

Chapter **2**

Looking Back: History and Decision-Making in Health Care

Sandra B. Lewenson

Nurses make decisions every day that affect the health of the individuals, families, communities, and populations they serve. They make decisions about the use of clinical interventions, the use of their political vote, the education of nurses, the application of new technologies, and a myriad of other issues as well—yet when nurses make decisions, they often use decision-making frameworks that do not take into account past practices. Nelson and Gordon (2004) write about the “rhetoric of rupture,” stating that nurses often discard and distance themselves from their past, leaving huge gaps in their knowledge. Nurses continually reinvent themselves and their practice at the expense of their history. Without understanding and valuing past contributions to practice or to society, nurses contribute to the “nursism” or bias toward the caring role that pervades this society (Lewenson, 1993). The omission of what nurses do on a day-to-day basis is a loss for both current and future generations of nurses and to others who might benefit from such knowledge.

In 1939, nurse historian Mary Roberts wrote that the “trends and events of today are the results of past experience as well as of varying conceptions of both present and future needs” (p. 1). Roberts recognized the need to examine the history of nursing to see how the profession could move forward. Another nurse historian, Teresa Christy (1978), explained how she could not “emphasize enough the relevance of an understanding of yesterday’s problems for illumination of today’s issues and concomitant potential for tomorrow’s solutions” (p. 5). More recently, historians Patricia D’Antonio and Julie Fairman (2010) wrote, “History provides a critically important perspective if we are to understand and address contemporary health system problems” (p. 113). The historical perspective and context of a particular issue can help in the decision-making of healthcare policies and nursing practice. D’Antonio and Fairman (2010) further explain that

... issues of quality and safety, for example, are not new: they led directly to the formation of training schools in hospitals throughout the country in the late 19th century as physicians needed what we have called in other work “educated allies” to maintain sepsis in surgical suites and on hospital wards. (p. 113)

And later Fairman and D’Antonio (2013) write, “historical influence can be subtle, difficult to extract, and contradictory, but its impact can be far-reaching and enduring” (p. 346). Regardless of whether nurses choose to use history in their decision-making process, history impacts their decisions. Keeling and Lewenson (2013) further note that history not only impacts decisions, but influences health policy, such as how society views issues addressing who should lead medical homes. Thus, as part of a reflective decision-making process, nurses need to know and value their history to make meaningful decisions about their current and future work. This chapter explores why history helps nurses in their decision-making process as well as briefly describes the history of decision-making in nursing.

Historical research provides a way of understanding the past and therefore provides a framework in which to study and apply history to decision-making. Although it is beyond the scope of this chapter to discuss the steps used in historical research, it identifies some of the historical studies that contribute to the evidence used in practice and professional growth. The case study opening this chapter illustrates how graduate nursing students use historical evidence to support the decision-making process in a community health clinical experience. The historical research presented later in this chapter offers examples of how history informs the decision-making efforts and thus enhances the leadership skills required by nurses when making decisions. The case study closing this chapter provides an illustration of how historical knowledge about nursing roles would help current nurses in their practice.

Case Study

A Community Assessment of the Lower East Side of New York City, 1893

What began as a study to look at the Lower East Side of New York City as Lillian Wald may have seen it when she established the Henry Street Settlement became an exciting exercise for contemporary students to explore how decisions were made. Nurses need to be able to assess a community and determine the types of services that would most benefit the community. To teach nurses how to assess a community, prioritize the community's primary health care needs, plan and develop an appropriate intervention, and examine the impact of their decisions, historical data were used. In this case study, graduate nursing students interested in community and the Henry Street Settlement in the Lower East Side of New York City joined in doing a historical community assessment as part of their requirement for a master's project. To complete this requirement, they examined the period of time in which the Henry Street Settlement house was first organized.

The Henry Street Settlement was started in 1893 by two public health nurses, Lillian Wald and her friend, Mary Brewster. Using the demographic data, photographs, and selected writings from 1893 enabled the current students to more fully understand what Wald and Brewster might have seen when they first established the nurses' settlement house on the Lower East Side of New York. The study helped students learn why Wald and Brewster opened a nurses' settlement house in the area, the kinds of healthcare issues they found, and the impact that their nursing decisions had on the health of that community. In addition, this project enabled students to look at the professional and healthcare issues over time and see how they compared with those of today. They used history to help them understand the role of the visiting nurse, the political activism that the nurses exhibited, and the obligation to society that nurses continue to maintain now in the twenty-first century. They also used their findings to help them make decisions about community health initiatives in the same community more than 100 years later.

Students studied the Lower East Side community, specifically the area designated as the seventh and tenth wards. In the late nineteenth century, New York City was divided into wards rather than the present-day census tracts, and data were therefore collected according to ward and sanitary districts. The students examined the demographics; morbidity and mortality rates; immigration patterns; police, fire, and sanitation support services; educational, religious, and social institutions in the community; and political and nursing issues of that period. Students identified the priority needs in the community and compared their ideas with the actual contributions of the

nurses at Henry Street. The students learned about the overcrowded living conditions that so many of the immigrants who populated the Lower East Side found in the tenements. In 1893 the total population in Manhattan (a borough of New York City in which the Lower East Side was a small section) totaled 1,758,000. About 1,332,773, or 69 percent of the total population, lived in the tenements of the Lower East Side. There were 180,359 children under the age of 5 (New York Board of Health, 1909).

The data showed that the residents of the Lower East Side came from Italy, Germany, Hungary, Russia, and other European countries. Once they arrived in the United States and moved to the Lower East Side, they found the tenements waiting for them. They experienced six-floor walk-up apartments, a lack of running water (this was prior to the cold-water flats that evolved following the inclusion of sinks in the tenements), outdoor plumbing until plumbing moved onto the hallway of each floor, as well as poor ventilation and poor lighting. Families, regardless of their size, resided in the two rooms that made up the apartments of the early tenements. Lack of privacy was just one of the many insults to the human condition that existed for those who lived in the tenements. The Tenement Museum in New York shows what life in the tenements was like, and students were able to access the museum's Web site (www.tenement.org) as well as personally visit this setting.

The inadequate housing conditions as well as the inhumane work conditions of so many of the immigrants contributed to the poor health conditions that they experienced. Some of the findings showed that infants accounted for 25 percent of all deaths in the community and that children under 5 accounted for 40 percent of all deaths in the community. The top causes of death in 1893 were pneumonia, phthis (pulmonary tuberculosis), digestive organ diseases, heart disease, and diphtheria. Infectious diseases were the cause of 42 percent of the deaths in this community, with pneumonia, phthis, diarrhea, and diphtheria leading the list of these illnesses (New York Board of Health, 1897, 1909).

Students learned that between 1892 and 1893 there was a 30 percent increase in suicide and that immigrants accounted for 80 percent of these suicides. They further examined how the social, economic, and political factors occurring around 1893 may have affected the suicide rates among the immigrant population. The financial depression of 1893 in the United States surely may have contributed to the increase in the number of suicides during this period. Students explored crime statistics and literacy rates, as well as houses of worship, social services, and other important areas of community support. They could visualize the effects of—or lack of—these supports by the outcomes they observed in the morbidity and mortality rates (New York Board of Health, 1897).

Students also read some of Wald's writings and began to learn about the programs that Wald and Brewster, along with the Henry Street nurses, brought to the community. The Henry Street visiting nurses, the students learned, lived at the settlement house and became neighbors of the families they served. They read about Wald's famous "baptism by fire": she met a young child who led her through the streets of the Lower East Side to visit her mother, who had been hemorrhaging for 2 days in bed after a difficult childbirth. Wald's graphic description provides a stark reality that allowed students to relate to the experience. Wald (1915) wrote:

Through Hester and Division streets we went to the end of Ludlow; past odorous fish-stands, for the streets were a marketplace, unregulated, unsupervised, unclean; past evil-smelling, uncovered garbage-cans; and—perhaps worst of all, where so many little children played. . . . The child led me on through a tenement hallway, across a court where open and unscreened closets were promiscuously used by men and women, up into a rear tenement, by slimy steps whose accumulated dirt was augmented that day by the mud of the streets, and finally into the sickroom. . . . Although the family of seven shared their two rooms with boarders . . . and although the sick woman lay on a wretched, unclean bed, soiled with a hemorrhage two days old, they were not degraded human beings . . . that morning's experience was a baptism of fire." (pp. 5–6)

Soon after Wald met the family of seven, she and her friend, Mary Brewster, began the Henry Street Settlement for the express purpose of improving the unhealthy living conditions they found in the community. Both nurses were social activists and strove to improve the life of the residents of the Lower East Side through political action and nursing interventions. Wald, especially, felt that nurses had the knowledge and skills to advocate political changes to improve the health of the families in the community. Wald (1900/1991) explained that

... among the many opportunities for civic and altruistic work pressing on all sides nurses having superior advantages in their practical training should not rest content with being only nurses, but should use their talents wherever possible in reform and civic movements. (p. 318)

Wald's belief that nurses were poised to advocate for change in the social, economic, and political conditions of the community in which they lived led to many of the reforms that contributed to the health of the citizens in the community. For example, Wald visited families in their home, providing access to nursing care; organized well-baby

classes for new mothers; advocated the first school nurse program in New York City, which placed a nurse in a city school; established a playground in the community, one of the first of its kind; and fostered an intellectual community of nurses who actively lobbied for social and political changes that supported the health of the citizens in the community.

Given the data that the students collected in their community assessment, they felt there was synergy between the programs that Wald established and the data they collected. Through the data, they witnessed the sights that Wald and Brewster saw as they made decisions to provide primary health care in the community. Students also saw the similarities between 1893 and the twenty-first century. What seemed to exist in 1893 continues to exist in a different (but similar) form. The inability to gain access to affordable care due to lack of sufficient funds or health insurance options, a rise in tuberculosis, women as primary caregivers, a close relationship between poverty and, large groups of immigrant populations, the need for social and political activism to support healthcare initiatives, and environmental factors affecting the health of children and adults in the community continue to be concerns in the same community in the twenty-first century. Students saw how public health nurses became leaders in health care because of the decisions they made. Although variations exist today on the particular environmental concerns, patterns of immigration, and political climate, what continues to be a constant is the need for nurses to make decisions about care and provide leadership in improving the health of individuals, families, and the communities they serve.

The students' use of history to learn about community assessments, community action, and nursing's role in political activism helped decide the kinds of health-promoting interventions they could use in their own community clinical experience. Understanding the history of Henry Street offers a way for students to see how decisions were made in the past and to value the remarkable outcomes that these decisions rendered in the nursing profession and the health of the community. They used some of the ideas of the past and introduced them with the ideas that they learned about primary health care in the twenty-first century. Teaching parenting skills, like Wald did in 1893, was one of the projects students initiated at Henry Street's abused women's shelter. Classes in parenting, nutrition, and other health promotion-type activities, which reflected the current thinking of the nursing students, continued the kinds of programming that the original public health nurses of the settlement house offered to the community. Students also saw the leadership displayed by Wald and other public health nurses in the late nineteenth and early twentieth centuries and how their activism continued to be a model for nurses today.

Nursing History Informs the Decision-Making Process

History provides a knowledge base that allows nurses to better understand their practice and profession. Knowing the evolution of nursing care, or the reasons why nurses for almost 100 years have debated the educational level into practice, or why each state requires separate licensing of nursing professionals affords nurses a way to understand the challenges that the profession has faced over time. Historical understanding allows for thoughtful decisions that facilitate innovation and change. Sometimes, however, tradition is mistaken for historical knowledge and, thus, confounds the decision-making process. Pape (2003) states that an organization's valuing of tradition may cause it to oppose changes in practice. Although tradition is part of history, understanding the origins of tradition through historical research allows a basis for comparison, critique, and ultimately decisions that allow for change. Historical research, rather than tradition, should be the key element used in providing evidence to support the decision-making efforts of nursing professionals.

Historical evidence provides depth, perspective, and context to issues nurses face today; as a result, the American Association for the History of Nursing (AAHN) supports the inclusion of nursing history in the curriculum. Keeling (2001) writes in an AAHN position paper that "nurses in the 21st century will need more than sheer information; they will need a greater sensitivity to contextual variables and ambiguity if they are to critically evaluate the information they receive." Nurses need the ability to study, understand, and value history. Integrating nursing history into nursing curricula at all levels is essential to help nurses identify their history; obtain the necessary skills to explore, study, and understand their history; and ultimately to use history in their decision-making process (Keeling, 2001; Lewenson, 2004).

Studying history provides nurses a conceptualization of the modern nursing movement from 1873 to the present day and affords continuity between the past and present. This continuity allows nurses to avoid the familiar adage: "Those who do not study history are doomed to repeat it." For nurses, not using history in the decision-making process may waste valuable time and resources in reinventing what was already previously discovered to work (or not work). Not using history also may deny the success of decisions made in nursing education, practice, research, or administration. Nurses need to know what worked and what did not work, and how they can seek the data to support decisions that need to be made by nurses. History is a valuable resource as a knowledge base and can be used as a form of evidence. The graduate students in the Henry Street case study "saw" the conditions the newly immigrated families experienced

in 1893 and some of the primary health care needs that Wald and her colleagues met. Without understanding the historical significance of the Lower East Side, the graduate students would miss the origins of some of the socially minded programs and ideology of the settlement houses that continue to exist in this area today. As students develop their historical knowledge, they are better able to situate some of the current issues being debated in the public arena, such as access to affordable care, into the decisions that are being made at the bedside as well as the national level.

Strumpf and Tomes (1993) examined the historical use of restraints in “troublesome patients” in the United States during the nineteenth century. They observed a difference between the common use of restraints in the United States versus the infrequent use of such devices in Great Britain. The cultural beliefs about the kind of care that these patients, including the mentally ill and the elderly, received differed historically in both countries and the outcomes of care varied as well. Strumpf and Tomes recognized the need to study history so that nurse administrators and nurses could examine their decisions about the use of restraints and gain a better understanding of why they continue to use them with the elderly when evidence does not support the use of these devices.

Contemporary observers often assume that this modern restraint crisis is a peculiar product of the late twentieth century, with its large population of aged and chronically ill, fiscal crisis, institutional overcrowding, and staff turnover. . . . Many of the contemporary dilemmas involving physical restraint can be traced back to an earlier “restraint crisis” that occurred during the middle of the nineteenth century. (Strumpf & Tomes, 1993, p. 4)

Like Strumpf and Tomes, historians search for reasons why things occurred and do so in the hope of informing contemporary issues that need thoughtful decisions. When nurses do a nursing assessment on a patient, they start with a nursing history. Nurses would not be able to appropriately assess their patients or develop plans of action without one. If that is the case, why would nursing leaders, educators, practitioners, researchers, and the like attempt to make decisions without getting the history first?

A Historical Look at Decision-Making in Nursing

In exploring the use of nursing history in decision-making, it is important to look at the history of decision-making in nursing, or when and how nurses made decisions. Questions arise such as whether nurses

actually made decisions overtly or just “downplayed” their own reasoning abilities to avoid alienating physicians if they assumed a more autonomous role. Did nurses always make decisions about care and about the profession? If so, what kinds of evidence did they use to make these decisions? How did they document these decisions? How did they take into account the lives of those they cared for, the political, social, or gendered roles that were prevalent at the time of study, or even now? Where was care situated—in the home, the office, or the hospital—and what did that mean for the care and the caregivers? How did nursing’s close ties with the women’s movement in the late 1800s and early 1900s affect the way nurses made decisions? Were nurses afraid of alienating politicians who could possibly help the nursing profession obtain nursing registration laws, as Lewenson (1993) suggests, or did they speak out in favor of women’s suffrage, regardless of how it affected these politicians? Did Wald and Brewster use the same available demographic data as in the case study about the Lower East Side when determining the need for healthcare programs in the community? Have nurses historically used “evidence” to support their practice? If so, what kind of evidence did they use and how did they find the evidence?

Nursing research, important to the decision-making process, evolved in the profession as nursing educators and leaders called for nurses to base their clinical decisions on empirical evidence. Nursing educator R. Louise McManus (1961) asked the question, “What is the place of nursing research—yesterday, today, and tomorrow?” (p. 76), and examined the evolution of nursing research. She understood the need to look at how research influenced the decisions of nursing leaders in order to plan for the future in nursing. McManus explained that nursing research—or the “methodological search for nursing knowledge”—differed from that of other professional groups because early studies focused more on nursing education and service rather than on practice. She reasoned that interest in nursing research differed from other professions because of the different “pressures upon the profession as a whole by social, political, and economic forces and the impact on nursing advances in scientific knowledge” (p. 76).

McManus (1961) highlights the early research efforts of Florence Nightingale, and the later studies of M. Adelaide Nutting, Isabel Stewart, and others who examined nursing education and the status of the profession. The studies, McManus said, usually were implemented by professional organizations, like the American Society of Superintendents of Training Schools for Nurses (which was renamed the National League of Nursing Education in 1912, and then the National League for Nursing in 1952), and as a result focused more on the issues related to education. Nurse educators, like Stewart, valued

research and participated in and led many such endeavors, such as her noted time-and-motion studies. Another noted nursing leader, Virginia Henderson, published early scientific studies such as the one McManus includes on “Medical and Surgical Asepsis” in 1939. Structure studies of how the professional organizations should look also were done and dramatically influenced the change in nursing organizations in the early 1950s.

McManus’s (1961) examination of history provides a view of the development of nursing research prior to the early 1960s that explains as well as raises questions about nursing’s interest in research and the subsequent culture of research. She noted that the way nursing organized around issues of practice and service as well as one of the first graduate educational programs for nurses situated in Teachers College, Columbia University (a college for teachers), was indicative of the kinds of studies and research of early nursing. McManus (1961) wrote that: “This happenstance of teachers pushing toward education and toward a teacher training institution for the first graduate programs may well have affected the course of nursing’s development considerably” (p. 79).

Many in nursing were interested in knowledge building to support decisions in nursing. In her 1934 article in the *American Journal of Nursing*, Sister M. Bernice Beck called for nurses to base their practice on scientific principles rather than on outdated models that supported a paternalistic hierarchy. Nurses, especially educators and administrators, needed to have a “scientific attitude,” which Beck described as being

... openminded, ready to learn the truth and accept it; observant, keen, clear-minded, cautious, alert, vigorous, original, and independent in thinking; she carefully weighs all the evidence and overlooks no factor which may influence the results; allows no personal preferences to influence decisions; holds only tentative scientific convictions, because aware that we have not yet arrived at the end of knowledge, but are constantly wresting more secrets from the hidden depths of Nature.” (p. 580)

The early move toward basing practice on nursing research required that nurses examine the way they carried out procedures and not just accept what they did without first examining the outcomes of their actions. Beck (1934) wrote that the teacher of nursing arts

... never insists that procedures, as taught, are the last word; that the unfounded statements of textbooks must be accepted without question, and that the ordering physician must be looked upon as an infallible authority. On the contrary, she urges her

students to find out why things are done as they are; whether there are not better ways of doing them; to challenge statements, to ask for proofs, to think for themselves, to make individual contributions. (p. 581)

Students were expected to learn to question and to make decisions based on the response to their questions. Decisions were not to be made by rote; rather they needed to be made using research data. In their noted text, *The Principles and Practice of Nursing*, Harmer and Henderson (1940) included a section on the “Professional Responsibilities in Relation to Method.” Nurses were to “accept the responsibility for studying its procedures and designing its method” (p. 469).

By the 1960s, educators like Francis Reiter (1966) advocated the use of basic sciences to govern the kind of care patients required and the use of rationale that directed the care she was providing. Reiter conceived of a master’s prepared nurse who would be competent in three areas, namely, “ranges of function, depth of understanding, and breadth of services” (p. 274). Being clinically competent meant that nurses worked in an interdisciplinary collaboration with physicians, and like the physicians would be able to make decisions about patient care within the realm of nursing. Fairman’s (2008) research on the development of nursing scholarship following World War II includes nurse educators like Reiter and others as they created clinical knowledge based on practice and research. As future generations of nursing scholars expanded on the ideas of these earlier educators, nursing decisions increasingly depended on research findings, rooting nursing practice within a scientifically oriented framework. Knowledge is contextual and contingent on the events of the day, and as such decisions nurses have made and will make must also be viewed within the context of the period in which they are made as well as the contingencies that affect these decisions.

In order to understand how decisions in nursing are made and the kinds of decision-making models or frameworks available, it is important to remember to place decisions within a context that looks at the particular period in which those decisions are made. The students in the case study presented earlier in this chapter examined the demographic data and the morbidity and mortality rates of the Lower East Side within the context of the late nineteenth-century United States. They explored the meaning of immigration within the social, political, and economic period of the day. In this way, they could compare and contrast the healthcare decisions that were made by nurses during that period with the more contemporary decisions made today in the same community. This may be beyond the scope of this chapter, but it is something to consider when looking at history and decision-making in nursing.

Historical Critiques Assist Decision-Making in Nursing

Historical research provides the data and the necessary critique that nurses require in their decision-making process. Historical evidence also provides a “sense of identity” and the tools to think critically when caring for others (Lewenson, 2013; Madsen, 2008, p. 525; Toman & Thifault, 2012). D’Antonio and Lewenson (2011) show how historical studies provide evidence for practice, earning “an important place in current practice” (p. xvi). For example, studies like the one by Arlene W. Keeling (2011) illustrate the work that nursing did during the 1918 influenza pandemic and has strong implications for nursing interventions today. Keeling’s work, “Treating Influenza 1918 and 2010: Recycled Interventions,” shows how strategies used in 1918 such as “advising patients to stay home, rest, and drink fluids until the flu subsided; to cover coughs and sneezes, to wash hands and to wear masks in public places” (p. 31) were not too different from the nursing interventions used today. Keeling (2011) wrote, “In fact, almost a century after the Great Flu of 1918, and despite major changes in medical and nursing therapeutics—including the availability of H1N1 vaccines and antiviral medications—much of the national and community response to the epidemic has been reminiscent of 1918” (p. 32). Keeling’s analysis provides current healthcare providers, nurses in particular, an opportunity to understand the interventions that were used, as well as how these strategies were implemented. History provides depth and breadth to the decisions that are being made today when flu-like epidemics threaten the health and well-being of society.

A study by Cynthia Connolly (2011), “Determining Children’s ‘Best Interests’ in the Midst of an Epidemic: A Cautionary Tale from History,” uses nurses and the preventorium, an early twentieth-century institution designed to prevent the emergence of active tuberculosis in poor children who had tested positive to the newly developed tuberculin test, as a case study with which to explore the way society responds to the care of children. Connolly used the Farmingdale Tuberculosis Preventorium for Children, opened in 1909, to illustrate the issues surrounding the care of children who were diagnosed as “pretubercular” by the newly developed tuberculin test. The tuberculin test spawned a public health movement that hoped to save children before any symptoms of the disease appeared. An outcome of this public health initiative was the preventoria that opened throughout the United States. Children, typically from poor homes, who received this pretubercular diagnosis were removed from their homes and placed within one of these institutions. The preventoria, primarily run by nurses, were designed to reduce the

progression of the dreaded disease. It was believed that poor children needed not only the kinds of interventions available at the time, such as light, good food, and rest, but also, as Connolly (2011) points out, “exposure to the social conditions and moral climate of the wealthier classes, treatment that was to be supplied through the institution’s nurses” (p. 24). Connolly’s analysis reflects on the care that these nurses provided, the interdisciplinary nature of their work with other healthcare providers who also shared the same goal in preventing tuberculosis, and the influence they had on healthcare policy and vice versa. Her study considers the tension among medical advances, the rights of the public, and the rights of families and children. The response to the epidemic was determined not only by the advances in science, but also by the ethnically, racially, and class-based bias that existed and influenced policies and the enactment of those policies. Connolly’s research offers nurses and other healthcare providers insights into the kinds of decisions that are being made as we address other kinds of epidemics in children today, such as obesity. What decisions are being made and what the reasoning is behind these decisions must be considered. Nursing leaders can use Connolly’s research to explore issues about the strategies being used in the care of children today, specifically poorer children.

Rima Apple’s (2011) study, “To Avoid Expense and Suffering: Public Health Nurses and the Struggle for Health Services,” opens with a description of a recent program called the Nurse-Family Partnership Program that provides evidence-based care to new mothers considered high risk. These women are assigned a nurse who makes home visits for a 2-year period starting prior to the birth of the infant. Apple compares the description of this program to one that existed 70 years prior in Wisconsin, called the Wisconsin Bureau of Maternal and Child Health (MCH). In a description of this earlier program, the director wrote that a public health nurse could visit expectant mothers and infants, provide health education in the homes of these families, and by doing so, improve the health of these mothers and infants. Although 70 years may have separated these two organizations, they shared a similar goal. The MCH, however, had even greater goals than simply providing care—it also advocated for local governmental support of a public health program that sent nurses into the homes of this population.

Apple’s study explored the essential role that nurses have played and continue to play in public health initiatives such as this one, especially in rural America. In this study, Apple looks at the high infant and maternal mortality rates in the early twentieth century and their effect on the health of the nation. Families living in rural settings, in particular, needed access to health care and health education programs. Although some programs were available in rural Wisconsin, such as the

Well-Child Trailers in the 1920s, limitations to this care existed, such as lack of continuity of care, lack of access to medical care, and lack of understanding of what the conditions in the home were like. As a result, the MCH staff argued the case for a public health nurse to be assigned to each county of the state in order to provide the care that was needed to the families in those counties.

Apple (2011) used a case study of Barron County, Wisconsin, during the 1930s and the work of two MCH demonstration nurses to show the “complicated role that demonstration nurses played to effect the establishment and maintenance of a critical public health initiative” (p. 177). The Bureau of Public Health sent Louise Steffen, a nurse from Milwaukee who earned a certificate in public health nursing from Marquette University in Milwaukee, to become Barron County’s first district MCH demonstration nurse in 1940. Apple studied Steffen’s description of her work and the frustrations she encountered when dealing with the conditions she found in this rural county. Travel for her, like for the mothers she visited, was made difficult by the long distances on poor roads that existed between physicians, healthcare centers, and patients’ homes. A heavy workload, unhelpful physicians, and inaccessible roads created challenges for Steffen as she continued to develop the role of public health nurse in the county in hopes of convincing the county to hire a full-time public health nurse, one of the aims of the demonstration project that sent her to this area. Her frustration with the difficult conditions as well as her inability to sway the county officials led to repeated negative votes by the county’s legislators. Budgetary conditions were cited as one of the reasons for not funding a public health nurse, and Steffen’s repeated efforts, although well-received by some in the community, were not viewed as reason for the county to spend its money on the services they received for free from the demonstration project that would be in effect for another year. Steffen left her position ahead of schedule in 1941, leaving the MCH demonstration position open until it was filled in January 1943 by another demonstration nurse, Hazel A. Nordley.

Apple described the differences that Nordley brought to the position. Whereas Steffen came from a large city, Nordley came from another more rural area in Wisconsin that perhaps made her more aware of those living in rural areas. Nordley’s reports to the board reflected similar problems as Steffen’s, but described the work with more detail and used a more positive tone when she wrote about the need, convincing the board of the need for public health nursing. In 1943 the Barron County board of legislators finally voted to support a position for a county nurse who would provide nursing services not just to children, but to all the families in the county. Apple (2011) wrote that there may have been several reasons for this change of heart (although she notes that the historical evidence is unclear or missing),

including a change in the economy; the war effort, which depleted the county of physicians and nurses; the differences between the two demonstration nurses; and maybe “the board members had finally come to realize that modern medicine, particularly public health, offered much to the county” (p. 187). What is clear about the history of this particular story in Barron County is that nurses played a pivotal role in the implementation of public health initiatives and continue to do so today.

Using Apple’s work to understand the kinds of decisions that needed to be made and should be made in relation to health care is important for us today. As nurse leaders make decisions about health care and how they can influence local and national legislators of the need for healthcare initiatives, historical studies such as the one completed by Apple offer perspective, context, and possible explanations for why and how decisions are made.

Other examples of historical research, such as the one published by Julie Fairman (2011), “The Visit: Nurse Practitioners and the Negotiation of Practice,” examine the context in which the nurse practitioner establishes a relationship with patients and the space in which this relationship exists. Fairman’s work builds on her larger study of the history of nurse practitioners and gives us insight into the many factors that influence the visit and what that means to the care provided. Fairman (2011) writes, “the clinical practice, then, is shaped by more than functional and technical tasks, but also by the partnership created through individual and personal interactions during the visit” (p. 189). The visit becomes even more complicated by other factors, including the “context of health care, the place of practice, and complexities of payment” (Fairman, 2011, p. 189). Negotiation between the physician and the nurse practitioner also impacts the visit and the relationships established during that visit with the patient. Fairman examines the visit in the context of the 1970s when early nurse practitioners were first establishing the relationships with physicians and both professions were struggling to maintain both professional authority and identity.

Another study by Helen Zuelzer (2011) examines pressure ulcers, a concern for healthcare providers that has lasted well over a century. Zuelzer studies the nursing interventions required to care for what were once called bedsores in, “‘An Obstinate and Sometimes Gangrenous Sore’: Prevention and Nursing Care of Bedsores, 1900 to 1940s.” Zuelzer asks us to consider the new federal legislation that will hold acute care settings accountable if patients develop pressure ulcers, and traces the history of the kind of care that had been used and places it within the context of practice, lending perspective to the debate about the cause and care of this alteration in health. The chapter opens with the late actor Christopher Reeve’s story about his traumatic

injury after a fall off a horse and his struggles with living with a severe spinal cord injury. Zuelzer (2011) writes that when Reeve was interviewed he spoke about his care, his full-time staff, and the equipment to assist in his care, and that he was privileged to be able to afford this kind of care. Reeve also spoke about the many pressure ulcers he had, even with the extraordinary care he received. And even with this care, Zuelzer continued, Reeve died from an infection from a pressure ulcer.

Zuelzer examines the history of how nurses treated these bedsores, assessed them, and wrote about them in nursing texts, and they remain a persistent problem today. Zuelzer wrote, “descriptions of pressure injury, sites of injury and sources of injury pressure, friction, and shear, facilitated by moisture, remain remarkably unchanged” (p. 57). The debate about whether they can be avoided remains as well. Decisions nurses make today about interventions, such as care of pressure ulcers, have broad implications in terms of political, social, and economic factors. Historical evidence, hereto, offers us a better understanding of the kinds of care that nurses and other healthcare providers can offer and contributes to the leadership providing direction and making decisions about that care.

History as Evidence

Historical studies such as those facilitated by Keeling (2011), Connolly (2011), Apple (2011), Fairman (2011), and Zuelzer (2011) provide today’s nurses with data of what was done in the past. They uncover the history of working nurses and make connections between then and now. Contemporary nurses struggle with decisions about advanced practice, nurse practice acts, federal legislation affecting Medicaid and Medicare reimbursement, epidemics, rural health care, and collaborating partnerships with physicians that would all benefit from the knowledge that these histories presented. Uncovering the history and analyzing its meaning contextualized by political, gender, ethnic, or racial factors informs not only the practice, but also the education and research and thus affects nursing outcomes today and in the future. Today’s professionals can learn from the wisdom, knowledge, mistakes, and vision of those earlier nurses.

A number of years ago when I was an instructor in a community health course on the Lower East Side in New York City, one of the students, who was a registered nurse returning to school for a baccalaureate degree in nursing, was visiting a “client” of the Henry Street Settlement Home Health Care agency in the home. The student professionally worked as a cardiac care nurse and was proficient in providing high-level care using the latest technology in cardiac care. However, when she entered this client’s home during the community

clinical rotation, she said she was shocked at the odor emanating from the client's feet and had difficulty knowing what her responsibilities were in this case. She wanted to know what could be done for this client, because there were no medical orders and she felt she could not do anything without them.

The goal of the community experience at the Henry Street Settlement (where the visiting nursing service had separated from the agency in 1944) was to visit clients who received homemaking services in the home. Students were expected to develop a nursing plan of care after completing a nursing assessment of the client, reviewing the client's concerns and the homemaker's concerns, and completing an assessment of the home and community resources. When I visited the client's home with the student nurse and saw the caked-on dirt and smelled the odor from the feet, I asked the homemaker to prepare a basin of warm water so that we could soak the client's feet. We instituted a nursing intervention, bathing of the feet, so that we could further assess the skin color, the temperature, and the integrity of the skin. As we bathed the feet, the student spoke with the client and began to build trust with him and develop a rapport with the homemaker. Following the simple "nursing" procedure, the student patted the feet dry, continued to assess the feet, and began to teach the client about proper foot care.

The student said on the walk back to Henry Street that although she could operate efficiently in the hospital setting, the home-care setting created new challenges to her perceived role of the nurse. She was unaware of what visiting nurses did or had done in the past. She lacked historical perspective that might have assisted her in understanding this middle ground where nurses provide nursing care autonomously. The autonomous role that she was learning in the community clinical experience had ties with earlier nurses in the same community. Yet not knowing the past creates challenges for her and all nurses who make decisions in their practice.

History provides today's nurses with an "overarching conceptual framework that allows us to more fully understand the disparate meaning of nursing and the different experiences of nurses" (D'Antonio, 2003, p. 1). Lynaugh and Reverby (1987) said that history "provides us with the tools to examine the full range of human existence and to assess the constraints under which decisions are made" (p. 4). Without understanding nursing history, decisions are at risk of failing and repeating past errors. History provides a way of knowing and understanding what has gone on before, what is happening now, and what may be expected in the future. Fairman (2012) stated in a paper presented at the International Nursing History Conference, *Nursing History in a Global Perspective* that, "Modern nursing is a practice profession and a scientific discipline, and history is critical

to its identity, cultural meaning, and relevance. . . . History provides meaning, and this meaning is infused into any area that we might want to study” (p. 8). If all knowledge has a historical dimension, then nurses need to take this dimension into account whenever a decision is made. All decisions, regardless of the decision-making approach that nurses may use, must include a historical dimension in the matrix. Like the case studies presented and the historical research identified, nurses can learn by understanding the past and using this understanding to support the kinds of decisions that they make today.

History is alive, and the search for answers in history is useful for solving present difficulties, directing behavior, and accomplishing the objectives of the nursing profession. When the answers are found, it is not the end. It is the beginning (Austin, 1978, p. viii).

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