Introduction

CHAPTER 1

Nursing's History of Advocacy and Action

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Overview

The American Nurses Association (ANA) reminds nurses of the social contract between nurses and the public that "reflects the profession's long-standing core values and ethics, which provide grounding for health care in society" (American Nurses Association [ANA], 2010, p. 10). The ANA *Social Policy Statement* has articulated nursing's social obligation since it was first published in 1980. Nurses turn to this document to understand how nursing fulfills this obligation by providing ethical and culturally competent care to individuals, families, communities, and populations. It also helps nurses explain their role to the larger society, to new members of the profession, and to nurses already working in the field.

This chapter explores political advocacy in light of nursing's role and responsibility to advocate and act on behalf of those for whom they have contracted to provide care. The first section of the chapter explains why nurses need to know history to be effective advocates and why knowing history matters to advocacy. It provides historical exemplars to highlight how history informs the profession as it continues to invoke the social contract that nursing maintains with society. The second part of the chapter examines a more contemporary look at nursing's political advocacy efforts and what it means for nurses, the profession, and the health of the public at large.

Objectives

- Discuss why nursing history is relevant to health policy and nursing advocacy and action.
- Explore historical exemplars that provide evidence of nursing's ability to advocate for individuals, families, communities, and populations.
- Analyze nursing's role in how political advocacy impacts nurses, the profession, and the health of the public at large.

Nurses as Advocates

Although society reportedly trusts nurses to work toward accomplishing the goals set forth for them by the profession (ANA, 2010), nurses may not be grounded in how they reached these the "long-standing core values" that the nursing profession developed over time. As nurses advocate for their patients—whether seen as individuals, families, communities, or populations—an understanding of nursing's enduring and longstanding values that are rooted in its history provide depth and breadth to their efforts. To this end, it is important to know nursing's historical role in assuring access to care; it is important to know nursing's contributions toward patient quality and safety measures; it is important to know how nursing interventions changed over time in response to the context in which they practiced; and it is important to know how nurses and the profession adapted to shifts in the social, political, economic, and cultural environment (D'Antonio & Lewenson, 2011).

Why Study Nursing History?

Historian and nurse educator Ellen Baer and colleagues respond to the question of why nursing history should be studied:

> Just as a nurse can make little progress caring for or curing a patient's presenting problem without knowing the patient's physiological, psychological, and cultural history so is it for a nurse trying to make sense out of the persistent problems and possibilities in nursing and health care. To make good decisions in planning nursing's future in the context of our complex health-care system, nurses must know the history of the actions being considered, the identities and points of view of the major players, and all the states that are at risk. These are the lessons of history. (Baer, D'Antonio, Rinker, Lynaugh, 2001, p. 7)

Some lessons from the past that support the understanding of political advocacy and action can be learned by examining how Florence Nightingale influenced the development of nursing education programs that started in 1873 and led to what became known as the Modern Nursing Movement. It began with the first three Nightingale training schools: the Bellevue Training School for Nurses in New York City; the Boston Training School for Nurses at Massachusetts General in Boston; and the Connecticut Training School in New Haven, Connecticut. Following the opening of these three schools, hospitals around the country recognized the value that student nurses bring to the hospital because care could be provided at relatively low cost and the hospital would have no obligation to hire the nurses when they graduated. Nurses, after their training was complete, would need to find work elsewhere, typically in private duty or in the emerging field of public health nursing.

Twenty years after the opening of these schools of nursing, early nursing leaders recognized the need to organize nurses to control the quality of practice and training as a way to protect the public. Between 1893 and 1912 four professional nursing organizations formed to do just that: the National League for Nurses that formed in 1893 (originally called the American Society of Superintendents of Training Schools for Nurses); the American Nurses Association that started in 1896 (originally named the Nurses' Associated Alumnae of the United States and Canada); the National

Association of Colored Graduate Nurses that formed to address racial bias in nursing and health care and was in existence between 1908 and 1952; and finally, in 1912, the National Organization of Public Health Nursing formed to control practice and educational standards during the rising movement of public health and public health nursing in the United States. This organization ended in 1952 when the National League for Nursing assumed the role of this organization (Lewenson, 1993).

Even before women in the United States gained the vote in 1920, nurses sought legislation that would define nursing practice, and they advocated for the protection of the public by prohibiting anyone who was not professionally trained from calling him- or herself a nurse. This required convincing lawmakers, at that time only men, to support nursing legislation; the nurses knew they could not vote into law the early nurse practice acts. While nurses struggled for statewide nursing registration, they had to "fight battles against long hours of work and opposition to nursing education" (Lewenson, 1993, p. 171). To accomplish their goals, some nurses, either individually or through the early nursing organizations, began to support the work of the suffragist movement and aligned themselves with the larger women's movement of the early 1900s. Individual nursing leaders, like public health pioneer Lillian Wald and nursing suffragist Lavinia Dock, advocated for healthcare reforms in the community and in the legislative arena. The professional organizations that formed during this period did so to protect the public from uneducated nurses and to develop standards for nursing education and practice.

Although an in-depth history of this time period is beyond the scope of this chapter, it is important for nurses to understand that political advocacy was part of the profession's early identity. Political advocacy and action in nursing is not new or innovative. Nurses have always been political advocates for those in their care (Lewenson, 2012). As a result, the early efforts made by nurses and their professional organizations provide a narrative and insight into today's advocacy efforts where protection of the public means assuring a level of education for all nurses, the development of quality and safety standards, and the ability of nurses to practice to the fullest extent of their education, as recommended by an Institute of Medicine report (2010).

History Counts

Fairman and D'Antonio (2013) wrote, "history counts in health policy debates" (p. 346). Bringing a historical perspective to discussions about health care deepens our understanding of the issues by recognizing the evolution of ideas across time. In the debate about control of the "newly" minted medical homes of today, understanding the roles of early public health nurses in providing primary healthcare services to individuals, families, communities, and populations in both urban and rural settings can trigger some useful ideas or solutions about what to call the new entity, who should finance it, and who should lead it (Keeling & Lewenson, 2013).

The current debate centered on medical homes provides such an example. The term was first coined in the 1960s and defined a medical model of care for chronically ill pediatric patients that looked at control issues, inter- and intradisciplinary issues of providing care, and the financial aspects of care. Physicians led the earlier medical home movement that has evolved to mean "a model of primary care that is accessible, continuous, comprehensive,

family-centered, coordinated, compassionate and culturally effective" ("Making Medical Homes Work," 2008, as cited in Keeling & Lewenson, 2013, p. 360). Nurses use the words that define the medical home of today to describe nursing's work of providing accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and cultural effective care. Knowing the history of nursing serves to highlight the profession's strong contribution to health care in the United States.

Advocacy and Public Health Nursing

Exploring some of the public health initiatives that Wald established—the Henry Street Settlement and the American Red Cross Town & County—offer excellent examples of how nursing, history, and political advocacy and action intersect. By studying the work of those nurses and nursing leaders within these settings we not only learn about the role nurses played in primary health care (as described by Keeling and Lewenson, 2013), we can also learn about the healthcare advocacy that public health nurses sought for those individuals, families, and communities. The next section uses these two early 20th century public health initiatives as examples of political advocacy by public health nurses.

Advocacy at Henry Street

Lillian Wald graduated from nurses' training in 1891 from the 2-year diploma-based program at New York Hospital in New York City. Within 2 years of graduating, she and her school friend Mary Brewster recognized the overwhelming healthcare needs of immigrant families living in the overcrowded and unclean conditions of the tenement houses on the Lower East Side of New York City. Filled with a sense of social obligation to improve the health of society, Wald and Brewster began the Henry Street Settlement and found support for the venture from philanthropists and other nursing leaders. Wald's work expanded from just nine public health nurses working in one settlement house that was established in 1893 to more than 250 nurses working throughout the New York City area in at least seven different locations (Buhler-Wilkerson, 2001; Keeling, 2007; Lewenson, 1993).

While caring for the families, Wald clearly saw a close relationship between the health of the public and civil responsibility. In a speech she delivered in 1900 at the sixth annual meeting of the American Society of Superintendents of Training Schools for Nurses, Wald said 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" (Wald, 1900, as cited in Birnbach & Lewenson, 1991, p. 318). In keeping with her beliefs, Wald and her colleagues at Henry Street introduced several legislative initiatives that would improve the health of children, such as the introduction of nurses in public schools (Wald, 1915). Wald (1915) described how she advocated for hiring nurses in the local public schools to decrease truancy rates because children were sent home due to illness and lack of treatment. As of 1897, physicians had only recently been hired by the New York City Department of Health to assess children in school. Doctors sent children home from school when any contagious illnesses were found. However, this did not address some of the pressing health issues because the

physicians did not provide treatment for conditions such as trachoma, a contagious eye infection, that plagued school-age children at the time. Wald (1915) wrote about her experience of convincing legislators of the value of assigning public health nurses in the schools in her book *The House on Henry Street*.

In 1902, when a reform administration came into power, the medical staff was reduced and the physicians' salary was increased to $100 per month, and they were expected to work only 3 hours per day. The health commissioner ordered an examination of all public school pupils and was horrified to learn of the prevalence of trachoma. Thousands of children were sent away from school because of this infection. Where medical inspections were the most thorough, the classrooms were empty. It was ironic that Wald watched the children who had been turned away from school playing with the children they had been sent home to protect. Few children received treatment, and it followed that truancy was encouraged:

> The time had come when it seemed right to urge the addition of the nurse's service to that of the doctor. My colleagues and I offered to show that with her assistance few children would lose their valuable school time and that it would be possible to bring under treatment those who needed it . . . I exacted a promise from several of the city officials that if the experiment were successful they would use their influence to have the nurse, like the doctor, paid from public funds. Four schools from which there had been the greatest number of exclusions for medical causes were selected, and an experienced nurse, who possessed tact and initiative, was chosen from the settlement staff to make the demonstration . . . Many of the children needed only disinfectant treatment of the eyes, collodion applied to ringworm, or instruction as to cleanliness, and such were returned at once to the class with a minimum loss of precious school time. Where more serious conditions existed the nurse called at the home. Wald, 1915 (pp. 51–52)

Within 1 month the experiment was deemed successful and an "enlightened Board of Estimate and Apportionment voted $30,000 for the employment of trained nurses, the first municipalized school nurses in the world" (Wald, 1915, p. 53).

Advocacy in the Town & Country

Wald's advocacy extended to families living in rural settings. One of the most compelling examples is the establishment of the American Red Cross Rural Nursing Service (later known as the Town & Country). As Keeling and Lewenson wrote (2013), this organization "served as the point of contact for families in rural communities where remoteness, isolation, and fewer physicians and nurses created barriers to care" (p. 362). Wald believed that the American Red Cross—already organized to provide nursing services during wartime and natural or manmade disasters—was the right vehicle in which to organize public health nursing services throughout the country during peacetime (Dock, Pickett, Clement, Fox, & Van Meter, 1922; Keeling & Lewenson, 2013). Through Wald's influence, philanthropists supported the implementation of this new rural public health nursing service. During the first year criteria were established for nurses who would collaborate with community leaders,

physicians, and families to provide both curative and preventive health care in rural settings. The requirements to become a rural public health nurse were far reaching and included pragmatic skills. Nurses were expected to ride a bicycle or a horse, or drive a car, so they could access their patients.

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More importantly, and often difficult to find, were nurses who had an education that prepared them to negotiate and collaborate with others in the community. Typical nurses' training programs did not provide these skills. It was determined that a minimum of a 4-month education was needed to prepare nurses to work independently in communities across America (American Red Cross Rural Nursing Service, 1912–1914). Educational programs were established, like the one established at Teachers College in New York, in conjunction with the Henry Street Settlement and the rural District Nursing Service of Northern Westchester soon after the American Red Cross Rural Nursing Service formed. By 1914 the new public health nurse curriculum offered courses in sociology, municipal and rural sanitation, and experiences in rural and urban public health settings. These courses were valuable for nurses who practiced in rural settings because they did not have the same support systems as urban areas.

Wald's advocacy extended to the use of media to show the public what a rural public health nurse could do and to garner support for the initiative. While she was at the third meeting of the American Red Cross Committee on Rural Nursing—the committee established by the American Red Cross in 1912 to develop the criteria for the Town & Country—Wald suggested that the committee "get in touch with the Publication Syndicate, and Rural Nursing written up possible [*sic*] in story form for the Ladies' Home Journal and other popular magazines" (Minutes of the Third Meeting, 1913, p. 2). At the same meeting, it was noted that Wald and others supported establishing a relationship with the Metropolitan Life Insurance Company and the Steel Corporation whereby the Rural Nursing Service would "undertake nursing for these large concerns" ("Minutes of the Third Meeting," 1913, p. 4). Many of the communities in question were rural mining communities that required public health nursing services. The committee believed this relationship would be beneficial in many ways, including possibly raising the standards of other nursing associations and economically supporting the cost of nursing supervision in these locations.

Advocacy took many forms that ranged from sitting on national committees to seeing that care was provided at local levels. The work of the public health nurse was framed by the needs of the community, the kinds of public healthcare organizations that were organized, and the geographical location. Each Red Cross rural nurse chapter—whether in the mountains of New Hampshire, in Kentucky, or in the West—directed the kinds of work that public health nurses would do, including bedside care for frostbite, well-baby clinics, school nursing, industrial nursing, classes in home hygiene

and care of the sick, advocacy on town boards, and educational and publicity efforts about her work (Fox, 1921). Sometimes there was only one public health nurse in an area. At other times there were other public health nurses to share a district. Sometimes a nurse faced barriers by communities that were uncomfortable with outsiders offering care. Yet the success of these American Red Cross Town & Country nurses relied on the ability to recruit and retain those who could handle the challenges of rural settings. This concern remained a constant and enduring problem throughout the life-span of the American Red Cross Town & Country.

History and Political Advocacy

Political advocacy requires the depth and breadth of an evolving historical narrative to inform contemporary debates in health care, to reflect the variety of perspectives that history can bring to the debate, and to offer a "way to think about the future" (Fairman & D'Antonio, 2013, p. 346). The work of the nurses at Henry Street Settlement and the American Red Cross Town & Country are two examples that can stimulate discussions about healthcare reform today. Readers are encouraged to explore the many historical studies being completed and the early writings of nurses that can be found in nursing journals, such as the *American Journal of Nursing*. This journal has digitalized its entire collection from 1900 to the present, allowing readers to easily access articles online and explore nursing advocacy over time. The American Association for the History of Nursing (AAHN) (www.aahn.org) also provides information and resources for where one can go to find nursing archives, learn more about historical methods, and attend the association's annual meeting where the latest in historical research is presented. The AAHN also publishes a well-respected journal, *Nursing History Review*, where readers can find outstanding historical research by leading historians. There are also many archival centers around the country, such as the Barbara Bates Center for the Study of Nursing History at the University of Pennsylvania and the Eleanor Crowder Bjoring Center for Nursing Historical Inquiry at the University of Virginia. Centers such as these provide a wealth of archival data and support for those interested in historical research. The websites for these centers and other resources are available on the AAHN website.

Nursing's Political Advocacy and Action

The next part of this chapter moves from the historical to the contemporary and further explores the meaning of advocacy and action, as well as what that means for nurses, the profession, and the health of the public. Today nurses must be politically active in professional nursing practice and health policy issues like the nurse reformers and activists before them. Nursing's historical roots in meaningful advocacy and action has shaped the profession's political astuteness and action to keep pace with professional regulatory, statutory, and legal changes in education, practice, and research. The profession must remain nimble and responsive to policy changes by promoting and protecting the well-being of the population and nurses themselves. To effectively manage the emerging needs of populations and the profession, every nurse must be engaged in the advocacy process. The American Nurses Association suggests that high-quality nursing practice includes advocacy as an essential aspect of

patient care (ANA, n.d.). Advocacy is considered both a philosophical principle of the profession and a part of ethical nursing practice that assures the rights and safety of the patient are protected and safeguarded. Advocacy is the one professional construct that demonstrates a complex interaction among nurses, patients, professional colleagues, and the public (Selanders & Crane, 2012).

To become engaged in advocacy, nurses must be informed about policy and how to influence nursing, health, and public policy at local, regional, national, and global levels. This engagement requires sound evidence and a political strategy that allows for increased understanding of the potential impact of linking the nursing work force with the globalization of health care, the implementation of the Patient Protection and Affordable Care Act (PPACA), and the ongoing disparities in health care and health outcomes. The demands for increased access and better healthcare outcomes will require nursing to widen its influence in policy areas that address the health and healthcare needs of underserved and minority populations (Villarruel, Bigelow, & Alvarez, 2014).

As political advocates, nurses are uniquely positioned to lead system change to improve care for patients and families, influence the implementation of the PPACA, and conduct a political environmental scan. As leaders, administrators, educators, and researchers, nurses have demonstrated the ability to manage complex processes and related data analytics around disparities, health outcomes, quality, and costs. The next section of this chapter discusses how nurses will continue to amplify their voices and advocate to meet the changing landscape of health care.

Nursing Strong

Professional nursing care is essential to the healthcare system. Of the more than 3.1 million registered nurses (RNs), approximately 84.7% are employed in nursing (62.2% in hospitals), making registered nursing the largest healthcare profession (ANA, n.d.). As such, nurses must advocate by bringing problems to the government and seek decisions in the form of programs, laws, regulations, or other official responses that create new innovations and care models to transform delivery and advance the nation's health.

To begin, nursing must advocate for changes within the profession. To successfully advance health care, the nursing profession must make significant strides to change the composition of the future work force. This will require greater efforts toward the successful recruitment of underrepresented minority groups into nursing. Phillips & Malone (2014) report that nurses from minority backgrounds represent 16.8% of the RN work force. The 2008 National Sample Survey of Registered Nurses showed that the RN work force is composed of 5.4% African American, 3.6% Hispanic, 5.8% Asian/Native Hawaiian, 0.3% American Indian/Native Alaskan, and 1.7% multiracial (U.S. Department of Health and Human Services, 2010). The work force is involved in the policy process and gives nurses ample opportunity to create a culturally and linguistically diverse care environment.

A diverse healthcare work force increases both minority participation in the health professions and the cultural competency of all patients. A U.S. Department of Health and Human Services report (2006) shows that increased diversity among healthcare professionals leads to improved patient satisfaction,

improved patient–nurse communication, and improved access to care for racial and ethnic minority patients who are best served by providers who are knowledgeable about their backgrounds and cultures. The intersecting goals of increasing work force diversity, ensuring fair and equal access to quality health care and healthcare resources, eliminating health disparities, and achieving health equity is where nursing's political advocacy and action will have its greatest impact.

Achieving health equity for all requires a collective effort across all disciplines and all sectors, including those outside nursing. Therefore, nurses must align themselves with other healthcare professionals to address health disparities and health equity, specifically within the context of the social determinants of health. As an interprofessional healthcare team, all professionals must "draw upon their moral responsibility to respond to human suffering and become acknowledged participants in the nation's efforts to correct health disparity" (Harrison & Falco, 2005, p. 261).

To promote the health of the public, nurses must work to eliminate the overuse, underuse, and misuse of services and resources (Orszag, 2008). Reducing healthcare spending is seen as one of the greatest challenges in health care. In 2011, U.S. healthcare spending grew 3.9% to reach $2.7 trillion, marking the third consecutive year of relatively slow growth. Growth in national healthcare spending closely tracked growth in nominal gross domestic product (GDP) in 2010 and 2011, and health spending as a share of GDP remained stable from 2009 through 2011 at 17.9% (Hartman, Martin, Benson, & Catlin, 2013). To address care gaps and avoid service duplication, the PPACA has invoked care coordination to improve the public's health.

With the provisions of the PPACA focused on improving the quality of patient-centered care and controlling costs within and across settings, nurses need to understand and interpret this legislation and health policy. By being able to interpret healthcare reform from a nursing perspective, nurses can determine how to best distribute resources to individuals, families, and populations. The law stimulates payment and delivery reforms that are highly relevant to nurses, particularly those working in primary care and ambulatory settings.

Nurses play a vital role in creating opportunities for better health, better health care, and lower costs through improvement. For example, chronic conditions such as diabetes, arthritis, hypertension, and kidney disease account for 7 of 10 deaths among Americans each year, and they account for 75% of the nation's healthcare spending (Conway, Goodrich, Macklin, Sasse, & Cohen, 2011). The obesity epidemic and growing levels of preventable diseases and chronic conditions greatly contribute to the high costs of health care. Additionally, an aging population has placed increasing demands to address the cost of care at the end of life in a cost-effective manner (Rice & Betcher, 2010). By understanding the burdens of caring for individuals with chronic conditions and the economic realities that are needed to control costs while achieving value in health care, nurses are using care coordination models as an integrative service. These models use case managers, health information technology, and other strategies to manage care delivery and support services for patients. Care coordination has been reported to have significant outcomes in high-risk populations and in patients with chronic conditions to reduce treatment costs and repeated hospitalizations.

Discussion Questions

1. How does history inform nursing's efforts to provide primary health care?
2. What is the relevance of nursing's history to political advocacy today?
3. Describe the role of advocacy within the history of nursing's development in the United States.

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