters" or "religious women") saw themselves as "dutifully promoting religion and caring for the sick and injured as Christ would."[30] The Catholic nuns were able to draw upon their spiritual legitimacy and support from the Catholic Church because they were "brides" of Christ and the representatives of the Catholic Church allowing them to oversee hospitals as opposed to physicians or laymen administrators such as in Protestant hospitals.[31] As Catholic hospitals expanded across the American frontier they were able to establish a presence in areas where there was a need to provide care. The Catholic hospital growth was coordinated by the nuns who administered the purchase of land, oversaw the construction of facilities, and operation of hospitals with the support of the Church hierarchy. Once established, the hospitals found that local communities were willing to engage with the Sisters to support hospital operational costs through fund raising and charity.[32] The rapid expansion of Catholic hospitals was not just to provide care for those in need, but save the souls of the dying. Catholic hospitals not only provided care for the dying, but also provided patients with the opportunity to convert to Catholicism, baptized, and provided the sacraments before death. The conversion experience were so important for the nuns that many hospitals kept records of baptisms and "good deaths."[33] The nuns established training schools that emphasized

moral and religious instruction along with the practical training taught by physicians who had to apply for the privilege to teach. [34] A point of contrast between the Protestant nursing schools with Catholic training schools, many of the Protestant hospital nursing programs were controlled by the hospitals boards that favored or influenced by physicians, possibly out of fear of creating a rival profession.[35] Ultimately, this leadership dynamic changed with the creation of Medicare and Medicaid programs when Catholic hospitals began to hire administrators to manage the growing hospital bureaucracies that maximized reimbursement from the federal programs to keep hospitals solvent and by the early 1980s the "voluntary not-for-profit hospitals engaged in a process of 'institutional isomorphism' in response to the changing secular healthcare markets.[36]

James Begun and Kenneth White argue that nursing is limited due to their dominant logic that includes the "ideology of professionalism, an emphasis on "caring," and a belief in oppressed status." To overcome the dominant logic to advance the profession nursing must first overcome its significant complacent inertia by changing with the dynamic healthcare environment in which nursing exists.[37] Hildegard Peplau adds to Begun and White's article by stating nursing's dominant logic has deep roots in its nursing history and nursing's "worker mentality" has persisted in nursing and had conflicted with nursing's effort to professionalize. She sites recent nursing publications that focus on nurse job security as opposed to professional expertise that focuses on the "worker mentality." In order to radically change the nursing profession, Begun and White argue, health professions must change to become more collaborative and integrated entities. "A profession constrained by developing only "nursing" knowledge, applied only by nurse-credentialed practitioners, rather than "health care" knowledge…is disadvantaged."[38] This crucial point is put another way by Angela Vicenzi,

Kenneth White, and James Begun as "successful adaptation in complex systems necessitates flexible, open environments and exchanges of energy and information – not isolation."[39]

The future of the nursing profession is not secure nor will it ever achieve a state of permanence unless the profession continues to remodel and align itself to the needs of society. Eliot Freidson argues that professions differ from occupations when they control its own work in its own field. But he warns that "if a profession's work comes to have little relationship to the knowledge and values of its society, it may have difficulty surviving."[40] Kenneth White and James Begun argue that though nursing did make significant improvements in its history by standardizing nursing curriculum, limiting entry into the profession through licensure, and fostered a field of nursing science; is not enough to sustain the nursing profession into the future. Since nursing is a complex adaptive system, it has the ability to adapt to its environment. The authors postulate that nursing's challenge will be to create and adopt a new framework to transform the profession while adapting and influencing a changing environment to meet the needs of society.[41] Nursing must shed its traditional profession building model for a framework founded in strategic adaptation that: establishes collaborative and interdependent relationships with other health professionals; develops skill and a knowledge base outside of the traditional nursing framework; progresses multidisciplinary theories that meets the needs of populations; and expands nursing's preparedness to influence and legitimize nursing's role into executive decision-making at the corporate level of healthcare organizations.

Methods and Framework

Two historians influence the historical methodology employed: Leopold von Ranke, and Richard Evans. Ranke's major contributions to history was to establish it as its own discipline

outside of literature or philosophy, by teaching that historical fact must not be examined by the standards of the present (presentism) and – this is key – testing their findings for consistencies by using other documents written during the same time period. Ranke wrote in the late nineteenth century as the sciences and other professions were growing. He once famously declared that history must describe the past as *wie es eigentlich gewesen* (as it actually occurred). Just as scientific facts could be known, so could historical facts.[42] Richard Evans agrees generally with Ranke that historical facts should stand external criticism (authenticity or validity) and internal criticism (reliability).[43] However, Evans posits that Ranke's methodological approach to assessing and recording historical fact through a scientific process based solely on facts without any interpretation is incomplete. This approach, Evans argues, strips the research of meaning and does not advance the understanding of historical events.[44] Evans admits that facts are a crucial part of history and must be verified by historians, but in sharing or documenting the facts the historian must play the role of providing substantive interpretations.[45]

For the purposes of this dissertation, however, I rely on the work of Evans, who argues that facts can be a crucial part of history, but they must be uncovered by historians who then provide substantive interpretations. Historical facts should stand external criticism (authenticity or validity) and internal criticism (reliability). For the purposes of this dissertation the authenticity of the sources that I will use have already been validated by archivists in the repositories. Regarding internal criticism, or reliability, throughout the dissertation I compare multiple sources to assess any repeatability and how they might differ in interpreting the context at the time the source was written.

The dissertation is interpreted within a social history framework that emphasizes the interactions between different groups in society. Interpreting the data involves placing it within

the historical context, connecting the different variables or sources, and considering contingencies, which, unlike scientific studies, cannot be controlled. For example, the sources may be ambiguous or incomplete, which I acknowledge. In the process, I narrate the story, highlight my findings, answer the research questions, and highlight any conflicts or ambiguities.

Chapter Overviews

Chapter 1: Introduction, Historiography, and Methods

Chapter 2: Nursing leadership during the rise of scientific medicine and hospitals: 1890-1920

This chapter examines the beginning of the modern hospital by focusing on the life of Isabel Hampton Robb and her work as a Superintendent at the Illinois Training School for Nurses and The Johns Hopkins Hospital. Also examined is Robb's role in establishing professional national nursing organizations and training school for future hospital superintendents.

Chapter 3: Black Nursing Leadership during Jim Crow Segregated Era in Chicago: 1920-1945

This chapter examines the life of a Black nurse, Belva L. Overton, in her role as Superintendent of Nurses at Provident Hospital and Training School in Chicago. In particular, Overton's role in supporting the success and future employment of Black nurses in the Jim Crow era in the US.

Chapter 4: Nursing leadership during the hospital modernization period: 1950-1990

This chapter focus on the contributions of Sister Mary Maurita Sengelaub in the consolidation of hospitals under a national organization and how she used organization to

promote the leadership of nuns on hospitals boards. Additionally, this chapter examines the life of Anne Zimmerman and her role in supporting nursing wages, working conditions, and independent practice of nurses through professional organizations, like the American Nurses Association.

Chapter 5: Discussion

The concluding chapter will be dedicated to answering the research questions and discussing themes that emerge from this research on nursing leaders through the late nineteenth and twentieth centuries in the US.

Chapter 1 Notes

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[8] Adelaide Nutting, *A Brief Account of the Course in Hospital Economics* (New York: Columbia University, 1910), 179.

[9] Nutting, *A Brief Account of the Course in Hospital Economics,* 182.

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[14] Reverby, *Ordered to Care*, 142, 190-191.

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[18] Stevens, *In Sickness and in Wealth*, 74.

[19] Keeling, Hehman, and Kirchgessner, *History of Professional Nursing in the United States*, 55.

[20] Stevens, *In Sickness and in Wealth*, 12.

[21] D'Antonio, *American Nursing*, 38-39.

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[29] Starr, *The Social Transformation of American Medicine*, 175.

[30] Barbra Mann Wall, "Called to a Mission of charity: The Sisters of St. Joseph," *Nursing History Review* 6 (1998): 103.

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[43] Maza, *Thinking About History*, 221.

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Chapter 2

Nursing Leadership during the Rise of Scientific Medicine and Hospitals: 1890-1920

> A motive that gives a subline rhythm to a woman's life, and exalts habit into partnership with the world's highest needs, is not to be had where and how she wills; to know that high initiation, she must often tread where it is hard to tread, and feel the chill air, and watch through darkness. It is not true that love makes all things easy; it makes us choose what is difficult.[1] – George Eliot

The quote written by Mary Anne Evans under the pseudonym George Eliot in her novel *Felix Holt, the Radical* appears in the preface of Isabel Hampton's (later Robb) book *Nursing: Its Principles and Practice*. Hampton likely selected this quote because it captures her the dedication for nursing and the significant challenges she faced throughout her career as she worked to build nursing in to a profession – specifically for women. This quote resonated not only with Hampton, but with women who lived in a society devalued the role women by constraining their professional opportunities. In the late nineteenth-century nursing provided one of those acceptable opportunities that demanded a strict moral code, a strong work ethic, and a robust constitution to care for patients in hospitals and in the community.

Historical Context

Since 1658, American hospitals had been founded to meet the needs of the sick and destitute, but it was not until the early twentieth century that hospitals became an indispensable resource to all, regardless of socioeconomic background. In her book: *In Sickness and in Wealth*, medical sociologist Rosemary Stevens shows that starting with the late nineteenth century and

into the twentieth century, superintendents of these hospitals – many of whom were nurses and women – played a significant role in providing leadership to hospitals through local and national organizations.[2] Charles Rosenberg and other medical historians support this claim documenting how nurses supervised hospital operations and, in many cases, also ran the nursing school that provided the hospitals with the labor force needed to care for the patients. Although the nurse superintendents' responsibilities varied in hospitals based on size, the superintendents managed the hospital finances, controlled the hospital physical spaces, oversaw the nurse training, and disciplined junior house officers and student nurses. The nurse superintendents also served as the intermediary between the hospitals' trustees, boards, and physicians. However, as hospitals began to increase in size and care for more complex patients, nurse superintendents began to recognize a need for training in their leadership roles.[3] The exception to this disputed leadership role– as will be discussed in a later chapter – are hospitals sponsored by the Roman Catholic Church throughout most of the mid-nineteenth and twentieth centuries.

Examination of Isabel Hampton Robb's leadership in the nursing profession relies heavily on her work and leadership in standardizing nursing education. It was during the decade of the 1880s that Robb made major contributions to nursing as the leader of The Johns Hopkins Training School and was instrumental in setting the vision for nursing as a profession. Her experience as the superintendent of the training school at The Johns Hopkins Hospital serves as a case study of nursing leadership in the late nineteenth-century.

Early Years of Isabel Hampton: Background for Leadership

Understanding Robb's background is essential to understanding Robb as a leader later in her life. Isabel Adams Hampton was born on August 26, 1859 in Ontario, Canada. Her parents

raised her in a thriving middle-class home that valued work ethic and intellectual curiosity. Her father (Samuel Hampton who ran a successful business as a tailor) warmly supported Hampton's energetic interest in learning and encouraged her ideas. Hampton's mother, Sarah, taught her the method of running a disciplined household with eight children. She also taught her to care for the sick and those in need in their community. She did so as a "natural nurse."[4] Sarah also taught Isabel to question authority and to minimize her dependence on other people. In fact, Sarah did not trust the local physician and she took it into her own hands to vaccinate her own children.[5] Isabel read avidly and aspired – encouraged by her father – to accomplish great things as a child. Her sister, Carolyn, remembered years later that she had a strong and determined character. She recalled her saying that "if I were a man, I wouldn't stop at anything; I would be Premier of Canada."[6] However, in the late nineteenth century, few respectable occupations outside of the home were open to women. These typically included nursing and teaching.

Hampton first decided to pursue a career in teaching. She excelled in school and at the age of sixteen earned her third-class teaching certificate – the credentials needed to teach at a lower-level school in Merriton, Canada. Though the school's reputation was unruly and difficult to manage, Hampton effectively controlled her students with a firm disciplinarian resolve. A member of the school's Board commented on the young teacher's ability to maintain "order simply by the force and influence of a remarkable personality."[7] Hampton remained at the school in Merriton when her family moved to Manitoba. During that time, she prepared for her second-class certificate exam studying at the St. Catherine's Collegiate Institute. When she did take her exam – three years after she began teaching – she failed mathematics.[8] It is not known why she decided to pursue a career in nursing that this point, but the confidence she gained living on her

own, combined with her personality, drew her to New York City. In 1881, Hampton turned her attention to nursing and entered the Bellevue Training School in New York.

The Education of Isabel Hampton

Prior to Hampton's arrival, wealthy women of New York's high-society worked to improve conditions at the eight hundred bed Bellevue hospital by introducing trained nurses to provide safe care to the patients. Louisa Lee Schuyler, great-granddaughter of Alexander Hamilton, led this transformation with the help of White philanthropic elite women of New York by establishing the Visiting Committee for the City of New York public hospitals. Elizabeth Christophers Kimball Hobson served on the Visiting Committee and wrote about her initial experiences at the hospital. She found several major problems: the laundry facilities had no soap for weeks; simple amputations would lead to patient's septic death because the hospital neglected to implement Lister's antiseptic techniques; and there were no attendants to care for patients at night. Instead, a watchman would summon a physician for very ill or dying patients.

To address some of these issues, The Visiting Committee recommended the establishment of a training school for nurses. However, the committee faced many challenges as they navigated the superintendent and physician leadership of the hospital to do so.[9] Hobson writes described this resistance:

> Strange to say, doctors were our chief antagonist… [noting that] "We were ignorant women interfering with what was none of our business." And when we tried to improve the nursing service, [they argued that] "they preferred nurses who would do as they were told"; the intelligent, educated women we proposed to introduce

> "would not be amenable to discipline." [In short] they were "utterly opposed to our interference."[10]

By enlisting the help of the infamous British nurse Florence Nightingale – who wrote an impassioned plea along with recommendations on integrating trained nurses into the hospital – and working with the State Charities Aid Association in New York, the Visiting Committee garnered the support of young physicians who supported the introduction of trained nurses at the Bellevue hospital. In 1873, the hospital "invited" the training school to manage one surgical obstetrical ward.[11] By the time Hampton arrived in 1881, the Visiting Committee had set a profound example of the power of women influencing the quality of care with patients in the hospital through an effective partnership. No doubt their work influenced Hampton's perspective on the power and influence women could make in hospitals.

In 1882, a year after Hampton began at Training School for Nurses at Bellevue, *The Century Magazine* published an article describing the impact of the trained nurse on the quality of care at Bellevue hospital. The article describes a picturesque life of a nurse, who is surrounded by a well-ordered and clean environment due to the nurse's careful attention to detail to the patient's health and comfort. According to the author, physicians "eagerly apply for [nurses]" and "in certain instances, have refused to perform operations without the subsequent assistance of a trained nurse."[12] The article notes that the full value of the nursing profession is still unknown. These words may have encouraged Hampton to see the potential of nursing in the future. They may even have provided her an opportunity to define the future of the profession.

After Hampton graduated from the Training School in 1883, she explored different experiences in her new career. After working as a relief nursing supervisor at Women's Hospital in New York for a few months she traveled to Rome, Italy, to work as a nurse in the operating

room at the St. Paul's House where care was provided for English and American travelers. During the summer months, Hampton worked as a private duty nurse for the wealthy Astor family in Germany. However, the experience as a private duty nurse did not suit her and Hampton mentioned in a letter to her friend that "…after finishing here I must hunt up a hospital to work in, by that time I shall have quite a sufficiency of the private nursing."[13] Hampton realized that ambition. After two years in Europe, she returned to the United States and accepted the position of Superintendent at the Illinois Training School for Nurses in Chicago.[14]

Isabel Hampton at the Illinois Training School for Nurses

Like the Visiting Committee at Bellevue, in 1880 wealthy elite women of Chicago formed a Board of Lady Managers to establish the Illinois Training School for Nurses. The Board penned the following purpose for the school:

> First, to train young women to care scientifically for the sick, so establishing a new and dignified profession for women and at the same time making available to the public a valuable service; second, to give the patients in the Cook County Hospital care far better than that rendered by the untrained and politically chosen attendants then employed.[15]

The Board recognized the value of providing purposeful education to women through the knowledge of science with the intent to establish a profession for women that would complement the work of the physician. To create a trained workforce of nurses through the use of scientific theory, however, the Board would need to overcome the dominant male physicians' and administrators' wariness of a trained female workforce. Just as the committee had done at Bellevue, the Board worked to overcome the fears and prejudices

of the physicians who felt threatened by the introduction of the trained nurses at Cook County Hospital. The Board first worked to secure the support of the Chicago Medical Society, but encountered significant resistance when they met with the Cook County Hospital Committee.[16]

At first, the Hospital Committee members largely ignored the Board's plea to introduce trained nurses into the hospital. Their reasoning was political: the members received their appointments through political favors, and since nurses were primarily women who could not vote, the Board members perceived that they would carry no political influence. Later however, as one Board member recalled, "an election carried off some of the objectors, and the new members who took their places, were more amenable to humane considerations."[17]

In response, the Board of Lady Managers strategically asked that trained nurses would only care for female patients in the operating room and on the female wards, knowing full well that once the nurses proved their worth, they would be invited to work on other wards. The Hospital Committee eventually approved the use of trained nurses in two wards. The Board agreed that the nurses would be under the Cook County Hospital governance, but that the selection and training of the students would be the responsibility of the Illinois Training School for Nurses.[18] In 1881 the school officially opened and accepted eight students to the program. Within a year the Cook County Hospital Committee would recognize the significance of the trained nurses in the hospital by writing to the Board that "one has but to visit that institution to see the invaluable service which that school now renders to the sick and wounded poor of this County."[19]

In 1886, a few years after the school opened, Hampton accepted the position of Superintendent of the Illinois Training School for Nurses in Chicago.[20] Upon her arrival she received a tepid reception at the school. When Hampton first stepped off the train, the matron of the hospital accidentally mistook her as a probationer – a new student nurse – and offered only a cordial greeting.[21] However, Hampton soon made her presence know. Within the first few months of her inauspicious arrival, Hampton quickly worked to establish a formal curriculum at the school. She also set standards for acceptable behavior, proceeding to dismiss several probationers who she thought were unfit for nursing. Hampton wrote to a friend about the experience:

> I've been having no end of a row for dismissing a nurse from school who has been here for six months. I see sullen looks and get cold bows – but I can't help it… The dismissed nurse was unreliable and I couldn't trust her. It will probably pass after a time I suppose.[22]

Not only did Hampton work to establish discipline with the students, but also established expectation on the wards with rules to be followed and respected, even at the objection of the physicians. Hampton shared in a letter to a friend a week after her arrival:

> The house doctor was perfectly furious and stormed all sorts at his head nurse about me. She came and told me how he felt, I sent for him. He came with wrath on his countenance but I was pleasant and after we had a fair out and out talk he was alright, said he was sorry and we are all good friends. Others remain stiff and hold off and I suppose there will be other trouble.[23]

Hampton's willingness and aptitude to talk directly to physicians and command their respect through difficult conversations emboldened her. That skill that would be useful to her in the future as she worked to promote her vision for the nursing profession.

Hampton applied herself to the role of Superintendent by transforming the program priority from providing labor to hospitals to creating professional nurse graduates. She redesigned the nurse training curriculum by providing a robust structure to the course work. She also introduced textbooks and established scheduled examinations and a fixed Commencement date. In writing the history of the school Grace Fay Schryver notes that Hampton's attention centered "on the professional education of the nurse, systematizing the course, abstracting and applying principles. The approach was to be scientific, rather than practical in the narrower sense." To align the school with professional education standards developing at the time, Hampton proposed that the students' monthly allowance be discontinued. The student would continue to receive support in lodging, Board, textbooks, uniforms, and one-hundred dollars upon the completion of the program. This action created a slight financial savings to the school, but ultimately received support from the Board of Lady Managers because of their commitment to supporting the academic goals of the pupils, as opposed to "hiring" labor to work in hospitals while they received their training. Furthermore, the decision put the school in alignment with other professional schools (such as medicine and dentistry) during the late nineteenth and early twentieth centuries.[24]

Hampton appreciated and prudently utilized the support she received from the Board of Lady Managers to support the changes to professionalize the school. The Board unequivocally supported Hampton's views on education and her commitment to discipline. They especially stood by Hampton and supported her management of the Training School in the spring of 1887

when seven members of the County Board and the Cook County Hospital Warden – who received his appointment as Warden of the hospital as a result of his political connections after he lost an election for Cook County Sheriff – came under attack for corruption and misuse of public funds.[25] The ensuing investigation found that the Warden received payments from Cook County for the operation of a vacant wing of the hospital that did not admit patients and pocketed the funds for his personal use. The school demonstrated that they neither received funds from the unoccupied wing for nursing services nor knew about the illegal payments to the hospital. Ultimately, the Warden fled to Canada and the School reorganized its finances to adapt to reduced reimbursements from Cook County, and the closed several units in the hospital due to the mismanagement of funds.[26]

Hampton's intellect and creativity in overcoming the financial challenges created by this corruption demonstrates her creativity and commitment to education for the nursing students. The school would now receive $850 per month – instead of the $1230 per month previously paid by Cook County – for thirteen units at the Cook County Hospital. Additionally, the hospital would reduce the total number of patients from 500 to 400, which led to the reduction of nurses required to care for patients from 42 to 34.[27]

Hampton identified a unique opportunity to help solve the financial challenges and logistic challenge of supporting a sudden excess of students while continuing to develop a robust education program. First, she proposed to eliminate the school's private nurse practice to dedicate more time for students in the classroom. During the late 1900s, many hospitals sent second year student nurses on private duty assignments either in the hospital or in the community and allowed hospitals to charge for this service. Rosenberg writes that hospitals offered diplomas in return for cheap labor and sources of revenue by sending student nurses on private duty

assignments. However, this practice often left students unsupervised as they cared for patients and did not enhance their knowledge nor skill set.[28] Hampton's decision to change this practice allowed student to have more time in a proctored environment and increased classroom time. While it did not support the fiduciary goals of the hospital, it demonstrated Hampton's and later the Board's commitment to the educational priorities of the school.

Second, to address the financial needs of the school and increase the experiences of the students with outside hospitals, Hampton worked to establish an affiliation with the Presbyterian Hospital in Chicago. That hospital had recently completed a new building with fifty private rooms and needed nurses to care for their patients. The Presbyterian Hospital agreed to pay monthly the school $25.00 per nurse, a price that exceeded the County's pay-rate of $22.50. Over the next year Hampton worked with her Board to complete the fifth-floor of the Illinois Training School Nurses' Home to accommodate a total of ninety students to support the nursing experiences between the two hospitals.[29] In an article commemorating the twenty-five-year anniversary of the Illinois Training School for Nurses, Hampton recalled:

> Through the broadmindedness of the Board of Lady Managers we were able to do away with the pernicious system of sending pupils out for private duty and to arrange for the affiliation with the Presbyterian Hospital, in order to care for its patients.[30]

Hampton's leadership, novel ideas in transforming nursing education, and meaningful relationship with the Board set a new standard in nursing education based on her experience at the Bellevue Training School for Nurses. Although she supervised the school for only two years, Hampton left an indelible impression on the school and hospital through the application of discipline and structure. Personally, Hampton developed confidence in her abilities as an

effective administrative hospital leader. In 1889 Hampton resigned her position as Superintendent of the Illinois Training School for Nurses to accept a new position at Johns Hopkins University Hospital.

Isabel Hampton's Leadership at Johns Hopkins Hospital

In 1867 Johns Hopkins, a railroad magnate and business man – received authorization from the State of Maryland to establish two corporations in his name for a university and a hospital. Six years later, Hopkins defined his vision for a nursing school to support the hospital through the creation of a "training school for female nurses" who would "benefit the whole community by supplying it with a class of trained and experienced nurses."[31] Hopkins appreciated the value of having a *trained* nurses who could provide care to the patients in the hospital. That appreciation demonstrated his insight to the future of hospital care.

Building a hospital took priority. To develop plans for the hospital the Trustees selected John S. Billings – Assistant Surgeon in the United States Army – to serve as a consultant. Billings spent three-months traveling Europe and visiting hospitals including St. Thomas' Hospital in London where he likely learned about the "Nightingale system." In a letter to the president of the Board of Trustees, Francis T. King, Billings advocated for the Nightingale system to be adopted at The Johns Hopkins Hospital. In that letter he also defined the character of the nurse and superintendent who would lead their work by asserting:

> [Nurses] should know as much as the surgeon about the dressing of wounds and as much as the physician about the meaning of symptoms… They must, of course, be of unspotted morals and chastity… It is insisted that women of this kind must not be subordinate to any man – and that it is only a woman who can understand and

> manage them – that the Superintendent of the female nurses should be the sole head of all the women employed in the hospital – and that she should not herself be subordinate to the Superintendent of the hospital but should report only to the Board of Trustees, nay, logically, the conclusion is that the Board of Trustees should be composed partly of women in order to carry out the principle that no woman shall be subordinate to a man.[32]

The Board of Trustees duly noted Billings' recommendations, but proceeded to place the Superintendent of the Training School for Nurse under the hospital superintendent and certainly did not include women on the Board. However, the first hospital superintendent and physician, Henry Mills Hurd, noted Billings' charge to hire a woman who would rise to the task of making nurses who would be knowledgeable and work proficiently with physicians in the care of patients. Ultimately, out of an applicant pool of eighty nurses, the committee responsible for selecting first Superintendent of the Training School for Nurses unanimously chose Hampton.[33]

Hampton arrived in Baltimore in the fall of 1889 and quickly established herself as the Superintendent of Nurses and Principal of the Training School for Nurses. Five months after the opening of The Johns Hopkins Hospital on 9 October, 1889, The Johns Hopkins Training School for Nurses officially opened with a ceremony commemorating the event. The attendees included the only surviving sister of Johns Hopkins, Cardinal Gibbons, the Sister Superior from Mount Hope Retreat, the mayor of Baltimore, the president of the Board of Trustees at Johns Hopkins, superintendents from Philadelphia hospitals, and over one-hundred ladies showing their support for the new training school. Empowered by her new responsibility, Hampton gave her keynote address at a ceremony commemorating the opening of the training school. Hampton identified the ideal nursing student candidate as "fairly intellectual… who [is] strong and enduring

physically, and who morally will recognize the sacredness of the work that they are engaged in."[34] She acknowledged that hospitals throughout the country had been establishing training schools that supported the function of the hospital rather than promoting the training of the nurse. She also noted how that decision influenced the quality of the trained nurse. Hampton then argued that hospitals like Johns Hopkins should produce trained nurses who would work in the smaller hospitals throughout the country to provide qualified nursing care to patients. As to criteria for application, Hampton argued that candidates should be between the ages of twenty-three and thirty-five (Hampton two months prior to this speech turned thirty years old).[35] She continued "the trained nurse is acknowledged superior by both physician and patient, for the simple reason that… technical skill can only be acquired by a systematic course of practical and theoretical study under competent teachers."[36] Hampton made it clear that the students would not passively obey the orders of the physician, but would "further his scientific study of disease by intelligently fulfilling his orders, in administering medicines… noting every unusual symptom in the patient, and keenly alive to its importance."[37]

Hampton shared her thoughts about the future of nursing and promoted the standardization of education that would benefit all social-economical classes of people. Hampton observed:

> For women they have created a profession, which is unquestionably womanly; thus far they have ministered chiefly to the rich and the very poor. The trained nurse is almost an unknown quantity to the poor in their homes, and to the great majority of people with only moderate incomes, who are obliged to struggle thro' with their sick as of yore, as best they may for the simple reason that a nurse is too great a luxury.[38]

In response to this need, Hampton outlined her plan to implement district nursing training in the student's second year caring for the poor in the community with a competent head nurse, modeled after the work done in New York – likely referring to Henry Street Settlement.

After Hampton's remarks, Henry M. Hurd, physician and Superintendent of the Johns Hopkins Hospital, welcomed Hampton's vison for nurses working as intellectual partners with physicians in the care of patients. Prior to Hampton's arrival Hurd posited that this arrangement did not allow nurses to "develop their own methods in the best manner" and that for the benefit of the education of the nurses the schools should be attached to the hospitals and independently managed by a nursing superintendent responsible to the Board of Trustees.[39] Hurd elaborated:

> The hands of a nurse are a physician's hands *lengthened out* to minister to the sick. Her presence at the bedside is a trained vigilance supplementing the perfecting his watchful care; her knowledge of the patient's condition an essential element in the diagnosis of disease; her management of the patient the practical side of medical science.[40]

Hurd did not see nursing as an instrument to support only nursing care in the hospital, but to promote nursing as a respectable profession for women who would participate in the advancement of medical science. He echoed many of the themes Hampton presented including Johns Hopkins Hospital's role in creating a curriculum based in science and establish nursing as a profession. He explained:

> She should consider nursing a profession and view it as a life work. It is not a trade, nor an occupation solely, nor a means of support simply, but a vocation which brings into activity the best sentiments of the human heard and enlist the finer sympathies of our better natures.[41]

Hurd also concurred with Hampton's position that the students would have dedicated time for education that would not conflict with the work on the wards. Additionally, Hurd emphasized the importance of having a training school that integrated directly with The Johns Hopkins Hospital, a significant difference from Hampton's previous experience. Hurd asserted that "in the eyes of the Trustees, nursing the sick is not to be considered a trade but a learned profession."[42]

With the support of the Board of Trustees and physician leadership. Hampton created a curriculum based on science and professional nursing care. First, she implemented a course titled the *Practical and Scientific Instruction in Invalid Cooking* that focused her students on the science behind the food and how it supported the health of patients. In her proficiency examination for the "science and practice of invalid cooking" she asked students to describe safe ways to prepare raw foods and describe the chemical composition of an egg.[43] D'Antonio describes how Hampton reframed the work of nurse through the use of medical content and language in providing professional care to patients by engaging students in understanding the scientific principles behind the work.[44] Hampton writes:

> And yet there is a deeper meaning which can only be appreciated by those who have mastered at least the broad principles of bacteriology. How hopeless and dull, not to say irritating, would be the many washings and the various aseptic precautions…unless she had learned from bacteriology to appreciate the fact that there exists a surgical, a microscopical cleanliness.[45]

Hampton taught two weekly classes and utilized visual aids in her classroom that included a skeleton, manikin with "visceral anatomy," and pictures. To her senior class she taught on subjects that included ethics, ward management, private and district nursing. Physicians taught

weekly lectures to all of the classes, including Hurd. Hampton spent a significant portion of her time teaching and supervising students directly on the wards.[46]

Hampton set strict expectations for her head-nurses and personally involved with the selection of new head-nurses independent of physician leadership at the hospital. Within the first two years of arriving at Johns Hopkins Hospital five out of the six head-nurses – who were hired before she arrived – resigned their positions.[47] Hampton filled the vacancies, but created conflict with some of the physicians who presumed they would be selecting nurses to help with surgeries in the operating rooms. Hampton made it clear that she was responsible for the assignment of nurses throughout the hospital, including in the operating room. In one incident, she overruled a surgeon, William S. Halsted, who insisted he had the right to appoint the nurses who would be assisting him in surgical cases.[48] Halsted went as far as removing the nurse Hampton selected to assist him and selected one of his understudies to replace the nurse. Only after two years of resistance did he agree to a nurse who met both his and Hampton's approval.[49] In this altercation Hurd did not intervene by compelling Hampton to bend to the wishes of the surgeon. Hampton held strongly to her convictions that the operating room should be a shared experience for her nursing pupils and they should have the exposure to the operating room.

Hurd respected Hampton and saw her as a visionary leader who if provided the independence to do her work – while under the authority of the Board of Trustees – would transform nursing and set an example for the rest of the country. Hurd shared his views on Hampton's role in a public comment during the *International Congress of Charities, Correction and Philanthropy* in 1893 in Chicago:

> The great difficulty has been in not giving enough authority to the superintendent of the nurses' training school… Allow her to carry out her own plans and ideas; let

> her select and discipline her nurses, and make her responsible for the well-being of the school… do not allow the Board of Trustees of the hospital to interfere in the internal management of the training school… I believe that the hospital and the training school should constantly work together, that nothing can hurt the training school without hurting the hospital, and that nothing can help the school which injures the hospital; and that training school and hospital should go on together.[50]

Hurd believed Hampton's independent operation of the superintendent role as this would allow for her to implement "her own special ideas as to the best management of the department, and thus to attain an excellence which would be impossible should one person attempt to decide executive details."[51] Based on Hurd's experience working with Hampton, he maintained that in smaller hospitals women could include the role of the Superintendent of the hospital – not just the training school – if provided "ample assistance upon the non-professional sides of her work."[52]

Hampton mastered her role as Principal of the Training School for Nurses revolutionizing how training schools should standardize education over a three-year program and eliminate the practice of private duty nursing. In collaboration with Hurd, Hampton also reduced the hours in which student nurses worked on the wards from twelve-hours to eight-hours to allow for leisure and education time.[53] Hampton had learned the valuable lessons from her experiences at Bellevue hospital as a student where long shifts coupled with late lectures into the night made for a very challenging learning environment that induced "nodding heads." As a result, she ensured these conditions did not exist at Johns Hopkins.[54]

As the Superintendent of Nurses, she skillfully navigated every challenge that presented itself in her role at The Johns Hopkins Hospital including changing the hospital as it related to

race and gender. In 1894, a Visiting Committee of Baltimore citizens asked for the establishment of a ward for Black patients. Hampton quickly established the ward with little disruption to the services provided on other wards in the hospital. She impressed the Visiting Committee who observed "colored [*sic*] patients seem pleased with their new quarters… every attention is paid to their comfort by the White nurses. In fact, the nurses seem partial to their colored patients."[55] Doubtless, Hampton played a significant role in overseeing this smooth transition. Possibly she began laying groundwork for this transition years before in 1892 when she started the Nurses' Journal Club and at its first meeting presented two articles for discussion *The Hampton Colored Nurses* and *The Georgia Infirmary*.[56]

Although The Johns Hopkins Hospital created an encouraging environment for women in within the confines of its training school, it did not afford the same privileges for women within the Medical School. The daughter of the president of the Board of Trustees – Elizabeth King – established the Women's Fund committee with the purpose of supporting women enrollment in the Medical School. Records indicate that Hampton attended the committee meeting on May 2, 1890 where they agreed to raise a "sufficient sum of money" that would be provided to the school as an endowment provided women acceptance into the Medical School. Through the gifts of wealthy philanthropists, the committee raised five-hundred thousand dollars and donated the needed funds to the Trustees with a letter outlining the conditions that provided women with the opportunity to apply for admittance to the Medical School. The Trustees accepted the gift along with the stipulations and in 1893 Johns Hopkins Medical School admitted their first female medical student.[57]

Isabel Hampton at the 1893 Chicago Columbian Exposition

In 1892, Billings and Hurd accepted the appointment of Chairman and Secretary, respectively, of the World Congress of Charities, Correction and Philanthropy that would convene in Chicago the following year at the Columbian Exposition of 1893. This allowed Johns Hopkins Hospital to display to the world the organization and thinking on hospitals, public health, medical schools, and especially nursing. Hampton accepted the chairmanship of the nursing subsection and put considerable effort design of nursing presenters to promote the evolution of nursing as a profession. Hampton wrote to Florence Nightingale inviting her to share her views in the nursing subsection. Nightingale did not attend; however, she sent a paper to be read at the meeting.[58]

On 14 June, 1893, Hampton delivered a landmark paper on the *Educational Standards for Nurses*. Hampton discussed the importance of a qualified *trained* nurse to carry out physicians' orders. But, the nursing education standards in the late nineteenth-century differed from school to school putting the young nursing profession at risk in the public eye. Hampton warned that:

> A "trained nurse" may mean then anything, everything, or next to nothing, and with this state of affairs the results are far from what they should be, and public criticism is frequently justly severe upon our shortcomings, or else is content with superficiality where like meets like.[59]

By not having an established curriculum with set years of education nursing in the United States would continue to produce poor quality nurses that would confuse the value of the trained nurse and lead to public distrust or worse, patient harm. Hampton called for three changes to put nursing on the path as a sustained profession: recruitment of quality

students, three years of education with a maximum eight-hour workday, and the standardization of nursing training.[60]

Hampton continued speaking to the importance of the superintendent and principal of the training school to learn from other schools throughout the country and learn from them, strongly hinting at the creation of a society to oversee the professionalization of nursing. Hampton propositioned the leaders of the schools:

> She must look into and go abroad among other schools, and teach her nurses to do the same, recognizing what is good in others and being every ready to adopt any improvement. There is so much that we can learn from each other, and sooner or later we must also recognize the fact that we are all trained nurses, and that until something of a common standard is reached the imperfections of the few must be borne by all.[61]

Hampton called upon the leaders in nursing to collaborate and not limit their work just for the development of their own schools within a vacuum. Hampton recognized the power women in nursing held in creating a profession through standardization, which would only be accomplished through unity.[62] Her paper would become an influential landmark document for the future of nursing.

As chairman of the nursing subsection, Hampton carefully assembled a panel of presenters who buttressed her remarks calling for a standardization in nursing outside of hospital or medical governance and the establishment of nursing associations who would support the development of the profession. Isabel McIsaac presented on the value of hospital-based nursing alumnae associations and Lavinia Dock – Hampton's assistant at Johns Hopkins Hospital – presented on the symbiotic, yet separate, relationship between nurses and physicians. Dock

argued that nurses should not simply be seen by hospitals as obedient soldiers responding mechanically to the physician's orders, but should be led independently of the medical profession within the hospital. Staying with the military illustration, Dock argues that it would make sense for physicians – or the "medical power" – to oversee nursing like a private responding to an officer's orders if nursing and medicine were of the same profession. Dock observes:

> The officer is also a soldier and knows every detail of the common soldier's work and life. The nurse and the physician have different professions. The doctor is not a nurse… On this fundamental difference rests the claim of the school to be ruled, as an educative and disciplinary body, by those of its own origin.[63]

Louise Darche – Superintendent of the New York Training School for Nurses – later presented a paper on the *Proper Organization of Training Schools in America* in which she observed that trained nurses systematically led the improvement of care in hospitals over the last twenty-years. As trained nursing became valued by physicians the question of who should manage nursing in hospitals. Darche pointed out that philanthropic ladies would organize training schools and negotiate and contract with hospitals the oversight of wards through supervisory boards. Over time the schools would become closely affiliated with hospitals, providing nursing care to all of the wards, but operate separate under nursing leaders. Darche argued that this system works stating:

> It was soon proved that nursing under a distinct management and head could and *did* work harmoniously with the hospital management and to the mutual benefit and advantage to both.[64]

After the World Congress of Charities, Correction and Philanthropy Hampton led the establishment of several organizations with the goal of standardizing nursing education and promoting the professionalization of nursing. After this meeting eighteen superintendents met to establish the first society – the American Society of Superintendents of Training Schools for Nurses, which would later be named the NLNE in 1912. In September 1896, the American Society of Superintendents of Training Schools for Nurses would meet to establish the Nurses Associated Alumnae of the United States and Canada with the purpose of standardizing education requirements for nurse training schools.[65] Leaders within the Nurses Associated Alumnae advocated for the use of graduate nurses at the bedside in hospitals, which, as historian Susan Reverby suggests, "would bring greater skills to the hospitals because she was older and more experienced, and greater loyalty because of her professionalism" as opposed to a student nurse workforce. But, driven by fears that higher standards of education would lead to the closure of smaller nursing schools from which they graduated, many nurses chose to be loyal to their school and supported their continued operation.[66]

In 1894, Hampton submitted her resignation to the Board of Trustees at Johns Hopkins to marry renowned gynecologist Hunter Robb.[67] After their wedding Isabel Hampton Robb moved with her husband to Cleveland, but she did not retire from nursing. Robb continued to work with nursing organizations holding offices and regularly presenting speeches promoting the nursing profession. Robb played an important part in establishing the American Journal of Nursing, transforming the Red Cross to include trained nurses, playing a pivotal role in establishing the Army Nurse Corps after the Spanish-American War in 1901. In addition to this, she was able to produce several books used as texts in nurse training schools: *Nursing: Its Principles and Practice for Hospital and Private Use, Nursing Ethics,* and *Educational Standards for Nursing*.

However, education continued to be her great passion and she recognized the need to create a school to train nurse superintendents beyond the nurse training programs.

Isabel Hampton Robb's School for Superintendents

In 1899, at the American Society of Superintendents of Training Schools for Nurses, Robb proposed the idea of establishing a program to advance the education of graduate nurses to become superintendents. This training would focus on developing the dichotomous superintendent roles in education and hospital management. She received warm support from the society, which appointed Robb to serve as the chairman of the Board of Examiners for the Teachers' Course in Hospital Economics. Robb and Nutting collaborated with the Dean of the Teachers College at Columbia University – James Earl Russell – to establish a course in "hospital economics designed to meet the needs of those directing schools of nursing in which hospital service is a predominant factor."[68]

Robb's novel vision for trained superintendents began in 1899 when the first two students – Anna Lowell Alline and Alice A. Gorman – enrolled in course. The program cost four-hundred dollars per student, which paid for room, Board, and courses at the Teachers College. Faculty who taught in the Hospital Economics course were unpaid and reimbursed for travel expenses only. Robb recognized that the program needed a dedicated teacher to oversee the program, coordinate visits to hospitals, and support the students as they completed classes at the Teachers College. For this position the Board of Examiners selected Alline who had just completed the inaugural Hospital Economics course earlier that year. Both Robb and Russell wanted Nutting to accept the position, but she declined possibly because the salary offered could not compete with her salary as Superintendent at Johns Hopkins.[69]

Robb worked tirelessly to establish the Hospital Economics course, but she faced several logistic and financial challenges in its first several years. Due to a series of unexpected delays, the course prospectus was released several months late and that yielded only two qualified applicants to program. Because of the low enrollment, the program continued to enroll students throughout the year, culminating at total of six students by October 1900. Alline worked with Robb to establish visits to food processing plants, charity headquarters, Henry Street Settlement, and supply-houses for students to learn about supply purchases. But, because of student confusion with the courses required to complete the certification, the Board of Examiners – chaired by Robb – decided to suspend the acceptance of more students to the program in December until the program "was more firmly established."[70]

Additionally, the Board of Examiners worried about the sustainability of raising four-hundred dollars to pay for Alline's salary. At that time, the Society of Superintendents raised funds through donations from training school alumnae associations and contributions by donors. The Board of Examiners recommended that Society of Superintendents seek to raise fifty-thousand dollars to fund an endowed chair through the Teachers College to support the program. In the meantime, the program continued on the goodwill of uncompensated teachers that included Robb, Dock, Annie Goodrich, Maud Banfield, and Estelle Massey Riddle.[71] After establishing a clear program of study the program reopened admissions.

After six years of hard work supporting the school with her time and advertising the value of the program at association meetings and through the *American Journal of Nursing*, Robb's vision for the Hospital Economic was course became accepted nationally as the premiere preparation course for hospital superintendents. Russell recalled a conversation with Robb regarding the course:

> She had devoted the best part of her later life to promoting this one idea… she said ‘I tell you that no matter what you may do or what your friends may do for nurses, there is no greater work today than that which aims at the generous, all around training of those women who are to head the nurse training schools.’[72]

After Alline received an appointment as Inspector of Nurses Training Schools in the Education Department of the State of New York, the Teachers College recognized the value of sustaining the Hospital Economics course and in April 1906 Russell offered Nutting the position of Professor and a salary of $2,500 over three years. Nutting – to Robb’s relief – accepted the position. Later in 1909 Helen Hartley Jenkins donated one-hundred-fifty thousand dollars for an endowment that formally established a professional chair of a new department named the Department of Nursing Education and Social Hygiene.[73]

Nutting’s contributions were significant. She expanded the Hospital Economics curriculum into four divisions of graduate nursing work: Teaching and Supervision in Training Schools; General Administration in Training Schools and Hospitals; Public Service as Teacher-Nurses, Visiting Nurses, Board of Health Assistants and Teachers of Hygiene; and Preparatory Course for Nurses. Nutting understood that nursing had a role in not only providing direct care to patients, but also in creating care environments in hospitals where nurses, doctors, and pharmacists could effectively provide care to their patients. Nutting reorganized the department for the purpose of “arranging and combining theory and practice in such a way as to provide adequate academic and practical preparation for women desiring to fill administrative posts in institutions.” [74] During the last two and a half years of the Hospital Economics course before the reorganization the program received 208 requests from hospitals for graduates of the program to

fill positions at their hospitals. Of the requests, 137 requests were for leadership positions in hospitals. Reflecting on this information, Nutting wrote:

> In posts of such great responsibility and difficulty which carry with them frequently great authority, women are needed of exceptional ability; and the vital nature of the issues with which they deal, and of the influences which they may exert renders essential that they should be fortified for their tasks by sound education, and higher specialized training. [75]

In gratitude for Robb's resolute commitment to creating the School, Nutting wrote of Robb as having an "organizing faculty" and thought if she were a man in the business world "nothing could have kept her from an active and controlling share in some of the great organizations."[76]

Nursing in the United States after Isabel Hampton Robb

Unfortunately, after Robb's untimely death in 1910, nursing leaders who worked with Robb struggled to establish education standards in American nurse training schools. Small hospitals – or cottage hospitals as Robb called them – which benefited from training schools that provided cheap labor in caring for patients and generating revenue from private duty nursing were unwilling to conform to the recommendations being made from nursing associations like the Society of Superintendents to expand the course of study to three years with an eight-hour day in patient care. Unlike the American College of Surgeons (ACS), which began to inspect and grade their medical schools, the nurse training schools were unable to standardize nursing education. In 1910 Abraham Flexner – who Robb worked with at Johns Hopkins Hospital – released his famed "Flexner Report" that led to the closure of several medical schools across the country due to their lack of programmatic rigor. Medical schools were evaluated using five

criteria: entrance requirements, size and training of faculty, financial resources, laboratories, and clinical facilities.[77] The Flexner Report transformed medical schools by requiring them to adhere to a higher standard of education causing the closure of poorer quality medical schools.

Leaders within the American Medical Association (AMA) and physician superintendents of large hospitals resisted Nutting's proposition that nurses had the preparation, training, and were well-suited to run hospitals. The minutes of the 1911 meeting of the AMA reflect signs of skepticism of nurses in any formalized role stating:

> The hospital… should be run by a physician hospital executive because the hospital was a 'first class hygienic machine.' Physician superintendents of hospitals had no desire to see nurses in positions of control over medical work. Nursing was 'only a differentiation of domestic duty,' and the nurse herself a 'half-baked social product, thrust unto the fulfillment of an uncertain social need." Nurses were not reportedly interested in the comfort of the patients, but only in the order and symmetry of the ward.[78]

Despite the physicians' general tone of cynicism by physicians, nurses continued to accept roles as superintendents and became active members of the AHA. In 1912, the AHA had 922 members. Of these 421 were nurses and 235 were physicians.[79] At this juncture one would suppose that the nursing influence and leadership over the development of the professional hospital administrator role would be significant. In addition, with the advent of World War I, nurses would be given more responsibility to exercise their leadership skills in managing field and base hospitals in Europe, and they would then return to the United States empowered, experienced, and ready to take on the role as hospital superintendents.

Nursing leaders in the United States professional nursing associations recognized the need for competent nursing leaders in hospital operations. The Goldmark Report published in 1923 provided the evidence and roadmap to support this claim. The report recommended that graduates of nursing programs replace the student staff in hospitals to provide nursing students with the support to dedicate more time to education. This would have, in effect, created the foundations of a permanent professional nursing workforce that would have been trained to align the burgeoning professional nurse with the nurse hospital superintendent, not just the physician in the direct care role. But, unlike the Flexner Report that transformed medical schools to adhere to a higher standard of education causing the closure of poorer quality medical schools, the Goldmark Report had a nominal effect on nursing schools – primarily due to the lack of autonomy nursing schools had from the sponsoring hospitals who benefited from student labor in their facilities. [80] The report recommended to create a standardized curriculum and that graduates of nursing programs augment the student nurses working in hospitals to provide nursing students with dedicated time for education. This would have, in effect, created the foundations of a permanent professional nursing workforce that would have been trained to align the burgeoning nursing profession, not just supporting the physician in the direct care role.[81]

Again in 1926, the NLNE leadership tried to unify the nursing profession to standardize the quality of the curriculum the release of the AHA committee on the Grading of Nursing Schools. But, because of the lack of an organized commitment to implement the study's recommendation, nursing schools did not apply the findings seriously and poor performing programs were able to continue to operate due to the nursing's limited political and economic power. [82] However, the NLNE did create an effective professional forum where nurses could

recommend programs for nurse educators that offered more robust nursing training thereby encouraging nursing advancement through degrees offered through collaborating universities.[83]

As nursing began to take a more passive and reactionary role in the development and management of hospitals, Black nurses worked to combat Jim Crow era racism and worked to gain power and influence where they were allowed. Black hospitals began to grow and attract Black nurses, administrators, and physicians as schools provided more training opportunities for people of color to enter into the hospitals. In Chapter 3, a more focused examination of how Black nurses were impacted by racism and how in some hospitals and nurse leaders – especially in the North –were able to establish professional training schools for Black nurses.

Chapter 2 Notes

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[4] Nancy Louise Noel, "Isabel Hampton Robb: Architect of American Nursing" (Ed.D. Thesis, Teachers College, Columbia University, 1979), 13-15.

[5] Ethel Johns and Blanche Pfefferkorn, *The Johns Hopkins Hospital School of Nursing, 1889-1949* (Baltimore: Johns Hopkins Press, 1954), 37.

[6] Noel, "Isabel Hampton Robb: Architect of American Nursing," 17.

[7] Noel, "Isabel Hampton Robb: Architect of American Nursing," 18-19.

[8] Noel, "Isabel Hampton Robb: Architect of American Nursing," 20.

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[10] Hobson, *Recollections of a Happy Life*, 91.

[11] Hobson, *Recollections of a Happy Life*, 100; Nutting and Dock, *A History of Nursing: The Evolution of Nursing Systems From the Earliest Times to the Foundation of the First English and American Training School for Nurses*, Volume 2, 388-393.

[12] Franklin H. North, "A New Profession for Women," *The Century Magazine*, 1882, 46.

[13] Noel, "Isabel Hampton Robb: Architect of American Nursing," 35-37.

[14] Noel, "Isabel Hampton Robb: Architect of American Nursing," 38.

[15] Grace Schryver, *A History of the Illinois Training School for Nurses, 1880-1929* (Chicago: Board of directors of the Illinois training school for nurses, 1930), 1.

[16] Schryver, *A History of the Illinois Training School for Nurses, 1880-1929*, 10-12.

[17] Schryver, *A History of the Illinois Training School for Nurses, 1880-1929*, 12.

[18] Schryver, *A History of the Illinois Training School for Nurses, 1880-1929*, 11-13.

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[19] Schryver, *A History of the Illinois Training School for Nurses, 1880-1929*, 36.

[20] M. E. Cameron, Isabel McIsaac, Lavinia Dock, Adelaide Nutting, and Isabel Hampton Robb, “Memorial sketches of Isabel Adams Hampton Robb,” *American Journal of Nursing*, 11, no. 1 (1910): 12-13, 21.

[21] Isabel Hampton Robb, "My association with the Illinois Training School," (1908).

[22] Noel, "Isabel Hampton Robb: Architect of American Nursing," 46.

[23] Noel, "Isabel Hampton Robb: Architect of American Nursing," 45.

[24] Schryver, *A History of the Illinois Training School for Nurses, 1880-1929*, 49.

[25] "The Financial, Not the Sanitary, System of the Hospital on Trial," *Chicago Daily Tribune* (Chicago), Feb 4, 1887 1887.

[26] Schryver, *A History of the Illinois Training School for Nurses, 1880-1929*, 55-56.

[27] "Trained Nurses at the Hospital: The Proposition of the Board of County Commissioners Accepted," *Chicago Daily Tribune* (Chicago), October 5, 1887; Schryver, *A History of the Illinois Training School for Nurses, 1880-1929*, 55-56.

[28] Rosenberg, *The Care of Strangers: the Rise of America’s Hospital System*, 221-222.

[29] Schryver, *A History of the Illinois Training School for Nurses, 1880-1929*, 58-59; Noel, "Isabel Hampton Robb: Architect of American Nursing," 48.

[30] Robb, "My association with the Illinois Training School."

[31] Charles J. M. Gwinn to the Trustees of the Johns Hopkins Hospital at the behest of Johns Hopkins, March 10, 1873. Johns and Pfefferkorn, *The Johns Hopkins Hospital School of Nursing, 1889-1949*, 8.

[32] John S. Billings to the Trustees of the Johns Hopkins Hospital in January 1877. Johns and Pfefferkorn, *The Johns Hopkins Hospital School of Nursing, 1889-1949*, 13-14.

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[34] "Opening of the Nurses’ Home and Inaugeration of the Training School for Nurses," *Johns Hopkins Hospital Bulletin* 1, no. 1 (December 1889): 6.

[35] "Opening of the Nurses’ Home and Inaugeration of the Training School for Nurses," 6-7.

[36] "Opening of the Nurses’ Home and Inaugeration of the Training School for Nurses," 6.

[37] "Opening of the Nurses’ Home and Inaugeration of the Training School for Nurses," 6.

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[39] Henry M. Hurd, "Who Shall Manage the Training School for Nurses," *Modern Hospital* 6 (1916): 115.

[40] "Opening of the Nurses’ Home and Inaugeration of the Training School for Nurses," 8.

[41] "Opening of the Nurses’ Home and Inaugeration of the Training School for Nurses," 8.

[42] "Opening of the Nurses’ Home and Inaugeration of the Training School for Nurses," 8.

[43] Isabel A. Hampton, "Practical and Scientific Instruction in Invalid Cooking," *Johns Hopkins Hospital Bulletin* 1, no. 9 (December 1890): 108.

[44] D'Antonio, *American Nursing: A History of Knowledge, Authority, and the Meaning of Work*, 48.

[45] Isabel Hampton Robb, *Educational Standards for Nurses with Other Addresses on Nursing Subjects* (Cleveland: E. C. Koeckert, 1907), 99-100.

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[46] Janet Wilson James, *Isabel Hampton and the Professionalization of Nursing in the 1890s*, ed. Morris J. Vogel and Charles E. Rosenberg, The Therapeutic Revolution, (Philadelphia: University of Pennsylvania Press, 1979), 217-218; Johns and Pfefferkorn, *The Johns Hopkins Hospital School of Nursing, 1889-1949*, 88.

[47] "Superintendent's Report of the Johns Hopkins Hospital," *Bulletin of Johns Hopkins Hospital* 2, no. 16 (September 1891): 127.

[48] While Hampton attended the Bellevue Training School for Nurses in 1883, Halsted performed surgeries at Bellevue as a visiting surgeon. This memory may have also contributed to Halsted's resistance to Hampton's decision on nursing support in the operating room. Noel, "Isabel Hampton Robb: Architect of American Nursing," 28.

[49] Johns and Pfefferkorn, *The Johns Hopkins Hospital School of Nursing, 1889-1949*, 87-88.

[50] John S. Billings and Henry M. Hurd, Hospitals, Dispensaries and Nursing: Papers and Discussionsin the International Congress of Charities, Correction and Philanthropy, Section III, Chicago, June 12th to 17th, 1893, (Baltimore: The Johns Hopkins Press, 1894), 97.

[51] Address given by Hurd to the Training School for Nurses at the University of Pennsylvania, February 17, 1897. Henry M. Hurd, "Hospital Organization and Management," *University Medical Magazine* 9 (1897): 492.

[52] Hurd, "Hospital Organization and Management," 494.

[53] Johns and Pfefferkorn, *The Johns Hopkins Hospital School of Nursing, 1889-1949*, 85-86.

[54] M. E. Cameron et al., "Memorial Sketches of Isabel Adams Hampton Robb," *The American Journal of Nursing* 11, no. 1 (1910): 30; Noel, "Isabel Hampton Robb: Architect of American Nursing," 67. Hampton encouraged the graduates of the school to form their own Alumnae Association, which they did in 1892, to maintain contact with graduates and encourage their active participation in the professionalization of nursing.

[55] Quoted from Noel's research on the *Visiting Committee Report*, May 15, 1891. Noel, "Isabel Hampton Robb: Architect of American Nursing," 70.

[56] "The Nurses' Journal Club," *Bulletin of Johns Hopkins Hospital* 4, no. 34 (1893): 100.

[57] Johns and Pfefferkorn, *The Johns Hopkins Hospital School of Nursing, 1889-1949*, 81-82; Noel, "Isabel Hampton Robb: Architect of American Nursing," 78-81.

[58] Keeling, Hehman, and Kirchgessner, *History of Professional Nursing in the United States: Toward a Culture of Health*, 105.

[59] Robb, *Educational Standards for Nurses with Other Addresses on Nursing Subjects*, 17.

[60] Robb, *Educational Standards for Nurses with Other Addresses on Nursing Subjects*, 9-29; Keeling, Hehman, and Kirchgessner, *History of Professional Nursing in the United States: Toward a Culture of Health*, 105.

[61] Robb, *Educational Standards for Nurses with Other Addresses on Nursing Subjects*, 22.

[62] Robb, *Educational Standards for Nurses with Other Addresses on Nursing Subjects*, 29.

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[64] Quoted from Louise Darche, "Proper Organization of Training Schools in America," in *Hospitals, Dispensaries and Nursing: Papers and Discussionsin the International Congress of Charities, Correction and Philanthropy, Section III, Chicago, June 12th to 17th, 1893*, ed. John S. Billings and Henry M. Hurd (Baltimore: The Johns Hopkins Press, 1984), 515.

[65] Keeling, Hehman, and Kirchgessner, *History of Professional Nursing in the United States: Toward a Culture of Health*, 106-109.

[66] Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (New York: Cambridge University Press, 1987), 190-191.

[67] Johns and Pfefferkorn, *The Johns Hopkins Hospital School of Nursing, 1889-1949*, 94.

[68] Johns and Pfefferkorn, *The Johns Hopkins Hospital School of Nursing, 1889-1949*, 146-147.

[69] Noel, "Isabel Hampton Robb: Architect of American Nursing," 157-160.

[70] *Proceedings of the Eighth Annual Convention of The American Society of Superintendents of Training Schools for Nurses*, (Harrisburg, 1902), 9-11; Noel, "Isabel Hampton Robb: Architect of American Nursing," 170.

[71] Noel, "Isabel Hampton Robb: Architect of American Nursing," 170.

[72] James E. Russell, "The Relation of Nursing to General Education," *The American Journal of Nursing* 10, no. 10 (1910): 715.

[73] Noel, "Isabel Hampton Robb: Architect of American Nursing," 171; Adelaide Nutting, "A Brief Account of the Course in Hospital Economics," *Teachers College Record* 11, no. 3 (1910).

[74] Nutting, "A Brief Account of the Course in Hospital Economics," 179.

[75] Nutting, "A Brief Account of the Course in Hospital Economics," 182.

[76] Cameron, et al., “Memorial sketches of Isabel Adams Hampton Robb,” 14: 18-19.

[77] Kenneth M. Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York: Basic Books, 1985), 166-190; James, "Isabel Hampton and the Professionalization of Nursing in the 1890s," 236.

[78] Quoted in Stevens, *In Sickness and in Wealth*, 68.

[79] Stevens, In Sickness and in Wealth, 69.

[80] Myrtle P. Matejski, “Nursing Education, Professionalism, and Autonomy: Social Constraints and the Goldmark Report,” *Advances in Nursing Science*, 3, no. 3 (1981): 23.

[81] Myrtle P. Matejski, “Nursing Education, Professionalism, and Autonomy: Social Constraints and the Goldmark Report,” *Advances in Nursing Science*, 3, no. 3 (1981): 23; Paul Starr, *The Social Transformation of American Medicine,* (New York, NY: Basic Books, 1982), 118.

[82] Keeling, Hehman, and Kirchgessner, *History of Professional Nursing in the United States*, 163; Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing 1850 - 1945.* (New York, NY: Cambridge University Press, 1987), 168.

[83] Anne Goodrich, *The Social and Ethical Significance of Nursing,* (New York, NY: The Macmillan Company, 1932), 300.

Chapter 3

Black Nursing Leadership during Jim Crow Segregated Era in Chicago: 1920-1945

> "It tends to confirm the lack of confidence that so many have in the ability of our physicians and our institution to provide as good a training as they can get elsewhere, that is, from White physicians and in White personnel, medical and nursing, when we have to send our students outside for their experience."[1] – Belva L. Overton, 1936

Belva L. Overton, a Black Superintendent of Nurses writing in the Provident Hospital and Training School in Chicago annual report in 1936, expressed concerns about the reputation of her hospital and school. Overton believed in the skill and ability of the Provident Hospital physicians who could provide her Black nursing students with a quality clinical experience in obstetrics. But her concerns were valid. The Provident Board of Directors denied her request to move the school's clinicals to the Black hospital at Provident for the sake of maintaining Provident Hospital's relationship with a prestigious White hospital in Chicago. Overton understood the context in which the hospital and school existed and worked to navigate the transitions of power as trained hospitals administrators – mainly men – began to replace women as the administrative leaders of hospitals.

The Historical Context

In the early twentieth century, nurses occupied a prominent role as superintendents who oversaw hospitals, infirmaries, and clinics. At this time, nursing superintendents were responsible for overseeing a growing healthcare workforce, implementing new licensure laws,

regulations, and larger and more sophisticated hospital plant and technology infrastructure.[2] Hospital superintendents assumed leadership for organizational operations as well the supervision of student nurses who received their education in the hospital's school, training in the hospital wards, and delivering direct patient care while they learned. The superintendents typically were responsible for both school and hospital operations – often in hospitals with fewer than fifty beds. The superintendent role was rapidly adopted in American hospitals to accommodate the increasingly complex care needs of patients benefiting from the advances of medical science, surgery, radiology, and pharmacology.

Yet by the 1930s, hospital administrative roles transitioned from nurses at the helm to predominately men, especially in large, urban hospitals. This transition divested nurses of their influential role.[3] Meanwhile, as formal nursing leadership roles developed in hospitals through the early twentieth century, Paul H. Fesler, superintendent of the Wesley Memorial Hospital in Chicago and the president of the AHA, addressed the AHA in Detroit in 1932 remarking on this problem. He advocated for advanced training in hospital administration, particularly for men, not women. He stated:

> It is deplorable to notice that some of the best hospitals in this country are administered by men with no experience or training in hospital administration. It seems that it would be for the benefit of our patients if a college of hospital administration could be created to train hospital executives… It is ridiculous to think that men without any training whatsoever are permitted to head institutions responsible for the saving of lives and representing millions of dollars… We regret little or no definite progress is being made in the training

> for the work of hospital administration… Some are succeeding, some are failing, and all are blundering for many of their early years in this work.[4]

Significantly, he did not mention women. Two years later, in 1934, the AHA supported the creation of the ACHA, which formalized the role as "hospital administrator." The complexity of managing hospital systems created a new profession, the hospital administrator, who eventually edged out – or outright excluded – nurses and women from influential, formal hospital leadership roles.

The establishment of the ACHA, coupled with the creation of new insurance programs such as Blue Cross that began in 1929, hospital leaders focused on revenue generation and the management of labor, specifically nursing, and made nursing an operating expense rather than a source of revenue for the hospital.[5] Then, as hospitals became more complex and specialized, nursing's influence over hospital operations and policies waned throughout the 1930s. The ACHA trained administrators – rather than nurse leaders – were to fill the leadership void.[6]

Several reasons have been given for this situation. Historians Joan Lynaugh and Barbara Brush suggest that hospital boards of the era perceived women's (most nurses were women) expertise and abilities innately lacking in the "financial management or institutional planning" of hospitals. This cultural perception of women as being subservient to male authority placed administrators and physicians in positions of power over women working in nursing.[7] Instead of building on the experience of nursing administration, medical superintendents and other (largely male) administrators sought to establish for themselves a new profession.[8]

Historian Rosemary Stevens states that nurses were "institutionally subsumed" because nursing training programs continued to adhere to Nightingale's philosophy for women in nursing – that they be self-sacrificing, dedicated to duty and obedient to superiors.[9] To Stevens, nursing

consisted of "all-purpose female service workers" without a defined scientific skill set that could compete with physicians who embodied the specialized science of healing. [10] By contrast, historian Patricia D'Antonio argues that nurses saw themselves as empowered by their claims to high standards and nursing morals: "while the public might tolerate the shortcomings of other 'professional' women, however, it would not tolerate them in nurses." Nurses, most if not all leaders and educators believed, would be held to a 'higher standard' of morality. They, and they alone, were privileged with duties of a much higher importance and ones that involved both "the great problems of life and the mysteries of death and suffering."[11] This was in fact why many women chose nursing because of the "meaning and power" brought to the woman's family and community. Equipped with unique skills and education, women thought they were in control of their destinies, and they created opportunities that they would not have had otherwise.[12]

Historian Susan Reverby provides yet another perspective: that nursing leaders experienced a dichotomous predicament of providing for better nursing wages, housing, and working conditions with hospital administrators and physician leadership while respecting the training and ideology of discipline and sacrifice being taught in nursing schools. Meanwhile, fearful of a loss of the cheap labor force provided by nursing students, paternalistic hospital administrators and physicians sought to control nurses by suppressing their advocacy and emphasizing their role a "caring" rather than a "curing" one.[13] This was validated by Isabel Stewart – Adelaide Nutting's successor at the Department of Nursing Education at Teachers College – who noted that "influential commercial interests… and medical men working against what they have called 'the overtraining of nurses,'" have advocated for a minimally trained workforce to replace nurses.[14]

Black Nurse Leaders during the Jim Crow Era

Within this context, during the 1920s – 1950s hospitals adjusted their operations to function in the setting of Jim Crow laws and racial segregation. In 1925 the Rockefeller Foundation funded a study conducted by Ethel Johns, a White Canadian nurse, to study Black women in the nursing profession throughout the United States. The results were disheartening. Johns found that a majority of the twenty-three hospitals she visited in both the North and South provided inadequate support to their Black nurses for education, income, and housing. The nurses endured "open hostility" from both Black and White patients and were blocked from advancement to supervisory positions from White nurses. Johns wrote at the end of the report that the Black nurses "in every part of the country feel very keenly that they are debarred from qualifying themselves for leadership."[15]

This exclusion of Black nurses from leadership positions also extended to them being denied full membership in state and national organizations, as social norms of the early twentieth century, specifically racial segregation, and profoundly affected Black nurses' experiences. Both the American Nurses' Association and the National League of Nursing Education excluded Black women from membership.[16] Because of this exclusion, in 1908 Black nurses formed the National Associate of Colored Graduate Nurses (NACGN). The goal was to establish their own standards for entrance to segregated Black nursing schools, establish educational curricula, and enforce professional practice standards much like the American Nurses Association (ANA). Later they would work to eliminate racial discrimination in nursing.[17]

That discrimination was long standing. Indeed, as historian Vanessa Northington Gamble has documented: the hospitals for Blacks were build out of the context of Jim Crow laws in the South and were a reaction to racist segregation experienced by Black patients, doctors, and

nurses. Evidence for this s clear: in 1922, nearly a quarter of all hospitals surveyed limited their services to White patients while only 1 percent provided services to only Black patients, which in 1940 improved slightly to one-fifth of hospitals limiting their services to White patients. In some cases, hospitals actively worked to decrease the admission of Black patients, charging them beyond their means. If they were admitted, often Black patients would be cared for in segregated wards located in unfavorable parts of the hospital.[18] In response, Black communities organized support for building their own hospitals and institutions to meet the needs of their communities.

Provident Hospital: A Chicago Hospital for Blacks in a Segregated Society

This expansion of Black hospitals created the necessity to train Black nurses to provide the nursing care; and due to required segregation, a system of Black nursing schools developed across the country.[19] It was during the late nineteenth century that several philanthropic organizations worked to support the development of Black hospitals and training schools for nursing. In particular, these included Julius Rosenwald Fund and the General Education Board, and the Rockefeller Foundation.

Daniel Hale Williams, a Black physician, founded the Provident Hospital in 1891. He drew inspiration to open the hospital from Emma Reynolds – sister of a prominent Black minister in Chicago – who applied to every nursing school in the Chicago area and was denied entrance. Williams worked with local communities to open a Black-controlled hospital that was integrated with White and Black patients and staffed by an interracial team of physicians. Contrary to some of the supporters of Provident Hospital, Williams believed the hospital should be supported by White philanthropists – not just by funds raised from the Black community – to establish the hospital to promote the care of all people, regardless of race. As the hospital grew

from a 12-bed hospital to a 65-bed hospital in 1898, so did its operating deficit. Indeed, many of the patients were unable to pay for the services they received. To manage the deficit, Provident Hospital regularly called upon its community members and local philanthropists to provide donations to manage the deficits.[20] In 1929, Provident Hospital was affiliated with the University of Chicago, and as Gamble notes, it was "a new strategy for Black hospital reform and Black medical education: the partnership of a Black hospital with a White university." Yet this partnership proved problematic over the next decade. Still, by 1930, Provident Hospital became one of the most highly regarded Black hospitals in the country.[21] It was in this context that Belva Overton worked as the Superintendent of Nurses at Provident Hospital, and she is the focus of the second case study, described in this chapter.

Belva Overton's Early Years

Understanding Overton's upbringing and early education is important to understanding her leadership at Provident Hospital. Belva Lockwood Overton was born in Williamsport, Pennsylvania at the turn of the century1 and was abandoned as an orphan with her two brothers, Frank Young and Russell C. Caution, both of whom became writers for Pittsburgh newspapers: *The Chicago Defender* and *Victor Press* respectively. She attended the Brooks Grammar school and the high school in Medford, Massachusetts, where she was the first female Black graduate. After taking a business class in bookkeeping, she found she was not able to find work. She asked a physician for advice on what to do next and he recommended that she go to Chicago to attend the Provident Hospital Nurses Training School to become a nurse.[22] She did just that.

Overton graduated from Provident's nursing school in 1916 and was immediately offered a position to work as a head nurse at the John A. Andrew Memorial Hospital in Tuskegee,

Alabama.[23] She returned to Provident in 1918 as a surgical supervisor.[24] In the meantime, Provident Hospital and Training School was receiving national accolades throughout the country for its success as a Black hospital. In 1918 Sophia P. Palmer, Editor for the *American Journal of Nursing*, praised Provident Hospital writing:

> From the stand point of order, dignity and technical skill, the nursing service of this hospital would seem to compare more than favorably with hospitals of the same size and class in other cities where the nursing service is composed of White women.[25]

This quote was a source of great pride for Provident Hospital. In fact, hospital administrators noted in several issues of their *Annual Reports* – even though the implication was that White run hospitals were assumed to be superior to hospitals run by Black nurses.

Violence at Provident Hospital in the Jim Crow Era

Overton affiliated with Provident Hospital during a period of violence that occurred throughout the country as a wave of race riots swept through both the North and South. Though Provident Hospital was lauded as one of the best Black hospitals in the country it was not protected racial conflict. On 27 July 1919, Eugene Williams, a Black seventeen-year-old, drowned because he was swimming too close to a beach designated Whites-only and drowned due to the stones thrown by the White crowd at the beach. The next morning Black Chicagoans were pulled from Street cars and attacked on the streets of Chicago near the Stock Yards and a region in Chicago called the "Black Belt," which ran from twenty-second Street to twenty-ninth Street. Two White men were injured while driving on State Street shooting Black bystanders. When they were taken into Provident Hospital, they had to be locked in a separate room to avoid

conflict with the other Black patients in the hospital. News of the injured White men at Provident spread and a Black mob formed and demonstrated outside of the hospital while the two White men were receiving care for their injuries. Eventually, the police arrived to remove the two White men from the hospital. Evelyn M. Kimmel, Provident's nursing superintendent at the time, was the only White nurse providing care to the wounded. At one point the Provident nurses had to forcibly escort Kimmel from the emergency room because the Black patients were starting to threaten her. The riot lasted for thirteen days and resulted thirty-three deaths and 306 injuries. It also left 2,000 people homeless.

Throughout the riots, Provident Hospital staff cared for both White and Black people affected by the violence.[26] The *Chicago Daily Tribune* reported that within the first two days of the conflict Provident Hospital had cared for 150 men with two dead and six more who were near death. Meanwhile, four nearby White hospitals disproportionally cared for thirteen Whites and one Black patient.

Provident Hospital staff needed help, at the same time that the health commissioner for Chicago, John Dill Robertson, was reported to have "held five physicians and twenty nurses in reserve…ready to respond to riot emergency calls from the hospitals." At the same time, at Provident Hospital, Kimmel shared with the *Tribune* that "the nurses and doctors here are all working heroically, but I'm afraid they cannot endure the strain much longer."[27] No help from the health commissioner arrived to support the struggling Provident Hospital during this crisis. In an era of racial segregation, Chicago leaders viewed Provident Hospital at the time as a hospital that should exclusively treat the Black population. This race riot, on the threshold of the Provident Hospital, along with the withholding of staffing support, must have left a lasting

impression on Overton. In particular, it must have affected her ability to trust in the resources provided by White Chicagoans as she was starting her career as a surgical supervisor.

The Rise of Belva Overton's Leadership at Provident Hospital

In 1921, Belva Overton was named the first Black Superintendent of Nurses of the Provident Hospital and Training School.[28] Her title was not the Superintendent of the hospital – a title held by her White predecessor – which indicates a shift in operational leadership to the Medical Director and Board of Directors. Despite this restricted role, over the next decade under Overton's leadership, the nurse training school reputation continued to grow as the school selectively recruited nurses from twenty-five states throughout the country.

The setting of Provident Hospital aided Overton's leadership efforts. During the 1920s the hospital was able to secure support from the Rosenwald Fund and the General Education Board through an affiliation with the University of Chicago, allowing the hospital to expand their physician training program and move to a new facility in 1928. The 1929 University of Chicago affiliation also provided Provident Hospital with the prestige of becoming one of seventeen Black hospitals to receive approval from the ACS and the AMA for medical internships.[29]

It was not until the 1930s that the nursing program begin to grow significantly under Overton's leadership. In 1933, the president of the Board of Trustees at Provident Hospital – in response to increasing patient volumes due to a significant Black migration from the South into the city – called for a "first class modern nurses' home such as is now deemed absolutely necessary in any modern first class hospital." This decision led to the purchase of two apartment buildings for new nurses' home.[30] To meet the increasing demand for nursing labor, the total student enrollment expanded to fifty students with the approval from the Board of Directors and

the Medical Director. In line with other nursing programs across the country, the next year Overton was able to expand the class size to fifty-four. Admissions occurred bi-annually. [31]

The nursing student's health was of paramount concern to Overton, and she implemented changes to that effect. First, she sought approval from the Board of Directors to establish a standard that students worked no more than eight-hours worked in a twenty-four-hour period.[32] White schools of nursing were also advocating for the eight-hour day. Overton was not alone in her request. She also wanted nursing students entering the program who were healthy enough to withstand the rigors of the nursing school program. In 1934, Overton initiated a thorough physical examination of all students that included "fluoroscopic examination of the chest, a Wassermann reaction, urinalysis, and blood counts. Additionally, all students and nurses were "immunized for scarlet fever, small pox, and typhoid." To further support students' physical health, she required all first year students were required to take courses in gymnastics and swimming at the YMCA at the local Wabash Avenue Branch.[33]

In addition to physical health, Overton saw character development as important. To that end, she expected her instructors to provide behavioral correction to mold nurses to embody the Nightingale virtues. She documented those efforts in one of her student's "Efficiency Report," dated November 1937, noting that:

> Miss Babb began her course in nursing with a general air of foolishness but early in the second month she made a right-about face and now is on the road of being an excellent scholar.
>
> She demonstrates now (1.) A lively interest (2.) A sympathetic attitude (3.) A splendid ability (4.) A healthy body

> But she must guard against (1.) Friends that are too influential (2.) A quick unorganized temper (3.) The results of having been spoiled at home. [34]

Overton nurtured relationships with students during their time at Provident, and many would continue to seek her advice after graduation. Some sought her advice navigating state Board requirements, employment, and making connections with other Provident graduate nurses in cities throughout the United States, such as in Detroit and New York. Overton maintained her relationships with the graduates through the Provident Alumnae Association, which released a catalog with names and locations of active Provident graduates.[35] This connection with Provident graduates provided a community to support graduate nurses as they worked in the Jim Crow era, a time when they had to rely on the Black community for support. Years after Overton retired, the Provident nurse graduates would continue to return to Provident for anniversaries and reunions.

Jim Crow at Provident Hospital in the 1930s

In the 1930s Overton led the nurses through a tumultuous relationship with the University of Chicago. The problems started with a situation in medicine rather than nursing. In 1934, the first clinical clerkship was offered to a Black medical student, Ulysses G. Mason, under the direct supervision of the University of Chicago rather than Provident Hospital. All theoretical work was to be completed at the University of Chicago and the "ward walks and practical study of patients" were to be conducted at Provident Hospital.[36] The Black community objected as did physicians that Provident Hospital was being turned into a Jim Crow hospital. From a prominent physician quoted in *The Chicago Defender*, "the money could not have been raised for the establishment of Provident Hospital had not there been a tacit understanding that it was to relieve

the Billings hospital of embarrassing situations which were constantly arising because of the presence of colored [*sic*] physicians during clinic clerkship at their institution."[37]

The affiliation did lead to Provident's purchase of a new hospital, the old Lying-In Hospital on 426 East and fifty-first Street that included a four-story outpatient building and a new student nurses home funded by the Rosenwald Fund and the General Education Board (GEB).[38] The Cook County Physician's Association – a Black medical society based in Chicago – engaged the National Association for the Advancement of Colored People (NAACP) and *The Chicago Defender* to speak out against Provident Hospital, especially when funds from the GEB were to be paid to the University of Chicago instead of Provident Hospital. Though forty-four Black physicians signed a statement condemning the actions of the Cook County Physician's Association, the damage was done.[39] According to Historian Darlene Clark Hine, Black Chicagoans saw the affiliation as a "blatant acquiescence to segregation and racial discrimination" because of the fear that the university would send its Black medical students to Provident Hospital in order to separate the Black students from those who were White.[40]

Over the next ten years the relationship between the University of Chicago's Billings Hospital and Provident Hospital was amicable, but tensions remained between the Black communities that perceived Provident Hospital as being used to promote Jim Crow segregation. The damage was especially felt in the community through reduced contributions to the hospital throughout the time of the affiliation.[41] The affiliation formally ended in 1944, but because the Provident emergency room service had one of the largest in the Chicago area and had extensive volumes of traumatic surgery, the University of Chicago requested permission to continue to send students for educational experiences.[42]

Overton again was pulled into the complexities of Jim Crow segregation in December 1935, when the Cook County Nurses Home abruptly prohibited the housing of Black student nurses in the home. The Black students who attempted to stay at the home were threatened with expulsion from the Cook County Hospital. This action prompted the NAACP to file a suit against the directors of the home. A. C. MacNeal, the NAACP president, confirmed with Overton that no Provident nursing students were housed in the Cook County Nurses Home and that she knew nothing of the housing crisis for the Cook County Black nurses. As Overton demurred, she stated that she preferred "having my girls where I can put my hands on them."[43] The Jim Crow practice continued into the following year, prompting churches to identify January 26th as a day of prayer to "break down the barriers of segregation at the Cook County Nurses Home." *The Chicago Defender* called on Provident Hospital to vote a protest, but the hospital leadership along with Overton, avoided getting involved with the incident, which included not providing rooms for the students who were displaced.[44]

Overton and the hospital's unwillingness to engage in this controversy is an example where Black hospitals had to selectively engage in racial conflicts especially when it impacted members of the Black community. Provident Hospital could have provided support to the displaced Black students of the Cook County Hospital, but the risk of harming the hospital's relationship with the Cook County Hospitals may have been too costly. Overton purposefully chose to isolate the nurses at Provident Hospital in an attempt to shield them from the racial inequalities experienced by the Black nurses at Cook County Hospital. This would not be the last time Provident Hospital and Overton would have to navigate the racial ambiguities to preserve social and financial ties in the White healthcare community of Chicago.

The Depression Years at Provident Hospital

In 1935, as the Depression continued to impact Chicago's economy, philanthropic contributions were greatly reduced from previous years. As a result, the hospital lost significant contributions from the Illinois Emergency Relief Commission (IERC), Chicago Relief Association (CRA). This loss of funds led to the reduction of staff at Provident Hospital.[45] The reduction, coupled with an increasing number of community admissions from the Emergency Welfare program, pushed nursing ratios to one nurse for fifteen or upward to twenty patients a shift.

The nurse to patient ratios created great concern for Overton. To ease this burden and allow for time for students to attend class three-hours a day, Overton was able to get the support from the Medical Director and the Board of Trustees to employ twelve graduate nurses by sacrificing the number of instructors on her staff. However, five months after the Board supported her request for more nurses, Overton was asked to "radically reduce" her staff at Provident Hospital to maintain financial solvency. Overton later closed her annual report with a refrain to the unspoken challenges experienced by the nursing department, stating, "we hope in the coming year to render more efficient service, to effect economies wherever possible, and to aid in the promotion of goodwill in the community toward Provident Hospital."[46]

The year 1936 continued to be a financially challenging one as contributions from the IERC and CRA continued to be less than expected. In a response to a reduction of clinic volume, the attending medical staff in the hospital was reduced from 110 to 88.[47] The reduction of patient volume also impacted the students' ability to complete all required clinical hours and required some students to stay longer than the thirty-six months to complete the requirements for graduation. In an attempt to address these issues, Overton reduced class size and, in the fall of

1935, admitted no new students. Overton wrote that the reduction in class size also occurred because of the lack of qualified paying applicants. Fees at that time were $10.00 for registration and $50.00 for tuition, and few young women had these resources. There was also a shortage of candidates who were interested in the nursing profession. According to Overton:

> Young women with sufficient funds to finance education beyond the high school level, prefer other vocations that nursing. Many of those who apply for the nursing course do so because they find it an inexpensive means of preparing themselves for future work rather than because of sincere desire to become nurses. There are many desirable young women who would like to take up nursing but because of the stigma attached to nurse, especially in our racial group, they are deterred from entering the work.[48]

During the 1930s, Overton continued to maintain affiliations with the Chicago Lying-In Hospital and the Cook County Hospital, but was embarrassed to report the days her senior student, claiming to be sick, failed to report to class and the affiliated assignments. The third-year students used 242 sick days, particularly when they were assigned to the Chicago Lying-In Hospital and the Visiting Nurse Staff – both services predominately run and worked by White nurses. Overton reflected that it might be better for the Provident to provide their own obstetrics experiences, rather than having students embarrass her by reporting sick to avoid the hostile racial experiences the students reported at those sites. According to Overton:

> Receiving this training at Chicago Lying-In Hospital lends a certain amount of prestige, on the other hand, it tends to confirm the lack of confidence that so many have in the ability of our physicians and our institution to provide as good a training as they can get elsewhere, that is, from White physicians and in White personnel,

> medical and nursing, when we have to send out students outside for their experience.[49]

The year 1937 brought more stability and optimism to Provident through the consistent support from the CRA and the consistent volume of private paying patients.[50] Notably, Overton reported that the number of days students were actually sick had dropped by 58 percent compared to the year before, a change she attributed to higher physical examination standards for applicants to the school. Also, conspicuously reported were the continued affiliations with Chicago Lying-In Hospital, and nothing more was mentioned of starting obstetrical experiences at Provident.[51] In the 1938 Annual Report Overton again mentions the need to end the affiliation with the Chicago Lying-In Hospital and use Provident Hospital's own obstetrics expertise to train the nurses, but because of the prestige of affiliation the relationship was to continue.[52] Overton brought this request to the Provident Hospital Medical Director and Board of Directors – who were overwhelmingly White – for three years, but was denied because they did not want to sacrifice the prestige of their affiliations.

Overton's Response to World War II

In 1940 the NACGN urged Black nurses to join the American Red Cross in the event the country went to war. However, many northern Black nursing schools were not able to meet the minimum requirements to join the Red Cross service. Overton was one of the first to join the Red Cross after the call went out.[53] The American Red Cross program supported hospitals throughout the country by sending volunteers to help in hospitals and provided a volunteer nurses' aide course to train aides to support nursing in domestic hospitals. As the war recruited more nurses into the military, nursing leaders called for a government program to help train more nurses to

meet the need in the military and in domestic hospitals after the war. In 1943, Congress passed the Bolton Act that established the Cadet Nurse Corps with the purpose of training nurses to meet the nursing shortage exacerbated by the war. The Act also ensured that public funds made available to establish the Corps did not discriminate "on account of race, creed, or color." [54]

Taking advantage of the Bolton Act, in 1944 Provident Hospital and Training School established a Cadet Nurse Training program. In September that year, Overton broke ground on a new cadet nurses' home at fiftieth Place and Vincennes Avenue, directly across from Provident's current nurses' home. The new structure would provide housing for thirty-two student nurses, contain a laboratory facility, and a classroom. To fund the $141,000 project the Bolton Act stipulated that the hospital had to raise $20,000 for the building. One of Board of Trustees member, Marshall Field a wealthy White businessman, provided substantial funds to meet the fund raising goal.[55]

Even with the establishment of Cadet Nurse Training programs throughout the country, the Army Nurse Corps continued to have severe staffing shortages and had difficulty in recruiting Black graduate nurses. The reason was the persistence of segregation in the Army. Overton stated that out of the fourteen graduates, "most of them are not interested in joining the Army Nurse Corps."[56] Erma Brannon, a White head nurse for the Army Nurse Corps recruiting division, shared that "racial segregation is an additional handicap they [Black nurses] must face" and that they were in no position to break the Army's racial codes.[57]

As Chicago pivoted to support the work effort, hospitals in Chicago – like Provident Hospital – struggled staff their hospitals with nurses, forcing increased patient care ratios with little compensation change. The increased availability of jobs due to the war effort attracted thousands of Black Americans to Chicago. According to the Chicago Housing Authority, the

Black population grew from 282,000 to 335,544 between 1940 and 1944. This increased demand on the hospital services coupled with low nursing salaries created a 50 percent turnover of their graduate nursing staff, which required an increase of admissions by 65 percent from the previous years to the Nurse Cadet Training program.[58] The strain on the graduate nurses reached a tipping point September 15, 1945, when graduate nurses – now expanded to 30 – went on strike citing that "hospital management failed to recognize their union as a bargaining agent." They claimed that the comptroller, Charles Beckett, cut vacation days from one month to eighteen days and cut salaries. Overton was unaware that the nurses were planning to strike and called the action as "unfair to the patients" and said that the salary decisions were managed by the Board of Trustees. Provident Hospital Medical Director, H. V. Wilburn, stated his desire for an "outstanding relationship" with the nurses but cited that since the hospital was a non-profit and voluntary hospital without endowments, they were already financially limited in what they could do to raise wages to compete with other hospitals in the city.[59] This was not true according to the 1944 Annual Report, which identified the hospital had received nearly $40,000 in endowments.[60] The nurses were receiving $90-$100 a month whereas other hospitals, like Cook County, nurses were making $135 a month.[61]

Overton's response to the strike was muted, if not frustrated by the action of the graduate nurses. Her response may represent nursing's loss of power in hospital leadership, signaling a rise of male administrators or medical directors in hospital operations. In this case, as was true in her response to establishing Provident-based obstetrics clinical experiences, Overton was largely powerless to impact financial or strategic decisions, except by appealing to the Medical Director or the Board of Directors. Her passivity in this situation may have been a tactic to protect her employment at Provident. Nonetheless, it is clear that operational decisions rested with the

medical directors who were Black physicians and the Board of Directors who were predominately White philanthropists or prominent members of the Chicago elite.

Belva Overton's Education and Black Nurse Leaders

Interestingly, Overton expanded her own education in hospital administration when she took classes in the subject at the University of Chicago. She graduated in 1937, earning Bachelor of Science degrees in Sociology and Nursing Education.[62] In 1942, Overton was awarded a travel grant from the GEB to take a two-month trip visiting nursing schools to learn from public health nurses in rural areas and to introduce a public health course at Provident. She visited the University of Toronto School of Nursing, Cornell Medical College, Johns Hopkins School of Nursing, Medical College School of Nursing in Richmond, Medical College School of Nursing affiliated with Meharry College, and Vanderbilt University School of Nursing. At the conclusion of her trip, she was able to implement a public health course in the nursing curriculum at Provident using the resources already available to her. In reflecting on her travel, she emphasized the importance of training quality nurses over the quantity and she especially marveled at the University of Toronto for their representation of "almost every nationality."[63] Nurses who graduated from Provident were continually encouraged to pursue an advanced education. Marilyn Danzy (graduated in 1947) recalled that the students were told "don't stop when you finish here [Provident Hospital] – continue." They were motivated to "aspire to the highest education level possible" for the purpose of becoming "highly professional nurse." Danzy completed her Bachelor's degree from Loyola University and later her master's degree.[64]

Throughout her tenure at Provident Hospital as the Superintendent of Nurses, Overton invited many of the leaders to give the principle address at capping services and graduations. It is

interesting to note that from 1935 – 1936, the guest speakers were White representatives from the University of Chicago, including Arthur C. Bachmeyer (Director of Clinics) and Miss Nellie Hawkinson (Professor of Nursing Education) during the first crucial months of the affiliation with the University of Chicago.[65] By 1938, however, Overton was introducing Black leaders into the ceremonies. These included Estelle Massey Riddle in 1938 and Frances F. Gaines in 1945 – both who were presidents of the NACGN.[66] In 1948, the American Nurses' Association voted to "extend professional recognition to QUALIFIED NEGRO NURSES." Among the names of Black nursing leaders identified in helping lead this change were Belva Overton and Mabel K. Staupers.[67]

Conclusion

The Jim Crow era racial segregation in the United States impacted the nurses and physicians working at the Provident Hospital and Training School by forcing the hospital to be governed a predominately by a White Board of Directors who at all times operated under the shadow of limited funds and the favor of the White run hospitals in the Chicago area. Hale's original vision for the hospital was for it to be a multiracial community of nurses and physicians that cared for all persons regardless of background or race.[68] However, as the hospital grew into one of the premiere Black hospitals in the 1920s, it sacrificed its independence from White leadership to maintain its prestige through its relationship with the University of Chicago and the Lying-In Hospital. Also, Provident Hospital's dependency on the support of the GEB and wealthy philanthropic leaders in Chicago contributed to Black leaders' marginalized authority. Overton was caught up in these events. In moments of crisis the hospital took a passive response to racist events – often opposing the will of the Black professional community – such as with the

first Black clerkship in affiliation with the University of Chicago. Jim Crowism impaired Provident Hospital's ability to effectively respond to the exclusion of Black nurses at the Cook County Nurses Home. Furthermore, when Overton made a plea to the Medical Directors and Board of Directors to establish their own obstetrics clinical rotation because of the nursing students' negative experiences at Chicago's famous Lying-In Hospital, they denied her request for the sake of maintaining its prestigious relationship with the hospital. This confirms what historian Claudrena Harold calls "the precarious nature of Black existence" at that time. Black leadership was limited and could not effectively challenge the dominance of Whites.[69]

It should be noted that despite the Jim Crow influence on the hospital and nursing leadership's loss of influence, Provident Hospital was able to grow and provide an invaluable source of Black nurses and physicians that supported the rapid growth of Black hospitals to the United States through the early to mid-twentieth century. Though the generosity of the Rockefeller Foundation and philanthropists the hospital was able to provide a Black community with a sense of pride and accomplishment during a tumultuous Jim Crow era. Through Overton's tenure she operated within her constraints to support her Black student and graduate nurses and to prepare them to be successful. Black hospitals competed for her graduates because of the high standard and strength she expected from her pupils in both mind and body. She was not training nurses to fulfill the Taylorism expectation of nurses fitting a role in the hospital industry, but to become effective Black nurses in the Jim Crow era through a supportive community of Provident graduates and professional associations.

Chapter 3 Notes

[1] Provident Hospital and Training School, *Annual Report for 1936*, 1936, 27-28.

[2] American Hospital Association, *Report of the Committee on The Training of Hospital Executives – 1927* (Chicago: American Hospital Association, 1927), 444-457.

[3] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*. (Baltimore: Johns Hopkins University Press, 1999), 157-158. There was one exception: religious orders of women (and a few men) affiliated with the Roman Catholic Church maintained their power at the helm of their sponsored hospitals as nurse leaders through the mid-twentieth century. See Wall, *American Catholic Hospitals*, 53.

[4] Quoted in Steven Neuhauser, *Coming of Age: A 60-Year History of the American College of Healthcare Executives and the Profession It Serves 1933-1993* (Ann Arbour: Health Administration Press, 1995), 20.

[5] John C. Kirchgessner, *A Reappraisal of Nursing Services and Shortages: A Case Study of the University of Virginia Hospital, 1945-1965* (Dissertation: University of Virginia, 2006).

[6] Steven Neuhauser, *Coming of Age: A 60-Year History of the American College of Healthcare Executives and the Profession It Serves 1933-1993* (Ann Arbour: Health Administration Press, 1995), 31.

[7] Joan E. Lynaugh and Barbara L. Brush. *American Nursing* (Cambridge, MA: Blackwell Publishers, Inc., 1996), 16.

[8] Stevens, *In Sickness and in Wealth*, 74.

[9] Arlene Wynbeek Keeling, Michelle C. Hehman, and John C. Kirchgessner, *History of Professional Nursing in the United States: Toward a Culture of Health* (New York: Springer Publishing Company, 2018, 2018), 55.

[10] Stevens, *In Sickness and in Wealth*, 12.

[11] D'Antonio, *American Nursing*, 38-39.

[12] D'Antonio, *American Nursing*, xiv.

[13] Reverby, *Ordered to Care: The dilemma of American nursing*, 121.

[14] Isabel Maitland Stewart, "Developments in nursing education since 1918," (Washington Government Printing Office, 1921), 18.

[15] Darlene Clark Hine, "The Ethel Johns Report: Black Women in the Nursing Profession, 1925," *The Journal of Negro History* 67, no. 3 (Autumn 1982): 212-221. Charemon Brooks and Barbra Wall, "Educating the Black Professional Nurse in Virginia: Race, Place, and Politics 1891-1939" (University of Virginia, Nursing - Graduate School of Arts and Sciences, PHD (Doctor of Philosophy), 2022, 2022).

[16] Hine, "The Ethel Johns Report: Black Women in the Nursing Profession, 1925," 221.

[17] D'Antonio, *American Nursing*, 138.

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[18] Stevens, *In Sickness and in Wealth*, 137, 175.

[19] Vanessa Northington Gamble, *Making a Place for Ourselves: The Black Hospital Movement, 1920-1945* (New York: Oxford University Press, Inc., 1995), 11-13.

[20] Darlene Clark Hine, *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession 1890 - 1950* (Indianapolis, IN: Indiana University Press, 1989), 28-30.

[21] Quoted in Gamble, *Making a Place for Ourselves: The Black Hospital Movement, 1920-1945* 131-132.

[22] Nettie George Speedy, "My Scrap Book of Doers: From the Lowest to the Highest Rung of Her Profession has been the Climb of Miss Overton," *The Chicago Defender* (Chicago, Ill.), Jul 25, 1925, 10; Julia Goens, "At the Seashore," *The Pittsburgh Courier* (Pittsburgh, Pa.), Jul 25, 1925, City Edition.

[23]Adah B. Thoms, *Pathfinders: A History of the Progress of Colored Graduate Nurses* (New York: Kay Printing House, Inc., 1929), 19-20; "Miss Overton Receives Tuskegee Appointment," *The Chicago Defender (Big Weekend Edition)* (Chicago, Ill.), Feb 24, 1917, 10.

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Chapter 4

Nursing Leadership during the Hospital Modernization Period: 1950-1990

> The image of the nurse cross-culturally has historically has been of someone active and good but relatively powerless.[1] – Angela Barron McBride

In McBride's 2011 book, *The Growth and Development of Nurse Leaders*, she references an international study in 1985 regarding nursing's public image in the context of how nurses in hospital leadership positions are perceived to be no longer "real" nurses because the public does not associate nurses with positions of leadership.[2] Indeed, nurses are known for their compassionate care and their ability to promote the public trust, but have consistently been overlooked for senior leadership positions within hospitals and the American health care system.[3] During the latter half of the twentieth century the hospital throughout the United States began to evolve into a new type of healthcare system driven by complex reimbursement structures and the consolidation of hospitals into corporations. As hospitals changed, so did the leadership structures within the hospitals. Nursing leaders within and outside of the hospital healthcare system were generally perceived as powerless leaders. But this certainly was not the case for all nursing leaders who worked to overcome this perception.

Historical Context 1950s – 1980s

At the conclusion of World War II, there were significant improvements in surgery and specialization surgical care and treatments, especially in renal therapy, cancer, and cardiac surgery. The therapeutic advances led to an increasing demand in specialized facilities to support the increasing complexity of patient care, such as the postoperative care units and intensive care

units. As the complexity increased the nurses caring for patients in the critically ill units became more specialized. [4] A 1944 study of 3,350 hospitals in the US and Canada, demonstrated that 1,640 (48 percent) had women administrators. Of this total, 836 women were administrators of hospitals with one-hundred beds or less and 224 women were administrators of hospitals that had between one-hundred and two-hundred beds.[5] This left 580 women administrators for hospitals with greater than two-hundred beds. According to that study, although most women administrators were in hospitals with fewer than two-hundred beds, women contributed very little to the development of policies or "group action" in the field of hospital administration.[6]

Susan Reverby argues that while physician "power and professional autonomy" increased in the 1930s, nursing's ability to professionalize and assume leadership roles in hospitals became encumbered not only by the quality of nurses nursing schools were producing – while benefiting from a cheap student labor force in hospitals – but, also by the coming of the Great Depression that transformed the nursing workforce. The Great Depression drove many private duty nurses out of work who eventually found new employment in hospitals who were looking for new sources of reliable labor to replace a transient student workforce. [7] This again created an opportunity for nurses to take an active role in leading hospital operational transformation, but nurses were frequently overlooked for leadership roles because it was thought too complex for nursing outside of the wards, especially in Protestant and academic hospitals.[8]

At the same time, nurses who had left their hospitals in the United States to work overseas during wartime did not come back to work after the war. Rather, White women stayed home to start families, and a nursing shortage developed that only worsened over the decades. During the 1950s the Hospital Survey and Construction Act – known as the Hill-Burton program – rapidly increased the number of hospitals serving rural and metropolitan areas. As hospitals

rapidly built and expanded services access to rural areas the demand for trained nurses increased.[9] Fueling this growth, the Hill-Burton program provided funding for hospitals and long-term care and ambulatory facilities. The funding targeted for low-income states, but by the 1950s the Hill-Burton funding extended to middle-income communities.[10] This increased competition between hospitals because of insurance companies – such as Blue Cross and Blue Shield – covered 50 percent of the civilian population's medical expenses in 1950 – making hospitalizations more affordable. By the early 1960s the hospitals – including Catholic hospitals – increased in numbers and size throughout the United States. This growth was supported by reimbursements from Blue Cross and other private insurers for medical technology, increasing physician fees, and additional personnel to meet growing public demand for health care. Reimbursements increased from $772 million in 1948 to $8.7 billion in 1964.[11] Historian Rosemary Stevens explains the growth of health care costs as "the pot of gold held out by third-party payers encouraged hospitals to respond to the market incentives of increased demand by providing more, more expensive, and better care, in areas that were most likely to be reimbursed."[12]

Hospitals used medical technology supported by specialized nurses and doctors to attract patients to their hospitals for their advanced medical care. Hospitals built private and semi-private rooms to provide patients with privacy, which added an increased complexity and workload for nurses versus the previous model with large wards with centralized beds.[13] The specialized nurses required more time with patients to meet their increasingly complex care needs. But hospital administrators failed to recognize the need to invest in more nurses' training programs to meet the increasing labor needs.[14] The long hours and low wages led to an exodus of nurses from the workforce creating a shortage of nurses that forced the closure of hospital beds

across the country.[15] To help address the critical shortage of nurses President Lyndon Johnson signed into law the Nurses Training Act in 1964 to develop basic and advanced nursing education.[16]

In 1965, Medicare and Medicaid programs were created to provide medical support for the poor and elderly, but hospitals quickly learned that reimbursements for services could be set by hospitals for the costs incurred as opposed to a fixed reimbursement for services. This coupled with depreciation on hospital assets and medical costs through the Medicare program led to significant unbridled costs to the US government.[17] In the 1970s, the American public opinion of the medical system shifted from support the rapidly growing and specializing within the medical system to one of scrutiny as access to basic medical care became a barrier for those who were not covered by insurance. Hospitals and doctors increased their reimbursable rates to maximize reimbursements from private insurance, which struggled to keep up with the increasing cost of health care.[18]

Running parallel to this transformation, Catholic hospitals continued to be controlled and managed by sister-administrators who were nurses. As historian Barbra Mann Wall writes, Catholic nuns were able to draw upon their spiritual legitimacy and support from the Catholic Church because they were "brides" of Christ and the representatives of the Catholic Church allowing them to oversee hospitals as opposed to physicians or laymen administrators.[19] Wall explains, nuns of the Catholic hospitals proved that women absolutely could manage complex financial operations. Catholic hospitals were run and managed by the Catholic sisters (and in a few cases, religious orders of men) who served not only as nurses but also stewards, agents and administrators of their institutions in compliance with Canon Law of the Roman Catholic

Church. This chapter builds on Wall's work on Catholic sisters by examining the work of Sister Mary Maurita Sengelaub and her leadership in the Catholic Hospital Association (CHA).

Sengelaub's Early Years in Nursing

Katherine Sengelaub was born on 28th of June 1918 on a farm near Reed City, Michigan. While helping on her family farm she also learned to care for sick relatives.[20] While in high school she weighed the decision as to become a teacher or a nurse. To help with the decision she volunteered in a twenty-bed hospital in Reed City. As she volunteered at the hospital, Sengelaub became friends with a nurse who encouraged her to become a nurse. However, after Sengelaub graduated from high school she decided to stay home and help care for her family. After a year, her father – who was a carpenter and bricklayer – gave Sengelaub $150 to help pay for her tuition at St. Mary's School of Nursing in Grand Rapids, Michigan. She enrolled in the school in 1937. While a student, the Sisters encouraged her to enroll in classes at a local college to earn credits toward a baccalaureate degree. Sengelaub graduated in 1940. Shortly after her graduation she received the news that her sister had died in an automobile accident. Sengelaub returned home and began her career at the Reed City Hospital. But the Sisters did not forget about her and 1942 offered Sengelaub a position as an instructor at the Bay City Mercy Hospital in Michigan to teach medical-surgical nursing.[21]

In Sengelaub's first few years as a nurse she struggled with what she wanted to do as a nurse and eventually it was the nuns that helped direct her career. While Sengelaub taught nursing cadets at Bay City she briefly thought about joining the Army as a nurse during World War II. However, after talking with the Sisters at Mercy Hospital, she was encouraged to stay

and enter the convent to begin the process of to be a vowed Religious Sister of Mercy. In 1945, Sengelaub entered the novitiate at Mercy College in Detroit for two years. For the next three years, she taught nursing at Mercy College while continuing to work toward her Bachelor's degree, which she earned in 1949. In 1951, Sengelaub took her final vows as a Religious Sister of Mercy and changed her name to Sister Mary Maurita Sengelaub. Shortly after becoming a Sister of Mercy, she met with the Mother Provincial who informed her that she would go to Saint Louis University to pursue a master's degree in hospital administration and study under the program's founder, Father John J. Flanagan.[22]

Sengelaub entered the hospital administration education program at Saint Louis University and at the time, there were fewer than ten programs sponsored by universities for the purpose of teaching graduate programs in hospital administration. Flanagan, trained as a Jesuit, understood the reluctance of Catholic hospitals to appoint lay persons to the administrator role. In response he established the program at St. Louis University to help Catholic hospitals prepare administrators who could manage the increasingly complex role as hospital administrators. Flanagan encouraged the integration of Catholic hospitals with lay administration while preserving the Catholic values in a different healthcare environment. Flanagan wrote:

> It is not easy today in a modern hospital to be as efficient in a business way as one would like to be, and at the same time maintain the spirit of charity and kindness and personal attention that has been traditional in our Catholic institutions… It is, however, a responsibility which, carried out, can make our institutions different from every other hospital.[23]

With this hope and vision for the Catholic hospitals – as well as for secular hospitals across the country – Flanagan established the hospital administrator school at St. Louis University in 1948.

Under Flanagan's leadership as its executive director, the CHA worked to support the training of sisters who were nurses in leadership roles at Catholic hospitals.[24]

Flanagan mentored Sengelaub as she progressed through the hospital administration program and instilled in her a strong foundation in social justice and the value of leadership in the secular healthcare environment. Flanagan taught:

> Leadership in our hospitals of tomorrow, men and women who…have a depth of religious knowledge and conviction which will enable them to handle the material things of life without having a materialistic outlook; which will strengthen them to meet the business man, the press and the public without becoming worldly minded. The basic education of the religious should… give her a thorough understanding of social problems and social justice, so that she can deal justly and kindly, yet firmly and securely, with personnel problems and public relations problems.[25]

His teaching and leadership in the CHA would have a deep impact on Sengelaub's philosophy in leadership.

Sengelaub's education and residency effectively prepared her to lead – as a nurse and a nun – Catholic hospitals throughout the Midwest. Most hospital administrator programs at this time were unstructured and relied heavily on Malcom MacEachern's *Hospital Organization and Management* and an exemplary residency experience to prepare hospital administrators. In 1953 Sengelaub completed a master's degree in hospital administration and entered her residency at St. Vincent's Hospital in New York under Sister Loretta Bernard. While at St. Vincent's Hospital she learned the details of running operations for the hospital and negotiation of reimbursement structures. At the conclusion of her residency, she returned to Mercy Hospital in Bay City as a floor supervisor and advanced to the hospital's administrator in 1954.[26]

Throughout Sengelaub's career, she encouraged nurses to pursue higher levels of education at the bachelor's or master's levels, especially if nurses wanted management responsibility. Drawing on her past experience as an educator, Sengelaub observed that "the curriculum the college students receive gives them a foundation that helps them to become whole persons as they move through life. It is a more rounded approach to the education of the human being."[27]

Sengelaub the Administrator

In her first year as administrator, Sengelaub applied for hospital accreditation from the recently established Joint Commission on Accreditation of Hospitals (JCAH). As she worked to upgrade hospital standards and organizational structures, however, the physicians at Mercy Hospital attempted to remove her from her position by writing to the Mother Provincial, Michigan State Medical Society, and Kenneth Babcock (the physician director of JCAH). Upon hearing of the developing coup at Mercy Hospital, the Mother Provincial invited Sengelaub to travel to Chicago to meet with her and Babcock to discuss the concerns presented by the physicians. At the conclusion of the meeting, Sengelaub recalled that Babcock "gave some good advice and when all was said and done, he said, 'Don't back down in what you are trying to do.'"[28] Encouraged by Babcock's support, Sengelaub returned to Mercy Hospital and proposed to her Mother Provincial that she contract with a consultancy firm to restructure the hospital's organization and practice standards. She received support for the consultants and over the next two years worked to implement the "close to fifty recommendations" for Mercy Hospital. Having succeeded in her goals, Sengelaub was reassigned to Mercy Hospital in Grand Rapids,

Michigan, in August 1957. Over the next four years, she upgraded the physical building, practice standards, and the operational structure of the hospital.[29]

Sengelaub's early success as an administrator in hospitals opened new leadership opportunities in the Catholic hospitals. In 1961, she accepted the role as the Assistant Provincial of the Sisters of Mercy in Detroit and served as the coordinator of twenty-seven hospitals throughout the province, which included hospitals in Michigan and Iowa and Indiana.[30] For decades, organizational structures within the hospitals were adhered to, with sisters in the leadership positions. Sengelaub recalled, "a Sister administrator, a Sister in charge of the operating room, a Sister in charge of the finances of the hospital and a Sister to be available to see the patients and family in the emergency room and on the floors in cases of critical illness."[31] She recognized the increasing complexities in hospital administration and the need to improve the performance of the hospitals and hired a consultation firm once again. Findings included that the hospitals did not have formal budgets or policies to govern personnel across the hospitals. Through this study, she centralized the oversight of the hospitals within the Detroit Province. Sengelaub identified several nuns who had potential to become hospital administrators and sent them to graduate healthcare administration programs for formal training.[32]

In 1965, Sengelaub was elected to serve on the General Council for the Sisters of Mercy of the Union and served as a consultant for ninety-two hospitals that across nine Provinces. The role provided her opportunities to hone her political acumen, representative leadership, and talent with working with finance committees in Congress and insurance companies. This experience later helped her establish the Office of Government Relations in Washington, DC, for the CHA. In this office, she worked with powerful bishops who traditionally held the highest authority in the Church. Then in 1969, her role on the General Council led her to serve in several key

positions in the Conference of Major Superiors of Religious Women (CMSW). This organization, established in 1956, became a key agent of change through the promotion of women's issues and empowerment, especially in hospital administration.[33] Sengelaub also worked with the United States Catholic Conference (USCC) that followed legislation in Congress and administrative policies from the executive branch, particularly any action that may impact the tax-exempt status of the churches. The USCC also promoted social legislation to support oppressed ethnic groups in the US. Sengelaub shared later in an interview that her involvement with the generalate, the CMSW, and the USCC prepared her for her leadership role as Executive Director of the CHA.[34]

In the late 1960s, the CHA recognized that for its hospitals to be competitive, large health care systems were needed. They followed what sociologist Paul Starr describes as the "Age of Corporations" that began in the 1960s.[35] In 1969, Tom Casey, a Jesuit priest who was then the CHA Executive Director, announced that he would step down from his role and initiated a search committee for his replacement through the CHA Board of Trustees. Sengelaub provided names of potential nominees to the search committee, but after the committee unsuccessfully vetted their initial candidates, they asked if Sengelaub would consider the position. Encouraged by her mentors, including her former teacher and mentor Father Flanagan, she accepted the position of Chief Executive Officer of the CHA in 1970. This was significant, because, since 1915, the CHA had selected Jesuit priests for the position. Sengelaub became the "first religious woman to step into the shoes of Jesuit."[36]

Sengelaub at the Catholic Hospital Association

From 1970 through 1976 Sengelaub worked to consolidate the Catholic hospitals – free-standing hospitals and long-term care facilities – under a health systems model. Sengelaub recognized that she needed to build a consensus with all the congregations and to develop the skills and abilities of the leaders in the hospitals and long-term care facilities. In response, she established the Catholic Health Services Leadership Program (CHSLP). Sengelaub described the idea behind the program as "a way to communicate, to develop policy together, and to [initiate] shared programs, it would strengthen Catholic health care."[37] In an article written in 1973, she added that the CHSLP would "promote mutual trust, accountability, and responsible leadership with direction… problem solving, and priority setting."[38] By the mid-1970s, the CHSLP had become an engine for helping hospitals create health systems by producing nine different models hospitals could use to form systems in any financial or societal conditions throughout the US. Sengelaub encouraged the formation of health systems through direct ownership of hospitals, not contracted relationships. She believed that through ownership of hospitals under a health system the hospitals would have a greater commitment and alignment. In a speech on the subject Sengelaub observed that "identity and commitment to and with one another are at the very core, and at the very being and within the spirit of a bona fide hospital system."[39] She also argued that the formation of health systems would lead to cost savings through shared expertise and resources such as medical equipment.[40] By 1986, Catholic hospitals across the country had organized into more than fifty Catholic health systems.[41]

To support this reorganization, Sengelaub facilitated the phasing out of the local advisory boards in the Catholic hospitals. To replace them, she created divisional boards – responsible for two to three hospitals – with clearly defined responsibilities and authority and accountable to the

corporate Board of Trustees. This effectively centralized the ineffective local boards under the Board of Trustees that would provide greater strategic and consolidated organizational power.[42] Sengelaub also created changes within the CHA by eliminating traditional departments such as dietetics, housekeeping, radiology, and nursing education and replaced them with departments focused on the long-term mission of the CHA. Under Sengelaub's leadership the CHA shifted the operational details of running hospitals to health systems and, as Catholic historian Christopher J. Kauffman writes, to focus "exclusively on (1) preserving and promoting the Catholic identity of member institutions and (2) advocating member interests in the areas of healthcare legislation and regulation."[43]

Sengelaub drew upon her previous experience in the USCC to testify before Congress for the CHA in 1971 and in 1974 in support of a national health insurance coverage, specifically regarding the establishment of a payroll tax-funded national health insurance plan.[44] In 1971 Sengelaub testified to the House of Representatives *Committee on Ways and Means* that the American health system should prioritize: preventive care programs, health education programs, health maintenance programs, and health systems that gave people the right of choice. Central to her argument for a national health insurance program was the prevention of disease and not just curing illnesses. Sengelaub also built on her experience as a nurse and nursing educator by stating:

> We must get at the roots of the problems and focus on maintenance of health and quality of life, not just the myopic focus of curing illness. I am convinced that a reallocation of our resources toward prevention of disease, health education and a healthy environment, from those earmarked for cure of illness, could result in a

> substantial decrease in those dollars need and absorbed in and by acute care services.[45]

Sengelaub returned to the committee in 1974 to speak to the financing of a national health insurance. She argued against the use of coinsurance and copays as it "impeded" access to health care for those in need. Coinsurance and copays, in her experience, was not an effective means of limiting overutilization. Rather, again she argued that health systems should focus on preventive maintenance care and education to help curb the rising cost in health care.[46]

Sengelaub continued to expand the mission and purpose of the CHA well beyond its role in supporting Catholic hospitals prior to the 1970s. The Second Vatican Council (1962-1965), or Vatican II, called on the Catholic Church to expand its purpose not only to support Catholic institutions, such as hospitals, but also to support all members of society as equals, especially the poor. "Preferential option for the poor" became a goal,[47] and Sengelaub applied this charge to all departments within the CHA. She also created a Department of Services for the Aging to address the needs and quality of care of patients in long-term facilities. She established a medical ethics department called the Pope John XXIII Center for Medical Moral Issues and Research whose mission was to address medical moral issues that stemmed from the new science of genetic engineering and organ transplants.[48] Unfortunately, due to complications to breast and uterine cancer and a heart attack, Sengelaub resigned her position as CEO of the CHA in 1976.[49]

Sengelaub's Continued Work after the Catholic Hospital Association

As Sengelaub recovered from cancer, she remained involved with the transition of Catholic hospitals into health systems. While working at the CHA, she helped with the growth of the health system in her home state of Michigan. In 1972, the Catholic hospitals in the Detroit

area had created a new health system called the Sisters of Mercy Health Corporation (SMHC). Sengelaub served on the SMHC's Board of Trustees as its chair until 1982. The SMHC proved to be a model health system, and Catholic hospitals across the country asked for the SMHC's counsel in creating their own health systems. In 1984, the SMHC created a subsidiary called the Mercy Collaborative that provided consultative services to Catholic hospitals and religious, which named Sengelaub as its president and chief executive officer. Over the next three years, Sengelaub advised hospitals, both domestic and international, and consultants for the Mercy Collaborative on sponsorship, management expertise, and governance. The Mercy Collaborative's work extended to several Pacific island nations and Australia where Sengelaub helped create its first Catholic health system.[50]

In 1978, Sengelaub established the National Migrant Workers Council in conjunction with the Conference of Major Superiors of Women to serve the health needs of migrant workers throughout the East Coast and Midwest. The Council recruited health care professionals, such as nurses and health aids, to care for migrants and their families during peak labor seasons. The Council created a base in Florida to care for the migrants in the winter. To fund this endeavor Sengelaub lobbied for funding from the Division of Community Health Services of the US Department of Health and Human Services and Catholic health systems throughout the country.[51]

Changing Roles for Sisters in the Modern Health System

Throughout the 1960s and 1970s, Catholic hospitals adapted to the increasing complexity of the reimbursement markets (e.g., Blue Cross, Blue Shield, Medicare, and Medicaid reimbursement schemes) by reorganizing their structures from individual hospitals to health

systems and by changing who led the organizations. Father Flanagan's progressive foresight into the changing healthcare environment encouraged the recruitment of people with business training to lead the operations within the hospitals. In the 1960s Catholic hospitals began to hire men and women who had collegiate preparation into hospital administrator positions. One sister who was a hospital administrator for a Chicago hospital during this time reflected:

> At the time, such people were usually men, so what had been almost entirely a women's ministry slowly became integrated. That was an important development. Sometimes there's conflict between men and women, but we also enrich each other. Catholic healthcare is the one area of the Church where there is equality between men and women.[52]

By the 1970s, a culture of equality and collaboration had been created, and a unique gender equality paradigm in healthcare developed that differed from non-Catholic hospitals in the US. With Flanagan's support, Sengelaub accepted the executive director position and later the chief executive officer role at CHA that Jesuit priests previously had occupied.[53] This transition signaled a change in women's roles, specifically nuns, in Catholic hospitals. As Wall writes, "When sisters left hospital administration and became active at the Board or Trustee level, their governance duties focused more on strategies than on operations."[54]

In response to this shifting role from operations to strategy on the boards, Sengelaub wrote several articles outlining the purpose of nuns and other members of the apostolate serving on the boards as trustees. She understood that this might be a new role for many sisters who had been in operations throughout their careers, for which they had received little to no preparation. The sisters were responsible for helping Catholic hospitals to be distinguishable from other non-profit hospitals by following two guiding principles. First, faith and the churches' mission to care

for the sick, the dying, and poor were to be every nun's guiding principle. Second, the Catholic hospitals' environment was to be peaceful and quiet environment that would "communicate the transcendent presence of a God of love who cares and heals, who understands suffering and pain and transforms it into hope and life."[55] However, providing guidance on religious and ethical issues was not their only purpose on hospital boards. Sisters were to be the voice of those who were not invited to participate. Sengelaub pointed out that though the sisters were seated on hospital boards, many of the boards (especially non-profit hospitals) did not have enough women, and the sisters were responsible for representing gender equality. Sengelaub argued:

> Sisters often represent women. In general, boards of trustees are not comfortable in selecting women to serve. Most business and enterprises are predominately made up of men. A sister can represent both the feminine and the religious dimensions of society… This provides for a cross-fertilization of ideas. It sets the stage for significant collaboration and sharing in different aspects of a specific apostolate.[56]

Sengelaub continued by acknowledging that nurses did not have a consistent seat on the boards but should have. It was the responsibility of the sister to ensure the nurses' views were represented. Sengelaub wrote: "Contributions that have so far been unnoticed and therefore underdeveloped… [is the] Sister as a professional woman, for example… a nurse. Many sisters are nurses; nurses have not been included on boards."[57]

Throughout the 1950s – 1970s, lay administrators in Catholic hospitals and health systems began to gain power and influence over hospital operations. Often lay administrators would exclude the nuns from operations and only defer mission, values, and ethics to the nuns on the boards. This left the nuns feeling as if they lost influence in decisions about the treatment of

employees working in the hospitals. As Wall writes, the changes in the nun's influence "resulted in many of the sisters struggling with inner conflicts between their religious ideals of social justice and inclusiveness and their personal desires for independence in decision-making."[58] This loss of influence was noticed by nursing unions who felt the hospital administrators and boards needed to provide better working conditions for nurses.

To examine how nursing leaders sought to gain influence in hospitals and health systems across the US through national nursing organizations we will examine the life and work of Anne Zimmerman.

Anne Zimmerman's Early Career in Nursing

Born in 1914 in a mining town of Marysville, Montana, Anne Larson became interested in nursing early in life when she cared for her sick mother and when she received care herself in a hospital for a broken femur. She graduated from Helena High School in 1932 and in 1935 graduated from the St. Johns Unit of the Sisters of Charity of Leavenworth School of Nursing. In 1936 she married and took the last name of Zimmerman. Zimmerman worked as a private duty nurse in Montana, but she wanted to work in a pediatric hospital. Thus, she attended a six-month post-graduate course at the Children's Hospital of Philadelphia. After completing the course, she returned to Montana to work as a pediatric supervisor at the Murray Hospital in Butte, Montana.[59]

Zimmerman struggled economically because four years after her marriage, she divorced and became a single parent raising an eighteen-month-old daughter. This created several socioeconomic challenges, as it did for other divorced women working as nurses in the 1940s. She struggled to find a hospital that would hire her as a single parent and find a landlord who

would lease a place for her to raise her child.[60] In the 1940s though hospitals were beginning to hire trained nurses to address the nursing labor shortage, many hospitals held to a Nightingale philosophy that nurses should be unencumbered by marriage or children. Historian Patricia D'Antonio demonstrated that there were less than 5 percent of self-reporting nurses who were divorced in the 1940.[61] This experience shaped Zimmerman's perspective of the importance of a living wage for nurses. Zimmerman recalls that while in nursing school her instructor Margaret Bottinelli (Troxel) taught her the "true meaning of social justice. Her teaching that the right to a just wage need not be at the expense of patient care stayed with me all my life."[62]

Wanting to make a change to the economic security of nurses' working conditions, Zimmerman joined the Montana State Nurses Association in 1945 as its Executive Secretary. By 1946 she had become the chair of the General Duty Nurses Section of the ANA.[63] In 1946 the ANA convention established the Economic Security program with four major objectives:

1) The improvement in hours and living conditions for nurses, including wider acceptance of the 40-hour with no decrease in salary and minimum salaries adequate to attract and hold nurses of quality and to enable them to maintain standards of living comparable to other professions.
2) Increased participation by nurses in the actual planning and in the administration of nursing services in all types of employment situations.
3) Greater development of nurses' professional associations as exclusive spokesmen for nurses in all questions affecting their employment and Economic Security.
4) Removal of barriers that prevent the full employment and professional development of nurses belonging to minority racial groups.[64]

The timing and the approval of the Economic Security program perfectly aligned with Zimmerman's interests and presented her with an opportunity to lead nurses through the power of organizations. The four points would become guiding principles for her career as a nurse leader through the ANA. In 1947 she moved to California to work on the economic and general welfare program with the California Nurses Association (CNA) where she met Shirley C. Titus who became her mentor in championing nurses' rights, improving working conditions and salaries for nurses in California. Reflecting years later, Zimmerman likened the next "seven years with CNA were the equivalent of graduate education… From that experience I learned every facet of organization work. I also learned how to convert the ideas of a genius into solutions to burning problems."[65]

Zimmerman's Leadership at the Illinois Nurses Association

Zimmerman's preparation – along with the support of leaders within the CNA and ANA – encouraged her to accept leadership positions within professional organization of the ANA as a champion for nurses in the US. After briefly working at the ANA office in New York directing the ANA's Economic and General Welfare program, in 1954 Zimmerman accepted an appointment as the Executive Director of the Illinois Nurses Association (INA). In this role Zimmerman worked to advocate for nurses throughout the state to improve working conditions and pay. She worked not only with hospitals throughout the country to improve salaries and working conditions for nurses, but also with industrial factories and for nurses working in the occupational health roles.[66] At the 1962 ANA convention in Detroit, Zimmerman addressed economic security issues of nurses when she stated: nurses, through continuing education and reasonable pay, would stay at the bedside. She predicted:

> The decade ahead will see economic rewards for the nurse who finds her satisfaction in nursing where administrative responsibilities are not a part of her job and who pursue continuing education to improve the quality of nursing care she gives to patients… Only when it is made economically reasonable for her to function in the clinical area as an excellent nurse will we see any substantial nurses remaining at the bed side.[67]

During her tenure at the INA she stepped into the national spotlight for her work in supporting the nurses at Chicago's Cook Count Hospital as they used collective bargaining to successfully improve nurse working conditions and pay by actively picketing with the striking nurses.[68] On 28 August 1966 the CNA for the first time broke from the ANA and actively supported strikes for the improvement of nurses' salaries.[69] Emboldened by this action, on 31 August 1966 Zimmerman negotiated with the Board of the Cook County School of Nursing – who provided nursing services by contract to the hospital – to sign a collective bargaining statement with the INA as its sole bargaining agent. Zimmerman acknowledged the ANA's position on the no-strike policy. But she warned that the policy was predicated on a "just treatment by the employer." and she warned that "unjust treatment by the employer would leave them (the nurses) with no alternative."[70] Zimmerman asked the Cook County Board to increase nurses' salaries from a $455/month starting salary to $545/month. This increase placed the hospital above the rate being offered by other hospitals in Chicago, with the intent to recruit more nurses to the Cook County Hospital.[71] Over the next two weeks, Zimmerman picketed with nurses and effectively communicated with the Chicago press, sharing the unacceptable working conditions nurses endured. Public opinion sided with the nurses. After talks stalled, Zimmerman mobilized 371 nurses (out of 400 nurses) to submit resignations. On 14 September 1966 the

Cook County Board agreed to terms, and the starting salaries for nurses increased to $545/ month.[72]

Zimmerman did not stop with this success. She also worked to improve the quality of care to the patients. In the first contract with the Cook County Board, Zimmerman included the creation of a Patient Care Review committee that included nurses throughout the hospital to study and resolve issues that impacted patient care. Additionally, she established visitation privileges for family visiting patients in the Obstetrical Department and a playroom for children in the Pediatric Department. A few years later Zimmerman led the INA to help the nurses of the Cook County Hospital to join with the hospital physicians to centralize hospital control with the health care professionals and away from the control of the Cook County Board.[73] The success at the Cook County Hospital set a precedence that led to hospitals throughout the Midwest voluntarily increasing salaries and benefits to nurses from 1966-1970. Also, nursing school enrollments increased throughout the state, attracting quality candidates to the programs. In a letter to the ANA, a Clinical Specialist from the University of Chicago wrote that Zimmerman was vindicated in her belief that "only a profession, well paid and internally controlled, could hope to attract the number and [caliber] of people needed to provide high quality care to patients."[74]

Zimmerman's Leadership at the American Nurses Association

In 1976 she ran and won the ANA presidency on the platform that nurses needed to play a more independent and assertive role with nursing in healthcare. As president, Zimmerman demonstrated the impact leaders within organizations have on the nursing profession. She went to Congress to advocate for the independent practice of nurses, clinical nurse specialists, and

nurse practitioners in rural areas of the country. On the 28th of February 1977, Zimmerman testified before the House of Representatives Subcommittee on Health of the Committee on Ways and Means on Medicare reimbursement for physician extenders practicing in rural health clinics. She called for the exclusion of nurse practitioners from the term "physician extenders."[75] Additionally, she argued for the change of the language of physician "supervision" be changed to physician "consultation and referrals." The AMA representation quickly attacked Zimmerman's arguing that "the physician should maintain the moral, ethical, and ultimate responsibility for the well-being of the patient. The patient looks to the physician, and we will accept that responsibility."[76]

Zimmerman returned to Congress a month later on the 29th of March 1977 before the Senate Subcommittee on Rural Development of the Committee on Agriculture, Nutrition and Forestry to argue for the removal of the physician extender descriptor for nurses. Zimmerman asserted:

> We believe that nurses have a designation that is recognized, it is understood everywhere, that the practice of a nurse is not dependent on another professional. And therefore, to say that a nurse is an extender of a physician, or a physician extended, is incorrect, in terms of the independent license under which she practices, the accountability that she has for her practice, the accountability she has for patient care, and the fact that she carries her own malpractice insurance.[77]

Again, the AMA and the American Academy of Physician Assistants rebutted Zimmerman's claim. Representing the AMA, Edgar T. Beddingfield, a family physician from North Carolina, contended:

> As the role of the nurse begins to expand, and nurses begin to do things that were traditionally done by doctors, and for which a doctor is responsible, I believe the proper word is 'supervision,' and I would insist on that. I think that at that point, the nurse is, in fact, an extension of the responsible physician, whether she admits it or not, and he is the person – that is where the buck stops.[78]

The committee chair gave Zimmerman the last word. She argued:

> I believe here again that it is those roles that are overlapping. We do not believe the nurse practices medicine. She is not a doctor; she is a nurse. If there are areas of overlap between the two that is the area where the doctor and the nurse determine what that nurse is going to do in consultation with her, and what the patient's needs are.[79]

Though her arguments in both committees did not impact the ultimate legislation changes requested, Zimmerman's advocacy foreshadowed a changing nursing practice and profession that became more independent and supported by those in the medical profession, as seen today. Zimmerman believed the nurse to be – by her own right – a professional with a practice that augmented the practice of the physician. She also believed that nursing leaders held the same independent role in the leadership of nursing within organizations.

Zimmerman returned to Congress again to advocate for a greater empowerment of nurse leaders within organizations, in particular America's largest healthcare organization, the Veterans' Affairs (VA). On the 6th of February 1978 Zimmerman testified before the Senate's committee on VA arguing again for the separation of nursing and medical care. She surmised:

> Health care and medical care are not synonymous. No one group, we believe, should control the entire health care system. We urge that the nursing leadership

> within the VA be made a part of the top policymaking level structure, to be comparable for others at this level such as creating an Assistant Chief Medical Office for Nursing. Nursing care services are the single most pervasive influence on the quality of institutional care services. Therefore, nurses at the executive level who carry responsibility and administrative authority for nursing services must participate fully in VA administration policymaking.[80]

Zimmerman recognized the importance of nursing participating in the development of institutional policy within the VA, but stopped short of nursing defining its practice outside of medicine. Two years later in 1980 the VA elevated the VA nursing director to a new title of "deputy assistant chief medical officer for nursing programs."[81]

Zimmerman's advocacy for nurses extended beyond the borders of the United States in 1975 when she presented a paper on US nursing in Moscow at the USSR Medical Workers Union. In 1977, she led the ANA's first delegation to the People's Republic of China.[82] Zimmerman applied her nursing knowledge with a commitment to workers' rights to elevate the nursing profession and to improve collaboration with physicians and hospital executives. In recognition of this work, Zimmerman was selected as the first female President of the Conference of Medical Society Executives of Greater Chicago and led initiatives to promote the funding of nursing programs across the state of Illinois.[83]

Conclusion

Throughout the latter half of the twentieth century, the American healthcare system changed from community-based hospitals to large conglomerate health systems. The shift from private, charity-based hospitals to health systems focused on maximizing reimbursements from

the insurance companies. Government-issued programs impacted how nurses jockeyed for power and influence in the new health systems. Nurses like Sengelaub and Zimmerman forged new ways for nursing leadership and advocacy outside of the traditional superintendent or director of nursing roles. Sengelaub, aided by the power of the Catholic Church, led from within the Catholic hospital system through the CHA. She effectively led the creation of multiple Catholic health systems by joining individual hospitals together under a singular leadership structure with a Board of Trustees overseeing the venture. Alternatively, Zimmerman demonstrated a novel approach to nursing leadership outside of the hospital or health systems through collective bargaining. As hospital administrator roles wrested power from nursing leadership roles within hospitals, Zimmerman and the ANA provided nurses a way improve nursing working conditions and pay, as well as provide nurses with the resources to better care for patients.

Both Sengelaub and Zimmerman recognized the influence of the Medicare and Medicaid government issue insurance programs on hospitals. Both actively testified in Congress making cases in the support for a national health insurance program. Both testified in favor of empowering nursing's role in hospitals, especially in the preventive and maintenance care outside of hospitals to lower costs. Sengelaub and Zimmerman's persistent presence in Congress created a new responsibility for organizations, such as the CHA and ANA, to stay engaged in the national conversation. In some cases, nurses collaborated with the AMA on the need for a national health insurance program, but at other times they vehemently disagreed with the AMA on the role of the independent nurse practitioner caring for patients in rural areas.

Sengelaub and Zimmerman are examples of nurse leaders who effectively used the power from their organizations to influence positive changes in healthcare for nursing. By their example, nurses continued to use organizations, such as the ANA and CHA, to champion nurses'

role in healthcare and its leadership. However, nurses continued to struggle to gain power in hospitals. Even the CHA eventually turned over its association leadership to trained hospital administrators in 1979.[84] However, in 1991 the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) wrote into the required regulation for accreditation that a "nurse executive, or designee(s), participates with leaders from the governing body, management, medical staff, and clinical areas in developing the hospital's mission, strategic plans, budgets, resources allocation, operation plans, and policies."[85] Nursing had finally solidified and regained a place at the table as an executive in hospitals and health systems.

Chapter 4 Notes

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Chapter 5

Conclusion

The existing archival evidence on nurses managing hospital operations at local and national levels during the period 1891-1991 is significant and provides insight into how nursing leadership operated within today's modern hospital system. Nurses participated in the development of the modern hospital and health systems by serving in senior leadership positions throughout the late nineteenth and twentieth centuries. Their movement in to and out of leadership positions within the hospitals was significantly influenced by the historical context of the environment, people, and political climate at the time. But it was not until 1991, when the Joint Commission on the Accreditation of Healthcare Organizations mandated that nurse executives participate in the strategic planning and governing of hospitals thereby establishing nursing leadership as an influential and required entity in American hospital systems.[1] Once overlooked for their leadership expertise, the US government and health systems recognized nursing's place at strategic and operational decision-making table by the end of the twentieth century.

By examining the lives of nurse leaders Isabel Hampton Robb, Belva Overton, Sister Mary Maurita Sengelaub, and Anne Zimmerman there are three themes that emerge to answer the research questions posed at the beginning of this research: 1) How did nursing leadership in United States hospitals change from 1891 - 1991? 2) How did certain nurse leaders adapt to changes within the societal, political, and economic changes with in hospitals? 3) What strategies did nurses carry out to strengthen their leadership roles in hospitals?

The Systematic Suppression of Nursing Leadership in Hospitals

The first theme, answering the first research question is nurses - the majority of whom were women – were systematically suppressed in their roles as nurses and nurse leaders in hospitals. At the end of the nineteenth century, physicians were slow to welcome trained nurses into hospitals. After nurses became an established presence in hospitals physicians asserted their dominance in the hospitals by controlling decision-making, marginalizing nursing power, and demanding respect from the nurses working on the wards. As nursing leaders began to fill Superintendent positions to manage the hospital and the nurse training schools, some physicians felt threatened by nurses in positions of power and influence. The research demonstrates several examples of nurses who when accepting a leadership position in hospital would sustain verbal confrontations by physicians and, in some cases, the physicians worked to oust the nurse from the hospital leadership position. This is observed in Robb's new roles as superintendent at the Illinois School for Nurses in Chicago and also at The Johns Hopkins Hospital. Sengelaub also experienced this opposition in her first administrator role where the physicians actively worked to have her fired by appealing to the director of the Joint Commission on the Accreditation of Hospitals – as it was known in the 1950s – and her Mother Superior. Additionally, Zimmerman experienced this conflict with the American Medical Association when she testified before Congress arguing that nurse practitioners were not "physician extenders" but could function as independent practitioners in rural areas.

I argue that this behavior was driven by the preservation of professional dominance of physicians in hospitals. They worked to keep nursing role, especially leadership roles, suppressed within the hospitals. As sociologist Eliot Freidson describes, a hierarchy of institutional expertise uses the division of labor to set medicine apart from the duties of nursing

to marginalize their power in hospitals.[2] Crossing this division of labor into hospital leadership roles often became a source of conflict for nursing leaders and physicians. As nursing attempted to organize and professionalize in the early twentieth century, physicians did little to support or encourage their movement. As a result, nursing leadership cautiously grew as a nursing profession in an environment that nurses were expected to work as subordinates to dominant physicians. Physician dominance persisted in the hospitals well into the 1960s and beyond. The power of physicians marginalized nursing's role further by actively supporting the development of the hospital administrator role – primarily for men – in hospital leadership and governance.

Drawing upon the examples of Robb and Overton, nurse leaders understood the importance of developing a nursing community to provide support to the nursing profession in a physician dominant healthcare model. Both Robb and Overton established effective alumnae associations connected to their training schools. The alumnae associations created a community that promoted the professional nursing practice and promoted the ongoing opportunities in education. Alumnae associations for Black nurses provided an alternative to professional organizations as they were excluded from national associations such as the ANA during the Jim Crow era. Black associations, from Overton's Provident Hospital, provided Black nurses with employment and educational opportunities shared by other alumnae members.

Nurses resisted marginalization in the hospital through education beyond the diploma degree. In the example of Overton, Sengelaub, and Zimmerman each nurse leader pursued advance education beyond their nursing diploma. Particularly, Overton and Sengelaub, used education to help solidify their roles as nursing leaders in hospitals and health systems. Both Overton and Sengelaub enrolled in classes on a part-time basis to earn their degrees on top of

their job responsibilities. Leading by this example, they encouraged their peers also to continue in their education. Sengelaub reflected on the importance of higher education:

> [A Bachelor's degree] is becoming more and more an acceptable requirement particularly for those who have any kind of management / supervisory responsibility… The curriculum the college students receive gives them a foundation that helps them to become whole persons as they move through life.[3]

Nursing Leaders Adapted to Non-nurse Hospital Administrators

The second theme, addressing the second research question, is nursing leadership adapted to the hospital administrator role by focusing on nursing practice and education. In the late nineteenth century, wealthy women formed boards or visiting committees to patronize hospitals and improve the conditions for patients and the nurses working in the hospitals. In additionally, the women established training schools for nurses to help staff the hospitals. The women worked together to negotiate with hospitals and the ownership of nurse training schools to cajole the hospitals into meeting their requests to improve patient care. After the Great Depression however, hospitals could no longer rely on charitable contributions and began to maximize reimbursements from insurance companies.[4] This shift moved power and influence away from the wealthy society volunteers into the hands of administrators who made the hospitals into businesses focused on maximizing reimbursements from insurance programs.

Nurses began to be excluded from leadership consideration and eventually replaced as hospital administrators when the ACHA established the first hospital administration program at the University of Chicago in 1934. In 1927 Michael Davis received funding from the Rockefeller Foundation to study the role of the hospital administrator. Davis claimed that there was no

"systematic training for hospital administration… available in any educational institution."[5] However, as this research pointed out, Robb had already established a school for the training of Superintendents at Teachers College with her first course titled "Hospital Economics" established in 1900. This program grew into four different programs under the leadership of Nutting, one of which titled "General Administration in Training Schools and Hospitals.[6] The program was complete with not only didactic training, but also included visits to neighboring hospitals to learn about the negotiation of supplies costs, and management of housekeeping and facilities upkeep.[7] I argue that this program was indeed the first program designed to prepare leaders to operate hospitals as superintendents or administrators, not the University of Chicago's program established in 1934. Davis, however, dismisses the program at Teachers College in his 1927 report saying that the program was not "designed to train hospital administrators, but to assist nurse administrators of training schools to understand the relationship of the training school to hospital administration."[8]

This dismissal of nursing's work to establish training programs in hospital administration was purposeful and a tactic used by the ACHA to create a new profession in hospital administration separate from nursing. According to the research, no attempt was made to expand upon or strengthen the nursing hospital administration programs. Hospital administrator programs at this time typically only admitted men, with the exception of nuns – as evidenced by Sengelaub's enrollment in the Saint Louis University program. Nursing could not effectively resist the creation of the ACHA nor the loss of training of hospital administrators through nursing led programs.

As the hospital administrator role became accepted with strong physician support, nursing leaders were forced from hospital leadership positions and their roles shifted from

hospital operations into the education and training of nursing students. As nursing researchers validate Margarete Arndt and Barbara Bigelow describe, nurses were excluded from formal hospital leadership positions. Except initially in Catholic hospitals where nurses were gradually excluded from an equal seat at the operational and strategic leadership table in favor of a business leader in the administrator role.[9] The driver behind this shift was financially and professionally motivated. As charitable hospital funding decreased through the Great Depression greater focus on insurance reimbursement created the opportunity to actively move nurses out of leadership roles.

Nursing Leadership Regained Power in Hospitals Harnessing the Power of the Collective

The third theme, answering the final research question, is nurse leaders reasserted their influence in hospitals and healthcare systems by the latter half of the twentieth century through professional organizations, associations, and the use of collective bargaining. In Sengelaub's unique role as the first female Chief Operating Officer of the Catholic Hospital Association (CHA) she recognized the power of organizing and consolidating hospitals. By collectively organizing hospitals together as a system and speaking with one voice through the creation of health system members of CHA, Sengelaub uncovered a new source of power and influence within the CHA and its member hospitals and health systems. She stated that the creation of health systems "provides a natural opportunity for greater collaboration, cooperation, and sharing, as well as developing a new kind of interdependent responsibility and accountability in witnessing to Gospel values."[10] Sengelaub capitalized on this collaboration to help develop leaders within the CHA through a program called the Catholic Health Services Leadership Program that encouraged congregations across the country to join hospitals into health systems.

This created more efficient hospitals through the sharing of resources and a unified leadership structure across the CHA, many of whom were nuns who were trained as nurses.

Similarly, Zimmerman found that through the use of associations and the collective representation of nurses in state and national associations, nurses were once again able to effectively influence hospitals through collective bargaining. Zimmerman, while Executive Director of the Illinois Nurses Association (INA), utilized her role as an effective platform for creating changes in hospitals where nurses' voices had been suppressed. Zimmerman influenced hospital policies and nurses' wages by representing the issues of nurses across the state of Illinois through the use of collective bargaining and the threat of organized strikes. Within the hospitals at that time, nursing directors were paralyzed and were largely ineffective in driving nursing changes from within the hospitals. As Joel Seidman – Professor in industrial relations – writes, the nursing director role focused on the standards of nursing care. When state and national organizations pursued collective bargaining, the nursing directors were concerned their roles may be obscured if collective bargaining went beyond economic issues and into nursing care.[11] Spurred by leaders like Sengelaub and Zimmerman the nursing leadership paradigm shifted from nursing practice and standards of care to organizational influence through the effective use of associations.

In conclusion, nursing leadership has evolved since the 1890s and has taken different forms throughout nursing history for the sake of preserving the nursing profession against the headwinds of competing medical and hospital administrator professions. Through the examination of the professional lives of Isabel Hampton Robb, Belva Overton, Sister Mary Maurita Sengelaub, and Anne Zimmerman, the evidence demonstrates that nursing leaders

adapted to internal (hospitals and health systems) and external (insurance reimbursements) factors. Starting with the initial strong position of nursing in superintendent roles in hospitals, to their forcible removal from leadership roles, and later the reemergence of influential nursing leaders.

This research is significant for all healthcare leaders, and especially nursing leaders today. By learning from the struggles and successes of past nursing leaders, we not only appreciate the history of nursing leadership in today's healthcare systems, but can learn how nursing leaders can respond rapidly to changing healthcare problems by adapting and strategically influencing hospitals and the government lead change. Although opportunities are not universally consistent for nurses to attain positions of power beyond the nurse executive role, the twenty-first century has witnessed an increase in the number of nurse leaders in hospitals and health systems in the chief executive and chief operating officer positions.[12] With the increased presence of nursing in senior leadership roles nursing has the opportunity to continue to shape the future of healthcare. Understanding the history of nursing leadership will provides context to empower of nurses in the future to use their knowledge, skills, and abilities to move into senior hospital leadership roles to become effective advocates for nursing and the patients they serve.

Chapter 5 Notes

[1] Joint Commission on the Accreditation of Healthcare Organizations, *Accredication Manual for Hospitals*, vol. 1 (Chicago, 1990), 137.

[2] Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (Chicago: Aldine Publishing Company, 1970), 136-137.

[3] *Sister M. Maurita Sengelaub: An Oral History*, ed. Lewis E. Weeks, Hospital Administration Oral History Collection, (Chicago: American Hospital Association & Hospital Research and Educational Trust, 1986), 66-67.

[4] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore, MD: Johns Hopkins University Press, 1999), 310-316.

[5] Quoted from Michael M. Davis, *Hospital Administration: A Career* (New York, 1929), ii.

[6] Adelaide Nutting, "A Brief Account of the Course in Hospital Economics," *Teachers College Record* 11, no. 3 (1910): 182.

[7] *Proceedings of the Eighth Annual Convention of The American Society of Superintendents of Training Schools for Nurses*, (Harrisburg, 1902), 9-11.

[8] Davis also includes descriptions of five schools who taught hospital administration lead by nursing that was established after the Teachers College program. Quoted from Davis, *Hospital Administration: A Career*, 91.

[9] Margarete Ardnt and Barbara Bigelow, "Hospital Administration in the Early 1900s: Visions for the Future and the Reality of Daily Practice," *Journal of Healthcare Management* 52, no. 1 (2007): 34-47.

[10] Mary Maurita Sengelaub, "Catholic Health Care Systems: A Sign of the Times," *Hospital Progress* 59, no. 11 (1978): 53.

[11] Joel Seidman, "Nurses and Collective Bargaining," *Industrial and Labor Relations Review* 23, no. 3 (1970): 340-341.

[12] Kenneth R. White, "The Future of Nursing Leadership: A Commentary," *Frontiers of Health Services Management* 31, no. 2 (2014): 27-34.