PART 1

Professional Roles for the Advanced Practice Nurse

In Part 1 of this book, we will consider the role of the advanced practice nurse from historical, present-day, and future perspectives. This content is intended to serve as a general introduction to select issues in professional role development for the advanced practice of nursing. As students progress in the educational process and develop greater knowledge and expertise, role issues and role transition should be integrated throughout the entire program.

In Chapter 1, Wolf presents a brief history of nursing and its progress toward professional practice. Although not specific to the role of the advanced practice nurse, the information presented in this chapter will assist the advanced practice nurse to gain a broader perspective on nursing and healthcare organizations and their future. This discussion lays the foundation for a deeper understanding of the historical development, current practice, and future opportunities for advanced practice in nursing.

In Chapter 2, Pulcini defines advanced practice nursing from a traditional perspective and traces the history of the roles. Traditionally, and as discussed by Pulcini, advanced practice has been limited to clinical roles and includes the clinical nurse specialist, nurse practitioner, certified nurse–midwife, and certified registered nurse anesthetist; the last three roles require a license beyond the basic RN license to practice. This book, however, uses an expanded definition of the advanced practice nursing that reflects current thinking. As you read this chapter, keep in mind this expanded definition and at the same time appreciate the development of the advanced clinical roles for nursing practice.

Since Pulcini's work in 2004, much has transpired related to the role and education of nurses for advanced practice. Most revolutionary is the mandate to have the clinical doctorate as the requirement for advanced clinical practice nursing by 2015 (American Association of Colleges of

Nursing, 2007). With this change, many master's programs for advanced practice nurses will transition to the doctoral level. The rationale for this position by the American Association of Colleges of Nursing (AACN) was based on several factors:

- The reality that current master's degree programs often require credit loads equivalent to doctoral degrees in other healthcare professions
- The changing complexity of the healthcare environment
- The need for the highest level of scientific knowledge and practice expertise to assure high-quality patient outcomes

In an effort to clarify the standards, titling, and outcomes of clinical doctorates, the Commission on Collegiate Nursing Education (CCNE)—the accreditation arm of AACN—has decided that only practice doctoral degrees awarding a doctorate of nursing practice (DNP) will be eligible for accreditation. In addition, the AACN has published *The Essentials of Doctoral Education for Advanced Nursing Practice,* which sets forth the standards for the development, implementation and program outcomes for DNP programs.

Needless to say, this recommendation has not been fully supported by the entire profession. For instance, the American Organization of Nurse Executives (AONE, 2007) does not support requiring a doctorate for managerial or executive practice based on expense, time commitment, and the cost benefit of the degree. It also suggests nurses may migrate toward a master's degree in business, social sciences, and public health in lieu of nursing. Further, AONE suggests there is a lack of evidence to support the need for doctoral education across all aspects of the care continuum. In contrast, doctoral and master's education for nurse managers and executives is encouraged.

For other advanced practice roles, including those of the clinical nurse leader, nurse educator, and nurse researcher, a different set of educational requirements exists. The clinical nurse leader as a generalist will remain as a master's program. For nurse educators, the position of AACN, although not universally accepted within the profession (as demonstrated by the existence of master's programs in nursing education), is that didactic knowledge and practical experience in pedagogy is additive to advanced clinical knowledge. Nurse researchers will continue to be prepared in PhD programs. Thus there will only be two doctoral programs in nursing, the DNP and the PhD. It will be important for readers to keep abreast of this movement as the profession further develops and debates this issue for implications for their own practice and professional development and within their own specialty. The best resource for this is the AACN website and the websites of specialty organizations.

The last three chapters of Part 1 discuss the future of advanced practice nursing and the evolution of doctoral education—in particular, the practice doctorate. Within today's rapidly changing and complex healthcare environment, members of the nursing profession are challenging themselves to expand the role of advanced practice nursing to include highly skilled practitioners, leaders, educators, researchers, and policymakers.

In Chapter 3, Carter reviews the historical development of doctoral programs, which provides important background information regarding how the profession has arrived at the aforementioned decisions. Of particular note is his discussion of the controversy surrounding the development of the clinical doctoral programs. Carter traces the roots of the PhD for research and clinical doctorate for practice. As doctorates in nursing developed in the latter part of the last century, the emerging diversity in titling and role expectations called for clarity and direction for the profession.

In Chapter 4, Chism defines the DNP degree and compares and contrasts the research doctorate and the practice doctorate. The focus

of the DNP degree is expertise in clinical practice. Additional foci include the *Essentials of Doctoral Education for Advanced Nursing Practice* as outlined by the AACN (2007), which include leadership, health policy and advocacy, and information technology. Role transitions for advanced practice nurses prepared at the doctoral level will call for an integration of roles focused on the provision of high-quality, patient-centered care.

Lastly, in Chapter 5, the authors discuss emerging roles of DNP graduates as nurse educators, nurse executives, and nurse entrepreneurs, along with advanced practice nurses' increased involvement in public health programming and integrative and complementary health modalities.

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CHAPTER 1

The Slow March to Professional Practice

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CHAPTER OBJECTIVES

1. Define professionalism.
2. Discuss the development of nursing as a profession over the last century.
3. Consider future trends in nursing that have the potential to positively affect the profession of nursing.

INTRODUCTION

Nursing's quest for professionalism has shaped nursing education and practice, past and present, in the United States and abroad. The emergence of professional practice models over the past quarter century represents the latest in professionalizing trends. This effort by nurses and healthcare managers to restructure the workplace and nursing work highlights the evolution of nursing from a simple matter of tasks to the complexity of knowledge-based practice in rapidly changing healthcare organizations. The current healthcare environment is faced with a wide range of regulatory and financial pressures. These include demands to justify healthcare service outcomes, the drive to maintain biomedical and technological currency, and a recurrent nursing shortage. Looking back through nursing history, one can see that crises in the healthcare system create opportunities for nursing. Too often, nursing's responses to crises have not created outcomes that serve both the interests of the profession and the public. Today, as nurses once again find themselves in the midst of a crisis, there is an opportunity to renegotiate the organizational realities of health care and to advance the contribution of professional nursing to healthcare outcomes.

NURSING AS A PROFESSION: KEY IDEAS FOR INTEGRATION

What makes work professional work? Nursing has struggled with this question throughout its history. For most of the 20th century, nursing was considered a semiprofession or a profession in progress by sociologists (Bucher & Strauss, 1961; Etzioni, 1969). The attention that nursing leaders have given to professional development is manifest in the push for control over educational standards, efforts to develop a theory base for nursing practice, the growth of professional organizations and journals, and, more recently, the reorganization of nursing work within professional nursing practice models. The nature of professional nursing work differs today from what it did for the sacred three professions of medicine, law, and the clergy in 1900. The autonomous solo professional serving the public with expert knowledge and skill is now a rare phenomenon. Few occupations can claim pure professional autonomy, because the reach of corporate and institutional control now dominates most sectors of the economy.

Autonomy, a hallmark of professionalism, can be differentiated into autonomy of decision making relative to the client and/or patient care and autonomy from the employing institution (Manthey, 1991). Autonomous practitioners are those who have direct lines of access to clients, who are responsible for their own practice decisions, and who are accountable to clients, peers, and professional organizations, as well as to the courts, for their conduct (Marram, Schlegel, & Bevis, 1974). The nursing profession has struggled with the idea of autonomy because most nurses are employed and subordinated to the authority of organizations such as hospitals (Ashley, 1976; Reverby, 1987; Wolf, 1993). The claim to autonomy with regard to the freedom to make decisions about patient care has advanced over the past few decades, fueled by the development of primary nursing models (Hegyvary, 1982). More recently, health services research studies have integrated the concept of nursing autonomy. For example, a recent study by Aiken, Clarke, Sloane, Sochalski, and Silber (2002) suggested that increasing nursing autonomy and control over the practice setting was associated with improved patient care outcomes.

Nursing can no longer be viewed as a subsidiary function of medicine that is proscribed by doctors' orders; nursing care now reflects a patient-centered approach based on nursing theory and shaped by a nursing process of reasoning. Current legal and professional regulations legitimate this nurse-driven process of practice. The body of statutory and case law that governs nursing practice holds nurses accountable to a definition of practice that recognizes and codifies practice in accordance with current nursing knowledge and clinical practice standards. Accountability is inherent to autonomy. By definition, accountability calls for professionals to accept responsibility or to account for their actions (*Merriam-Webster's Collegiate Dictionary,* 2006). The demand for professional accountability has been spurred on by the health-outcomes movement and patient safety concerns.

Professionalism should and does benefit the public. However, professionalism also arises out of self-interest and provides a means by which occupational groups exert influence to advance their own interests in society. The interest may reflect a desire for greater societal power and/or an increase of rewards or benefits for the group. As such, the quest for professional status by nursing reflects an attempt to access and achieve mobility. Professionalism, by reflecting the underlying meritocratic values of our society, offers a rational system for distributing status and rewards.

Professionalization provides access to social mobility. According to Hughes (1971), there are two types of mobility. The first is the rise of the individual by entering an occupation of high prestige or by achieving special success in

his or her profession. The second is the collective effort of an organized occupation to improve its place and increase its power in relation to other occupational groups. In the case of nursing, mobility has traditionally been measured against or referenced to other groups, such as physicians.

Since the 1970s, interest in professionalizing nursing work has emerged in healthcare organizations as a means to provide a substitute motivation for workers with blocked access to structures of mobility. The ideological draw of professionalism is that it offers the promise of higher status and control. A crucial issue that arises out of the trend to professionalize work is the struggle of workers, including nurses, to exercise control over the context (environment) and content of their work. The ability to exercise control, however tentative, appears to mediate individual and collective tensions that arise from the heightened expectations of a more educated nursing workforce. By professionalizing the workplace, management seeks to counter more traditional collective action, such as unionism. Educated to be professionals in colleges and universities, nurses now expect to exercise their knowledge and skills without organizational or bureaucratic constraint. The heightened expectations of nurses represent a double-edged sword, offering a challenge to traditional hierarchical controls and opportunity for institutional enhancement.

As hospitals and other healthcare institutions confront the increasing complexity in health care, the application of professional knowledge and skills becomes essential to institutional functioning. That professional knowledge and skills serve institutional goals to solve institutional problems is now embraced by healthcare administrators as an asset, rather than a threat to traditional authority. Perrow (1972) observed in his classic treatise on bureaucracy that professionals, far from antithetical to institutional bureaucracy, are in fact readily harnessed to serve the needs and problems of organizations. Nurses have historically highlighted this phenomenon. More recently, other traditional professions (physicians, lawyers) have become organizational professions. Yet, despite nurses' central role in healthcare services, they have struggled to develop, assert, and be recognized for their professional expertise. Imbued with managerialism, nursing work in hospitals has evidenced a professional paradox (Fourcher & Howard, 1981). The application of nursing knowledge and skill in managing patient care in hospitals has a long history of being subjugated to nursing and hospital administration. Nursing expertise has more often than not been invisible and undervalued, and autonomy of practice has been absent.

ROOTS OF NURSING CONTRADICTIONS

The concept and actual practice of nursing work has evolved dramatically over the past 100 years. But like many evolutionary paths, old or outdated conceptions of nursing persist. As a result, both popular and professional conceptions of nursing are riddled with contradictory views. Prior to Florence Nightingale's reforms in England, nursing was largely women's work. Nursing was viewed as an extension of motherhood, midwifery, or religious duty. By the late 19th century, women working as nurses began to fill a role in the administration of poverty. Because health care and nursing care of the sick were intertwined with poverty, caring for the sick was largely caring for the poor. Nursing was commonly carried out by impoverished women who worked as nurses in almshouses caring for the poor, the sick, and the destitute. These untrained, able-bodied paupers worked for room and board. The harsh reality was that these nurses were viewed as part of the chaotic environments in which they worked. The Dickinsonian image of Sairey Gamp, a low-class drunkard and disheveled woman, was reflective of the persistent stigma that Nightingale

sought to escape with the formal education of a higher class of women (Dean & Bolton, 1980; Williams, 1980).

Although some few nurses saw their work as a religious service, the role of religious values waned with the disintegration of church-based nursing orders with the rise of Protestantism in England. Hospitals, lacking the support of religious nursing orders, struggled to provide nursing care that was haphazard at best. Nurses lacked a systematic set of skills, a knowledge base, or training. Nightingale sought to modernize nursing by developing a trained nursing labor force composed of a higher class of women.

Nightingale also sought to link nursing education with the more formalized development of hospitals. Influenced by her experiences in the Crimea, Nightingale recognized that nursing care was the major determinant of hospital outcomes. A brilliant and politically astute woman, she took on nursing reformation with a passion born of her religious beliefs and desire to reform social expectations for women. Nightingale advanced her case for training nurses based on data. Nightingale contributed some of the earliest biostatistical data of hospital conditions and outcomes, drawing connections between the environments of care and the contribution of nurses (Dossey, 1999).

Despite Nightingale's innovative ideas to systematize the education of nurses, the origins of modern nursing were seeded with social constraints. Nightingale (1866) wrote to a friend that "the whole reform in nursing both at home and abroad has consisted of this: to take all power over the nursing out of the hands of men and put into the hands of one female trained head and making her responsible for everything. . ." (p. 25). Nightingale and her contemporaries purposely overlooked the traditions of men in nursing, such as the work of the Knights Templar (Bullough & Bullough, 1984). The concept of nursing discipline projected by Nightingale, as well as by nursing leaders in the 20th century, held nursing to conventional standards of female subservience within a hierarchy of a moral female authority. Nursing was embraced as a feminine endeavor that was to be the singular focus of the nurse's life. Imbued with inherent religious values, nursing was viewed as a selfless act, and the reward for nursing work was deemed intrinsic to the work itself. Nightingale, although a feminist and supporter of women's suffrage, struggled with contradictions of class and gender as she advanced her campaigns for nursing and health. Despite Nightingale's political opinions, modern nursing was reconceptualized as a woman's calling, and hence doubly subordinated to the paternalism of society.

NURSING TAKES ROOT IN THE UNITED STATES

The universal traditions and nursing functions of caring for the sick have existed for centuries. The power of Nightingale's reforms to formalize and reshape nursing has been evident in their global reach. In the United States, as in many other countries, the importation of the Nightingale schools of nursing legitimated nursing work as an occupation for women. Hospital-based schools of nursing offered women access to education and the potential for employment, creating an option for a sustainable livelihood. Employment as a head nurse or private duty nurse was a welcome alternative to agrarian domesticity or mill work.

The demand for nursing grew in response to hospital growth. As industrialization spurred the growth of larger communities, hospitals proliferated and became a central feature of community life (Rosenberg, 1989). Social reformism was a major force because it spurred the development of both public health and hospital-based services to provide health care to the growing industrial labor force (Rosenberg, 1989; Starr, 1982). From 1875 to 1924, the number of hospitals grew from just over 170 to

more than 7,000 (Rosner, 1989). However, as noted by Stevens (1989), the central role that health care would take in American society was being shaped by the growing power of medicine. A benevolent paternalism pervaded the structure of healthcare services and harnessed the potential of nursing to support the role of medicine and hospitals (Ashley, 1976). By the early 1900s, the growth of hospitals in the United States generated an unprecedented demand for nurses. The growth of technology from basic advances such as X-rays and anesthesia fueled excitement in hospital investment. Physicians invested their money and technology into hospitals, securing power in their communities as well. Hospitals became a focal point of community life, and hospitals became both a symbol of the prosperity of a community and a focus for social reformism.

The thirst for a cheap and rapidly produced labor supply overshadowed concerns over standards of quality education. From 1900 to 1920, the nursing profession grew "from one in which there were more than 10 times as many physicians as nurses, to one in which there was less than one physician for every nurse" (Burgess, 1928, p. 43). As hospitals grew, schools of nursing were created to provide a labor force for the hospitals, often at the expense of adequate education (Ashley, 1976). As Dock and Stewart (1938) noted in their history of nursing, "the excess of poor schools and poorly prepared nurses was attributed in large measure to the apprenticeship system that prevailed, with its overemphasis on practice service at the expense of education" (p. 183). Formal studies of nursing education, such as the Goldmark report (1923) and the grading committee report of the National League for Nursing Education (1926), addressed the issue of raising standards for nursing education. Dock and Stewart (1938) suggested that despite the many recommendations for reform, "the system was too deeply rooted and the funds for putting nursing schools on a sound economic and education basis were simply not generally available" (p. 183). Despite forward movement with the establishment of university schools of nursing at Columbia, Yale, and Western Reserve, the push to establish college entrance as a requirement for practice was eclipsed by the hospital training schools. The fundamental professional goal to control the entry into the profession was overridden by hospitals' needs for a cheap labor supply.

The rapid expansion of a nursing labor force occurred with little regard for educational quality. Hospital administrators recognized the economic benefit of using student labor, and physicians began to appreciate the good nursing care offered by graduates of such training. But by the 1930s, concerns about overproduction of nurses emerged and were underscored by the Great Depression. A third of all hospital schools of nursing closed between 1929 and 1939. Nurses, no longer able to secure private duty work, sought employment in hospital wards for hourly or group nursing work. But as Reverby (1979) noted, hospitals were slow to hire graduates as staff nurses, despite admonishments by the nursing leaders and the American Nurses Association. Modified grouped private duty nursing efforts served as a transition to the development to staff nursing. The dire economic conditions of the Depression reshaped nursing work and healthcare services. Nursing shifted away from private freelance work to organized nursing services in hospitals and public health. As nursing became embedded in hospitals, the primacy of the nurse–patient relationship—a characteristic of private duty nursing—eroded, and the nurse became subordinated to the paternalism of the hospital (Ashley, 1976; Dock & Stewart, 1938).

THE CHANGING ORGANIZATION OF WORK

The organizational culture of hospitals, characterized by strong gender-based roles and a hierarchical authority structure, was fertile ground

for the application of industrial management methods. The ideas of scientific management made an easy leap from factory floor to hospitals in the first half of the 20th century. Frederick Taylor, the architect of many scientific management ideas, was of a new breed of industrial engineers. His primary concerns were enhancing worker productivity and limiting the threats of unions so as to increase the profits from capitalism. Scientific methods were intended to extract labor from workers at the shop-floor level by dividing work into discrete tasks to be done by individual workers. "Taylorism" spread to hospitals and was embraced by nursing leaders, and the quest for efficiency in hospital operations mirrored the factory push toward mechanistic functioning. The application of Taylor's scientific management methods to hospitals included division of labor, the task orientation of functional nursing, and standardized and proscriptive procedure manuals. Hospitals were in a unique position to maximize the control and the execution of nursing work, because they were often both the diploma schools for training nurses and the employer. The hospital culture was able to secure the loyalty of nurses through both school ties and training (Wolf, 1993).

Management in hospitals emerged largely at the ward level. Mobility in nursing became tied to the management structure. Nursing leadership embraced managerialism, because it offered the potential for mobility and status recognition for women. Subordinated to physicians, nurses were unable to gain control over access to patients, use of technology, or application of knowledge. Nursing leader Isabel Stewart attempted to advance scientific nursing, which she thought could be employed in conjunction with industrial methods for standardization and efficiency of hospital care to wrest control from hospitals. However, her academic approach to building a scientific basis for practice was viewed skeptically by nurses and never gained sufficient financial support (Reverby, 1987). Nurses continued to follow orders under a system where work conception was clearly separate from execution.

That the adage "a nurse is a nurse is a nurse" was born in this period reflects the view that nurses were considered an interchangeable part of the hospital machine. Although many nurses preferred to work as private duty nurses, the changing economics of the Great Depression made this an unstable option by the 1930s (Reverby, 1999). As a result of application of scientific management methods to nursing, patient care became fragmented, task oriented, and management focused. Case-based nursing, rooted in the tradition of private duty nursing, fell victim to what was viewed as progress. New models of care, such as group nursing and functional nursing, reflected the pooling of scarce nursing labor resources to meet the needs of the organization, not the patient.

Following World War II, team nursing became the common model of nursing care organization. The team nursing concept was influenced by wartime experiences and the emerging human relations school of management. The goal was to create a team of nursing care providers led by a professional nurse. Emphasis was placed on effective communication and delegation to enhance team functioning. However, nursing shortages often resulted in team leaders struggling to provide care with inadequately trained staff. The result of the team approach was more a functional approach to care, with emphasis on task completion rather than patient care (Hegyvary, 1982). Because of tradition and nursing shortages, remnants of mechanistic task performance continued to permeate the work culture of hospitals and counter professionalization attempts.

Nursing leader Lydia Hall, a fierce opponent of team nursing, challenged nursing to put its rhetoric of professionalism to the test of practice. In 1963, she instituted a system of professional nursing practice at the Loeb Center, Montefiore Medical Center, in New York City. The Loeb model of care emphasized nursing autonomy and accountability, giving the nurse

responsibility for providing care and making care decisions for his or her patients during the full duration of their hospital stay (Hall, 1969). Her visionary efforts planted ideas for change; however, few hospitals adopted her model.

INSTABILITY IN THE NURSING LABOR FORCE

Despite the emphasis on efficiency and rationality in hospital management, the nursing labor force continued to be wracked by instability. Recurrent nursing shortages during the 1940s and 1960s led to the policies that increased the production of more nurses—short-training nurses in particular. These nursing shortages set the pattern for subsequent policy initiatives dominated by hospital interests (Grando, 1998). Hospital administrators and nursing leaders first encouraged licensed practical nurses and then associate degree nurses. In the midst of the shortages, attempts to fill nursing positions were like filling a leaking bucket. Nurses were clearly unhappy with work conditions and compensation. Shortages of nurses left team nurse leaders working alone as captains of understaffed nursing teams. While hospital nursing administrators struggled with the outflow of nurses, nursing educators struggled with the quest to professionalize nursing. The development of nursing knowledge and skills took on renewed urgency at mid-century. Nursing scholars such as Virginia Henderson (1966) sought to reclaim the primacy of the nurse–patient relationship and expand the focus of nursing care beyond efficiency to a process-oriented effectiveness.

The post–World War II period led to increased federal funding for nursing and health care. Along with the funding came a new closer scrutiny of hospital costs. As the federal government became more involved with funding hospital care, the drive to disentangle educational costs from nursing care costs took force.

By the late 1960s, funding of nursing education began to move away from the hospital training schools to colleges and universities. Early doctoral programs developed as hybrid degrees, between nursing and fields such as education, sociology, psychology, and biology. These graduate programs had as their primary focus the development of a pool of nursing educators. But within a few years, collegiate nursing education institutions expanded programs in nursing administration and clinical specialization. Graduate education became the primary incubator for nursing theory and the growth of professional knowledge and values.

By the 1970s, a culture of professionalism emerged in nursing, fueled by the growth of nursing scholarship. This resulted in a gap between nurses' expectations and the experiential reality of nursing work. This gap, or reality shock (Kramer, 1974), was evidenced by the rapid turnover in staff nursing and nurses' growing discontent. Despite the move to a more efficient hospital functioning, the nursing labor force continued to be wracked by instability. Once again, nursing shortages led to the increased production of nurses, in particular short-training nurses. Hospital administrators and nursing leaders encouraged the addition of associate degree nurse production as a solution.

Nursing education, long tied to hospitals through the tradition of hospital diploma schools, began to break free in the 1960s. The federal government took up more of the financial burden for nursing education. But as nursing education moved into colleges, the trade-off was the loss of nurses' loyalty to hospitals, a central characteristic of hospital-diploma-school nurses. While hospital administrators struggled with the outflow of nurses, the growth of college-based programs at the baccalaureate and associate degree levels infused nursing with a new drive for professional status. As the development of nursing knowledge and skills took on more status and legitimacy, the predominance of nursing management as the primary means of career mobility came to an end (Wolf, 1993).

MILITANCY ROCKS THE HOSPITAL BOAT

Discontent with the reality of nursing work reflected the changing values and expectations of nurses. With rising expectations of professionalism, nurses' desires for control over their work were influenced by the new social realities of women's employment. Nursing was no longer viewed as a transient occupation for women to keep them busy until they married. The growing careerism sharpened nurses' lenses to workplace realities. Turnover rates in hospitals reflected the discontent with working conditions and benefits. Nurses, college educated and empowered by the emerging women's movement, were no longer willing to bow to the paternalism of hospital administrators.

At various points in nursing history, nurses had discussed or attempted the use of collective action or unionism. The rate of nurses organizing for collective bargaining began to increase in the 1960s, but it was not until 1974, with the addition of amendments to the federal Taft-Hartley Act, that the potential impact of collective bargaining was realized (Foley, 1993). These amendments provided federal protection to nurses and other healthcare employees of nonprofit healthcare institutions with regard to the right to organize. The operational structure of the amendments emphasized that nurses were to be a separate and distinct bargaining unit.

The potential of the nursing labor force to be a catalyst for the unionization of the entire hospital labor force was clearly recognized by hospital administrators and union busting consultants. This, in turn, resulted in the idea of requiring hospital employees to organize into separate bargaining groups. Nurses were courted initially by professional nursing organizations, such as the ANA-affiliated state nursing organizations. Within a few years, more traditional industrial and trade unions, such as the United Auto Workers (UAW) and the American Federation of Teachers (AFT) joined efforts to organize nurses and other healthcare workers. The ANA-associated state nursing organizations were viewed as the lesser of two evils because the professionalism inherent in the nursing leadership tempered the militancy.

Hospital administrators explored a variety of means to fight the spread of hospital unionism (Kohles, 1994). Treating various types of hospital workers as contract workers was common, but this approach was neither cost- nor outcome-effective for nursing. Another approach was to create a new work culture and structure that would divide nurses from other hospital employees. This served a double purpose. First, it helped to insulate other hospital workers from nursing collective action. Second, it held the potential to curb the militancy. To effectively bridge the reality gap that had led to nurse militancy, nursing and hospital administrators needed to realistically grapple with the roots of nurses' frustration. The long-standing paternalism was no longer an effective means of controlling nurses.

NURSING IS NOT ALONE: THE NATIONAL CRISIS IN THE QUALITY OF WORK LIFE

By the late 1970s, professionalism, long viewed as an unnecessary extravagance, was to become a mantra for nursing management. The growing belief that creating a more professional work climate could mitigate the potential for workplace militancy shaped efforts to restructure nursing work in hospitals. As hospital administrators and nursing grappled with what was perceived to be an issue of militancy versus professionalization, the issue was reflected in broader discussions of an emerging national crisis in workplace relations. Nationally, as concerns over decreases in worker productivity grew, labor experts debated the origins and solutions to worker discontent across a wide range of occupations and professions. The U.S. Department of Health, Education, and Welfare (1973) funded a study—"Work in America"—that asked the question, "What do workers want?" The

study yielded the following answers: interesting work, enough help and equipment to get the job done, enough information to get the job done, enough authority to get the job done, good pay, opportunities to develop special abilities, job security, and the ability to see the results of one's work. National labor and management experts debated innovations such as worker control programs and work restructuring. However, the long-standing dominance of industrial labor skewed the perspective of labor experts who were slow to recognize the power and problems of the emerging service sector, and specifically the healthcare labor force.

By the mid-1970s, the nursing profession was in the midst of a collective feminist consciousness raising (Wolf, 1993). Nursing's perspective on nurses' discontent with their work held that the conditions nurses faced were unique and were often viewed within the context of gender and professionalism. Jo Ann Ashley (1996), a feminist nursing historian, offered the most vocal of the feminist perspectives. She described nurses' perceived powerlessness to change their situations as a consequence of their unique socialization as a female-gendered occupation and a result of the cultural barriers to the exercise of the power of nursing within paternalistic institutions.

Caught in a rapid current of cultural change, nursing and hospital administrators were pushed by nurses and pulled by larger social, economic, and political currents to face change in healthcare organizations. Collegiate nursing education, which had begun to embrace the notion of nurses as change agents, contributed to a new professional consciousness. The power to change nursing realities was slowly unleashed.

The unfreezing of hospital nursing to change was rapidly catalyzed as the potential threat of collective bargaining became evident to nursing and hospital industry management. Nurses, like workers in other industries and service sectors, wanted control over their work and a more equitable and open system of resource allocation and rewards. Control involved complex problems of achieving and sustaining authority and ensuring accountability for nursing practice. The potential scope of control ranged from specific day-to-day patient care decision making to participation in organizational governance, such as goal setting and finance (Siriani, 1984; Witte, 1972). Hospital decision making is typically viewed as hierarchical, with organizational control at the top and bedside or patient-care issues at the bottom. But in reality, the arenas of decision making are overlapping and interconnected within hospital organizations.

PATIENT-CENTERED CARE AND THE EMERGENCE OF PRIMARY NURSING

As the workplace reforms movement moved forward in the 1970s, the desire for control over patient care took precedence in most organizations. This reflected the growing necessity for greater nursing decision making given the rapidly increasing complexity of the patient care. The most influential development was primary nursing. According to Marram, Schlegel, and Bevis (1974), primary nursing was a developmental step in professional practice development that supported "the distribution of nursing so that the total care of an individual patient is the responsibility of one nurse, not many nurses" (p. 1). Many of the ideas inherent in primary nursing were previously noted by Lydia Hall (1969) at the Loeb Center. Influenced by the wave of quality in work life ideas in the contemporary management literature, primary nursing was invented as an approach to job redesign. This job-redesign approach had been applied successfully in industrial management in Europe and Japan. The primary nursing model offered hospital management a way to counter worker complaints about deskilling. The work of nursing was restructured and enlarged to make nurses accountable for the whole of patient care rather than just for specific tasks.

Primary nursing was also ideologically imbued with professionalism.

The association between primary nursing and enhanced professional orientation was noted in many studies beginning in the 1970s (Marram, Schlegel, & Bevis, 1974). Manthey (1980), an early proponent of primary nursing, noted that primary nursing reflected a philosophical commitment to decision making at the level of action. Primary nursing, drawing on professionalism, sought increased accountability by the nurse for patient care, a rational system of care provided by the nurse who is most knowledgeable about the patient, individualized and personalized patient care, and increased equality among nursing staff (Marram, Schlegel, & Bevis, 1974). To support the initiation of primary nursing, registered nurses had to be reskilled, and hospitals sought to increase the staffing levels of registered nurses while decreasing the employment and roles of licensed practical nurses and nursing assistants. In most instances, this necessitated increased funding or significant reallocation of funds, made possible in the late 1970s by government and private support to hospitals.

Primary nursing provided a process by which patient-centered care could be individualized yet applied within a standardized nursing process. However unique each patient-care situation might be, the process of nursing judgment and discretion became predictable. The application of the nursing process as a method of solving nursing care problems became central to nursing education and practice in the 1970s. The development of professional nursing standards for care by the ANA further codified this process orientation. However, the growing complexity of patient care and the increasing body of nursing theory would soon shift nursing's emphasis to critical thinking.

Despite the shift in control over nursing education from hospitals to academic institutions, the reality was that most nursing graduates were going to be employed by hospitals. Nursing educators faced pressure to produce a product nurse that met the hospital labor market needs in terms of skill as well as price.

As legal and regulatory pressures for greater accountability mounted, new demands for documentation shaped the day of hospital nurses. Nurses expressed a sense of being pushed into documentation at the expense of being pulled away from patient care. As one primary nurse noted, "Make sure your patient care is your priority, but don't forget your paperwork" (Wolf, 1993, p. 115). The strain of competing demands between the work of nursing and the documentation of the work emerged as a recurring theme underlying alienation and nurse dissatisfaction. As nurses grappled with the potential of primary nursing to provide rewards, the reality of the system's constraints and the contextual issues of organizational control became more apparent.

THE MISSING LINKS: SHARED GOVERNANCE AND RECOGNITION

The initiation of shared governance in healthcare institutions in the 1980s highlighted an attempt to ease the tensions between administrative controls and professional work. Primary nursing, while restructuring nursing work, was quickly found to be limited in its scope. The work of nurses was embedded in the organizational context and was shaped by decisions that were often removed from their sphere of action. From staffing to equipment choice, these decisions often impacted patient care, leaving nurses frustrated, which compounded problems of turnover and militancy. Just as American industry struggled with the push to expand worker control without sacrificing managerial prerogatives, the push for workplace participation in decision making grew. Genuine participation was made difficult by the complex hospital authority structure, which kept nurses trapped between the dual hierarchies of medicine and the hospital administration.

The climb by nurses out from between these two systems of control generated both a threat and an opportunity for the reallocation of power in hospitals. Nursing leaders such as Manthey (1991) cautioned that for the reallocation of power to occur, a major change was required in the structure and operation of nursing departments. Change would require a major dismantling of the hospital hierarchy, beginning with the nursing departments. As Porter-O'Grady (2001) noted, "Implementing an empowered format such as shared governance means that the relationships, decisions, structures, and processes will be forever changed at every level of the system and that all the players in the organization will be different and behave differently as a result" (p. 5). The changes in patterns of communication and behaviors extended across relationships, not only nurse–nurse or nurse–patient, but also nurse–physician. Many physicians were initially ambivalent and threatened by shared governance (Wolf, 1993).

In the 1980s and 1990s, many hospitals moved toward flatter management structures in an effort to move toward shared governance. Work, previously viewed as a management prerogative, was typically distributed across the flattened structure to involve staff nurses as well as administrators in decision-making processes at the committee level. Nurse participation was concentrated at the committee level. A study by Jenkins (1988) observed that the expanded committee structure resulted in more time spent in meetings and an overall drop in hours per full-time employee. For example, Massachusetts General Hospital provides a wide range of committees in its governance structure, including such foci as patient-care quality, diversity, and staff recruitment (Erickson, 1996). Participation is based on an application; it is a selective process that draws from a pool of dedicated full- and part-time nursing staff who give generously of their time and expertise.

A parallel concern to expanded decision making has been the need to recognize nurses for their efforts (McCoy, 1999). Hospital nursing is complex and difficult work. Keeping experienced nurses at the bedside improves the quality of patient care and reduces recruitment and orientation costs. The challenge has been to find a way to reward nurses for a career in direct care rather than management. Career ladders typify the development of new reward systems. Career ladders provide a hierarchical system of rewarding professional behaviors, such as advanced education; scholarship; and contributions to the institution, such as committee work or clinical projects. This system provides the semblance of mobility by recognizing those nurses who choose to stay at the bedside. Given the recurrent stresses of nursing shortages, career ladders have provided another mechanism to attract and retain clinically expert nurses. The career ladder system has codified the job enlargement of the professional nurse, while stimulating nurse productivity in a variety of areas, such as quality assurance, practice policy development, hospital public relations, and nurse recruitment (Wolf, 1993).

However, the linking of remuneration with career-ladder progression historically has been problematic for many hospitals. The hospital budget process and pressures to control nurse salaries has thwarted career-ladder development efforts in some hospitals. Many senior nurses find themselves hitting the glass ceiling with new hires rapidly gaining more compensation. Healthcare organizations have also adopted nonmonetary systems of nurse recognition, such as the professional nurse of the month awards. These symbolic rewards, while recognizing clinical excellence, divert attention away from the concrete contextual realities of practice.

THE ATTRACTION OF MAGNET HOSPITALS

In the early 1980s, the American Academy of Nursing launched an effort to recognize hospitals for their ability to attract and retain nursing staff (Upenickes, 2003). The Magnet

Hospital program was launched based on a study that identified hospitals having low staff turnover, high nurse job satisfaction, and low staff nurse vacancy rates. The initial recognition went to some 41 hospitals. The results of the early magnet hospital studies highlighted the importance of organizational factors, such as participatory structures and processes, perceived autonomy of nurses, and empowering leadership (Scott, Sochalski, & Aiken, 1999). The characteristics of these hospitals paralleled many of the recommended changes of the quality of work life advocates. Policy reports by the Institute of Medicine (1981) and the National Commission on Nursing (1981) report by the American Hospital Association gave added legitimacy to the move to restructure hospitals to better attract and retain nursing staff. Some 20 years after the initial magnet studies, a body of research has been collected to justify continuing support for the restructuring of systems of care. Current efforts focus on validating outcomes of care in magnet hospital systems, but a better understanding of the relationship between outcomes and nurses' autonomy is needed (Havens & Aiken, 1999; Ritter-Teital, 2002; Scott et al., 1999).

PROFESSIONAL NURSING AND NURSE STAFFING: CHICKEN OR EGG?

How well hospitals are able to sustain professional models is dependent on the political and economic climate of the healthcare market. Past nursing shortages generated greater leverage for nursing stakeholders. Yet as tensions in labor ease or are overcome by greater organizational pressure to contain or depress labor costs, the potential for backpedaling on professional nursing gains increases. Nursing has a greater potential to enhance quality outcomes by maximizing the use of professional expertise. As has been noted in recent studies, sustaining adequate nurse staffing may be one of the most important key factors in patient care outcomes (Aiken et al., 2002; Cho, Ketefian, Barkauskas, & Smith, 2003). Such research further underscores the importance of continuing professional models of development as they support the recruitment and retention of staff. For too long the value of nursing has been hidden in health care by data collection and information systems that give primacy to medicine. Ideally, emerging advances in nursing informatics will add to nursing's visibility and support continued vitality. A firm investment in professional models will also call for healthcare organizations to effectively match nursing education and talents with the complexity of the work. The corporatization of hospitals provides a relative opportunity for nursing to gain power in the healthcare organization. It is time for nursing to cease its dependence on the good will of institutions and to demand full participation in institutional policy making.

CONCLUSION

Throughout the history of nursing, professionalization has been a driving force for change. From the earliest innovations of Nightingale to the most recent nursing shortage, the work culture of nursing has been reshaped to meet the needs of society or managerial interests, often in the midst of crises. The slow march toward professional practice continues as models of nursing practice offer a powerful ideological hold. Nursing has been influenced by ideas drawn from sociology, management, and industry, resulting in workplace reforms reframed within a professional lens. The power of professionalization has contributed significantly to the success of this reform, offering benefits to both healthcare institutions and nurses. However, nursing shortages remain. Challenging questions for the future include the following: To what extent are professional models of practice sustainable in the face of economic uncertainty? Can institutional control truly be ceded to nurses without a fundamental revolution in the overall restructuring of healthcare financing and service structure?

DISCUSSION QUESTIONS

1. In this chapter, the author argues that nursing's role in hospitals is imbued with managerialism, causing a paradox (Fourcher & Howard, 1981). The application of nursing knowledge and skill in managing patient care in hospitals has a long history of being subjugated to nursing and hospital administration. Nursing expertise has more often than not been invisible and undervalued, and autonomy of practice has been absent. Reflecting on this statement, do you agree or disagree?
2. How has societal and healthcare policy affected the development of nursing?
3. What are the pros and cons of unionization in nursing?
4. How will the Magnet Hospital program, shared governance, and mandated staffing ratios affect nursing in the future?

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