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THE ROLE OF THE NURSE IN THE SCHOOL SETTING:
AN HISTORICAL VIEW AS REFLECTED IN THE LITERATURE
FROM 1902 THROUGH 1982

DISSERTATION

Presented in Partial Fulfillment of the Requirement for
the Degree Doctor of Philosophy in the Graduate
School of the Ohio State University

by
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1986

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PROLOGUE

The school nurse has it in her power not only to remedy the existing conditions which are menaces to right living but also has the opportunity to open up new avenues of social service. Her work is not alone with those who have defects or disease but very largely with those who are well. Her duty will become more the supervision of the life habits of the well; therefore much more teaching of the laws of health will be observed and the result to humanity can be better imagined than described.\(^1\)

School nursing has come a long way since Lina Rogers first went into the schools of New York City in 1902. It has emerged, evolved, and expanded from the simple, practical skills of communicable disease control and promotion of cleanliness to a complexity of roles and responsibilities. Today the functions of the school nurse range from health counseling, health instruction, and health services on an individual or small group basis through the broader aspects of community health and preventive health care.

But, at the same time, the role of the nurse in the school is plagued with confusion and controversy. What is school nursing? What is the role of the nurse in the school

---

health program? What should be the preparation of the nurse for work in the school setting? What unique contribution does the nurse make to the school health team? What is the common role expectation of the nurse in the school?

Sound thinking about the present, and future, role of the nurse in the school, requires a critical analysis of the past. Traditions, ideas, and events of yesteryear can explain, in part, current practices, problems, and perplexities. Moreover, experiences of the past can provide direction for the future.

Using data derived from the literature, this study endeavors to record a reliable, unbiased narrative tracing the role of the nurse in the school from 1902 through 1982. Since only a fraction of school nursing history may be recorded in the literature, the intent is not to chronicle a definitive history of school nursing but to document and describe forces and factors that were influential in shaping the role of the school nurse. Sources are quoted frequently to elicit a sense of the past, to preserve the author's message, and to allow individuals to speak for themselves.

Looking back through the decades of this century can provide a basis for understanding the role of the nurse in the school setting, as well as lend support to the belief that a primary function of the school nurse is education for health, not just care of the sick. Perhaps the nurse in the
school can use perspectives generated by the study to appraise recurring problems and issues with greater insight. Knowing what school nursing has been is a requisite for understanding what school nursing is and can be.

No occupation can be intelligently followed or understood unless it is, at least to some extent, illumined by the light of history interpreted from the human standpoint. The origin of our various activities, the spirit animating the founders of a profession, and the long struggle toward an ideal as revealed by a search into the past, — these vivify and ennoble the most prosaic labors, clarify their relation to all else that humanity is doing, and give workers an unfailing inspiration in the consciousness of being one part of a great whole.²

CHAPTER I
INTRODUCTION TO THE STUDY

Only a thorough awareness of their heritage allows nurses to make their professional decisions in the same way as they make their personal ones: by reflecting on previous events and consequences. History is thus a compass that can guide nurses into the future, and when the future seems to be a troubled one, such a compass is badly needed.¹

For a number of years the nurse has struggled to define and establish a role for herself² within the school setting. Traditionally, the nurse in the school has been identified with the service component of the school health program. Health services are generally viewed as an accessory, but not necessarily an integral part, of health education.³ The common assumption is that nurses are employed by schools to administer first aid, keep health records, and provide communicable disease control.


²Historically, the pronouns, "she" and "her" more accurately describe the school nurse. Hence, the school nurse is referred to in the feminine gender, rather than contemporary usage "he/she", throughout the text of this paper. No discrimination against male nurses is intended.

Yet, the traditional role of the nurse at the clinical level is restrictive in the school setting. The school nurse is more than a professional with technical training in care of the sick. School nursing is a specialty with the dual role of health service and health education. The school nurse is a part of the educational system and, as such, has a unique contribution to make in promoting the health of children and youth. At all times she is concerned with maintaining, improving, and promoting health. The focus of her responsibility is largely with those who are well, not with those who are sick or injured. Since promoting, protecting, and improving health is basically an educative process, the nurse in the school oftentimes is "expected to function" as a school health educator.\(^4\)

**Statement of the Problem**

The purpose of this study is to investigate, from an historical perspective, the role of the nurse in the school setting as reflected in the literature from 1902 through 1982. The study aims to (1) trace the role of the nurse in the school setting; (2) to document and describe movements and benchmark events in both school health education and nursing which were influential in shaping the role of the

\(^4\text{Ibid., p. 11.}\)
nurse in the school, and (3) to draw inferences about the future of school nursing.

Research Questions

The study seeks to answer the following questions:

1. How did events and movements in both school health education and nursing affect the role of the school nurse? When did these events and movements occur? Why did they occur?

2. In what ways has the dual professional preparation of the school nurse enhanced or hindered her role?

3. What influences have official agencies and professional health, education, and nursing organizations exerted on the development of school nursing?

4. What part have nationally known leaders in school nursing played in the evolution of the role of the school nurse?

5. Historically, what relationship has school nursing had to the mission of the school? What special contribution has the school nurse made to justify her position in the school setting?

6. How can the role of the nurse in the school be effectively and creatively fulfilled in the future?
Rationale

Five assumptions served as rationale for conducting an historical study of the nurse's role in the school setting.

First of all, historical research continues to lag behind other types of research in both nursing and health education. Historical research in nursing has long been hampered by a combination of factors: the questionable qualifications of nurses to conduct historical research, limited emphasis on history in educational programs, and the disinterest of nurses in historical study. A major reason for the dearth of historical research in nursing is the lack of value placed on historical study by a "doing" or practice-oriented profession. "Nurses tend to concentrate on empirical or experimental research which will provide answers to immediate problems."5

Throughout the twentieth century nurses have rigorously studied their practice, but seldom their "roots" or heritage. Not until the late 1960s did nurses, in any number, begin to conduct and publish scholarly historical inquiry: Christy, Cornerstone of Nursing Education (1969); Fitzpatrick, The National Organization for Public Health Nursing, 1912-1952: Development of a Practice Field (1975); Marshall, Mary Adelaide Nutting: Pioneer of Modern Nursing

5Elizabeth Norman, "Who and Where are Nursing's Historians?" Nursing Forum 20 (1981): 140-141.

(1972); Regan, "An Historical Study of the Nurse's Role in School Health Programs from 1902 to 1973" (1974); Safier, Contemporary American Leaders in Nursing (1977).

Similarly, health educators have given more attention to descriptive and experimental research than historical inquiry. In 1959 Van Dalen voiced regret that source materials needed for an accurate, definitive history of the profession were already lost or destroyed. Several years later Means noted only a passing interest was accorded health education history.

The indolent attitude of many toward the history of the selected field in which they are engaged is apparent. That such an atmosphere has persisted for a number of years is also evident.

During the 1960s and 1970s health educators made commendable efforts to preserve "the stuff of history," but a valid case for historical research persists. Emphasizing the relevancy of historical study to one's discipline, Strong declares:

The history of any field is its heritage. It can be fascinating research and will teach us much that we can apply to our present work as well as assist us in predicting the future.

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9Clinton Strong, "Historical Research: Does It Apply to Health Education?" Health Education 12 (July-August 1981): 35.
Grosshans maintains that an awareness of past events, individuals, and philosophies contribute to an overall perception of the profession and its potential. Likewise, Nolte sees the history of health education providing a foundation for the discovery and building of new knowledge. "Through sharing historical research there is great potential for influencing the future of health education."11

Secondly, a comprehensive historical study of the role of the school nurse within the framework of school health education has not been recorded. A review of the literature indicated a paucity of historical studies related to school nursing. Troop reviewed the educational preparation of the school nurse from 1902 through 1962, focusing on professional organizations, nurse educators, and school nurses who collaborated to raise the educational standards of the school nurse.12 Regan investigated the historical role development of the school nurse within the context of societal, medical, educational, and nursing influences.13


The school nurse's role in determining pupil health status was an area examined by Baum in an historical study of Columbus Public Schools Health Services.\textsuperscript{14}

Addressing research needs in the early 1960s, Staton acknowledged the school nurse had a "long and significant history in the story of school health," but omitted historical study as a research concern.\textsuperscript{15} Several decades later, however, Strong called for an intensive historical treatise on school nursing. "Do we really know and understand the evolution of the school nurse in health education? How did we get to the present status of the position?"\textsuperscript{16} The scarcity of historical research in school nursing gives credence to this study and others validating and recording school nursing history.

Thirdly, a dual role concept inherently poses a dilemma for school nurses. Supposedly, "no man can serve two masters" but school nurses continue to do so. The dual allegiance to nursing and teaching, creates an "identity crisis" for school nurses. Statements in the literature recommend school nurses assume a multifaceted role integrating education, nursing, and health; but, in


\textsuperscript{16}Strong. \textit{op. cit.} 34.
practice, school nurses often find practicing "wellness- and prevention-oriented nursing" difficult. A stereotypical image of the school nurse as a bandaider, record keeper, communicable disease detector, and emergency caretaker persists.

However expanded or altered or traditional the nurse may perceive her role to be, those who utilize the health services in school may or may not have role perceptions which are congruent with the nurse's. It is obvious that this role discrepancy can profoundly affect the bounds of nursing practice and can result in interactive role stress.

The efforts of school nurses to provide integrated services are hampered not only by role expectations of other school personnel but also by school nurses themselves. A lack of consensus regarding their role and practice prevails. Each nurse does "her own thing"; that is, selects and prioritizes activities she will perform. What exists then is a "hodgepodge" of activities. Differing philosophies produce just as many interpretations of "what a school nurse is" and "what a school nurse does".

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Fourthly, there is a dearth of research on the role of the nurse in the school health program. Articles describing the role of the nurse as a school health educator have appeared from time to time in the literature, but research rigorously addressing this function is sparse. Yet, clarifying the role of the nurse in school health education has long been recognized as a viable topic for study.

In 1963 Staton saw the role of the school nurse in health instruction and counseling as a high priority research need. Over a decade ago, Hawkins warned that lack of studies differentiating preventive, educational, and service aspects of school nursing may intensify stereotypes and perpetuate role ambiguities. According to Hawkins, research on the role of the school nurse is limited and of questionable validity. "Professionally significant questions have not even been recognized. These are questions involving such matters as relationships, reciprocal expectations, and stereotypes."

Because of recent financial woes and budgetary cutbacks, research in school nursing is becoming an essential tool for survival. If the school nurse is to remain a viable part of the school health program, she must

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20 Staton, _op. cit._, p. 420.


22 Ibid., p. 751.
document her effectiveness; she must demonstrate that her skills enhance or promote learning.23 School nurses must become involved in meaningful research that will document the cost effectiveness of their services.24 School nurses must actively define their roles, using research data to explain and justify their actions.25

Lamenting the lack of research in school nursing, Wold calls on school nurses to validate their practice through research. "Whatever the reasons behind the appalling lack of research to support school nursing interventions and to document their outcomes, there is an acute need for immediate action to correct the problem."26 Wold concludes that research is needed in virtually all aspects of school nursing.

Fifthly, recorded history is an essential component of disciplines and professions. It illuminates past achievements, offers perspectives on current issues, and serves as a springboard for future progress. "The depth of a field, its traditions, and even its present, comes from


26Ibid., p. 488.
its history. Insight into what school nursing is and what school nursing may be springs from the knowledge of school nursing past.

Limitations and Delimitations

Several limitations and delimitations are inherent in this study.

Limitations

This study is limited by:

(1) knowledge and competence of authors in school nursing literature from 1902 through 1982;

(2) bias of authors in school nursing literature from 1902 through 1982;

(3) missing or inaccessible source materials in school nursing literature;

(4) a researcher's effect: inability of the researcher to maintain complete objectivity in the process of selecting, sorting, and interpreting data.

Delimitations

The study is restricted to:

(1) school nursing in the United States;

(2) school nursing literature in the 1902-1982 time span;

(3) the role of the nurse in the school setting;

(4) selected issues associated with the role: professional preparation, service functions and responsibilities, health instruction, and interpersonal relationships;

(5) selected articles from professional education, health education, nursing, and public health

27 Strong, op. cit., p. 34.
Definition of Terms

In order to clarify terminology, the following terms are defined: Health Education; Literature; Movements; Nurse Educator; Official Agencies; Professional Health, Education, and Nursing Organizations; Role; School Health Educator; School Nurse; and School Nurse Practitioner.

Health Education: The process of providing learning experiences which favorably influence knowledge, attitudes, and practices relating to individual and community health. (Joint Committee on Health Problems in Education of the National Education Association and American Medical Association, 1964.)

Literature: Articles from professional education, health education, nursing, and public health journals; school nursing texts; nursing history texts; public health nursing texts and manuals; curriculum guides; school nursing monographs; and published addresses, speeches, memoirs, and committee reports.

Movements: A series of events or incidents that influence trends in a particular discipline or field.

Nurse Educator: A registered nurse teaching in a college (or school) of nursing.
Official Agencies: Tax supported agencies, including local Departments of Health and Education, State Departments of Health and Education, and the U.S. Office of Education.

Professional Health, Education, and Nursing Organizations: Dues supported organizations, including American Alliance for Health, Physical Education, Recreation, and Dance; American Nurses Association; American Public Health Association; American School Health Association; National Association of School Nurses; National League for Nursing; National Organization for Public Health Nursing; National Education Association.

Role: A set of assigned behaviors and responsibilities associated with a distinctive position in the social system.

School Health Educator: An individual with professional preparation in health education who is qualified for certification as a health teacher and participator in the development and implementation of school health education programs. (Paraphrased from Report of the Joint Committee on Health Education Terminology, 1973.)

School Nurse: A registered nurse who functions under the auspices of a board of education or health department for the purpose of improving, protecting, and maintaining the health of school-age children, youth, and school personnel.

School Nurse Practitioner: A registered nurse who has completed a formal program of study designed to prepare her
to function in an expanded role and deliver primary health care.

Glossary of Abbreviations

The names of many organizations and associations involved with school nursing are lengthy and cumbersome. In oral communication these groups are frequently referred to by letter abbreviations. That practice is followed in this study for purposes of clarity and comprehension. The reader may refer to the following list for an explanation of abbreviations.

A.A.H.P.E.R. - American Association for Health, Physical Education, and Recreation


A.N.A. - American Nurses Association

A.P.H.A. - American Public Health Association

A.S.H.A. - American School Health Association

N.A.S.N. - National Association of School Nurses

N.E.A. - National Education Association

N.L.N. - National League for Nursing

N.L.N.E. - National League of Nursing Education

N.O.P.H.N. - National Organization for Public Health Nursing
Summary

Using data derived from school nursing literature in the 1902-1982 time span, the intent of this study is to investigate historically the role of the nurse in the school setting. The rationale for the study as well as its limitations, delimitations, key definitions, and glossary of abbreviations were discussed in this chapter.
CHAPTER II
PROCEDURES OF THE STUDY

History, the meaningful record of man's achievement, helps him to understand the present and, to some extent, to predict the future. Historical research is the application of scientific method to the description and analysis of past events.¹

According to Hockett, there are three essential steps in historical research: gathering the data, criticizing the data, and recording interpretations and conclusions.² The historical method delineated by Van Dalen includes five procedural steps: formulating the problem, collecting source materials, criticizing source materials, formulating hypotheses to explain events or conditions, and interpreting and reporting findings.³ Gay notes that the steps involved in historical study are essentially the same as other types of research: defining a problem, formulating hypotheses or questions to be answered, systematically collecting data, and


evaluating data, and confirming or disconfirming hypotheses.4

Five steps, derived from the methodologies of Gay and Van Dalen, comprise the design of this study: (1) selecting the problem, (2) formulating research questions, (3) collecting the data, (4) criticizing the data sources, and (5) interpreting and reporting findings.

Selecting the Problem

This study emerged from an assignment in Professor Mary K. Beyrer's "Historical Perspectives on Health Education" class. Being a nurse-health educator, with a keen interest in history, the writer was curious about the origin and development of school nursing. Completing a term project on the history of school nursing further stirred the writer's curiosity. Subsequently, a personal and professional interest in the heritage of school nursing motivated the writer to investigate, from an historical perspective, the role of the nurse in the school setting as reflected in the literature from 1902 through 1982.

In addition, a preliminary search of the literature suggested a need for the study. The search revealed a paucity of historical inquiry in school nursing, limited study of the school nurse's role, and a call for research

projects to validate the practice of school nurses. Given the dearth of historical study in school nursing, the writer concluded that the investigation could partially fulfill a research need as well as offer perspectives on the nurse's role in the school health program.

**Formulating Research Questions**

The formation of research questions emerged from an initial review of the literature. Recognizing that a comprehensive investigation of events, developments, issues, and changes comprising the eighty-year history of school nursing was beyond the scope of this study, the investigator compiled a list of topics most frequently mentioned or inferred during the review. An overall analysis of topics showed the following issues emerging: professional preparation, service functions and responsibilities, health instruction role, and interpersonal relationships.

In lieu of research hypotheses, questions, relative to the issues, were raised as a frame of reference for data gathering and interpreting findings.

1. How did events and movements in both school health education and nursing affect the role of the school nurse? When did these events and movements occur? Why did they occur?

2. In what ways has the dual professional preparation of the school nurse enhanced or hindered her role?
3. What influences have official agencies and professional health, education, and nursing organizations exerted on the development of school nursing?

4. What part have nationally known leaders in school nursing played in the evolution of the role of the school nurse?

5. Historically, what relationship has school nursing had to the mission of the school? What special contribution has the school nurse made to justify her position in the school setting?

6. How can the role of the nurse in the school be effectively and creatively fulfilled in the future?

Hypotheses to confirm or disconfirm causality were not proposed. The primary thrust of the study was to seek answers to the preceding questions. Antecedent conditions behind movements and benchmark events were recorded but no attempt was made to confirm causation.

Collecting the Data

Literature from a variety of sources was reviewed to gather data for the study. Personal interviews with living pioneers and early practitioners of school nursing may have added a dimension of interest and valuable information, but time constraints, limited budget, travel concerns, and the demise of notable pioneers negated this approach. Hence
data were drawn from printed materials. Library research seemed a feasible, and valid, option.

Aside from the direct knowledge of an event by an eyewitness, or a firsthand investigation on the scene through interviews, laboratory, or field work, or the study of relics, the shortest path to the facts is library research.5

Best noted that many old materials may be useful as primary sources of data: records and reports of legislative bodies, state departments of public instruction, and educational committees; professional and lay periodicals; curriculum guides; courses of study; textbooks; letters; diaries; and autobiographies.6 Using Best's list as a guide, data were derived from the following sources:

1. articles in professional education, health education, nursing, and public health journals;

2. reports of national conferences, commissions, and committees; for example, the Brown Report, the Goldmark Report, the National Commission for the Study of Nursing Education, the Committee on the Grading of Nursing Schools, and Report of the National Conference on School Nursing Services;

3. published addresses and speeches of school nurses and public health nurses;


4. published memoirs and addresses of leaders and pioneers in nursing and school nursing;
5. books written by school nurses;
6. books written by public health nurses;
7. curriculum guides published by the National Organization for Public Health Nursing and National League of Nursing Education;
8. public health nursing manuals;
9. school nursing monographs.

Biographies and general histories of nursing were used as secondary sources to gather basic factual information, to elicit a chronological synthesis of events and milestones fundamental to the development of school nursing, and to procure additional sources of data.

Every effort was made to locate original publications and sources narrating personal experiences and observations of contemporaries. According to Gottschalk, primary sources are produced by contemporaries of the events being narrated.7 Primary sources need not be original in the legal sense of the work original, that is, the first written draft. They need be original only in the sense of first-hand testimony.8

Sources, in other words, whether primary or secondary, are important to the historian because

8Ibid., p. 55.
they contain primary particulars (or at least suggest leads to primary particulars). The particulars they furnish are trustworthy not because of the book or article or report they are in but because of the reliability of the narrator as a witness of those particulars.\(^8\)

The specific procedure involved in the collection of data is outlined below.

1. Source materials selected for the study were located by using *A Bibliography of Nursing Literature 1859-1960*, *Cumulative Index to Nursing Literature, Cumulative Index to Allied Health and Nursing Literature, Education Index, Nursing: A Historical Bibliography, Nursing Studies Index*, and *Reader's Guide to Periodical Literature*.

2. Bibliographic information for each source was recorded.

3. Sources were searched for statements pertaining to four major issues associated with the role of the school nurse: professional preparation, service functions and responsibilities, health instruction, and interpersonal relationships.

4. Sources yielding data relevant to the four issues were photocopied and coded according to topic.

5. Sources were divided further into four chronological periods: 1902-1920, 1921-1940, 1941-1960, 1961-1982.

\(^8\)Ibid., p. 57.
6. Sources from each time period were examined then
with respect to the four issues.

Criticizing the Data Sources

Data sources were analyzed to determine their
authenticity (external criticism) and accuracy (internal
criticism). Elements of historical criticism set forth by
Gay\(^\text{10}\), as well as questions framed by Van Dalen\(^\text{11}\), guided
the process of examining source materials.

The authenticity of each source was evaluated by
critically examining and affirming:

1. Authorship
2. Date of Publication
3. Publication in which data was found
4. Textual integrity: Were the language and spelling
typical of the period in which the source was
written? Did the author describe events that a
person of that period would probably have known?
Did sources, quoted by the author, agree in content
and date with the original publication?

The accuracy of each source was addressed by critically
evaluating:

1. Knowledge and competence of the author: Were the
author’s professional training, competency, and

\(^{10}\text{Gay, op. cit., pp. 120-121.}\)

\(^{11}\text{Van Dalen, op. cit., pp. 356-360.}\)
location favorable for observing the events reported?

2. Bias and motives of the author: did the author have possible biases concerning races, religions, socioeconomic groups, or nursing/educational philosophies that influenced writings?

3. Time lapse between the occurrence of an event and recording of facts: Did the author report on direct observations or borrowed sources?

4. Consistency of data: Were accounts of other competent authors in agreement with the report?

An effort was made to classify relevant data as fact, probability, or possibility using criteria presented by Fox. Information was considered factual when primary and secondary sources corroborated without any source disagreeing. Probability was assumed if one primary source was without corroboration or contradiction or two independent secondary sources were without contradiction. Evidence was regarded as a possibility when primary sources disagreed or a primary source was of questionable reliability.

Establishing authenticity and accuracy of data sources generally was not a problem. The investigator found no reason to doubt the authenticity and accuracy of articles,

speeches, addresses, committee reports, and position
statements published in professional education, health
education, nursing, and public health journals. Neither was
there reason to question the authenticity and accuracy of
reports of national committees and commissions, proceedings
of national conferences, public health nursing manuals,
histories of nursing, books written by school nursing and
public health nurses, published memoirs and addresses of
leaders and pioneers in nursing and school nursing,
biographies, and school nursing monographs.

Presumably some data were biased in the sense that
perceptions of the authors colored what was seen, heard, and
recorded.

... Everything which an individual reports
is a function of her own perceptions and so is
biased in the sense that it reflects what the
individual saw and how the individual reacted.
This is particularly true when we consider the
reporting of attitudes of others and the reactions
of others and the attribution of motives to
others.\textsuperscript{13}

In some instances, personal beliefs and values also may have
shaded data.

Interpreting and Reporting Findings

Data, derived from the literature and evaluated via
external and internal criticism, were synthesized into a
narrative form. Findings were recorded using a

\textsuperscript{13}Ibid., p. 145.
chronological-topical arrangement. Data were organized around four issues associated with the role of the school nurse. Each issue was examined in the context of four time periods: 1902-1920, 1921-1940, 1941-1960, 1961-1982.

Data are reported in Chapters IV through VIII. Chapter IV traces briefly the heritages from which school nursing evolved. Subsequent chapters are devoted to the four issues:

Chapter V - Professional Preparation of The School Nurse

Chapter VI - Service Functions and Responsibilities of the School Nurse

Chapter VII - The Teaching Role of the School Nurse

Chapter VIII - Interpersonal Relationships of the School Nurse

Each of the preceding chapters is divided into four time periods:

The Early Years (1902 - 1920)

The Twenties and Thirties (1921 - 1940)

The Midcentury Years (1941 -1960)

Recent Years (1961 - 1982)

In the data chapters special emphasis is placed on:

1. identifying and describing movements and benchmark events which affected the professional preparation, service functions and responsibilities, teaching

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14Barzun, op. cit., p. 213.
role of the school nurse, and interpersonal relationships;

2. ascertaining to what extent the dual professional preparation of the school nurse has enhanced or hindered her role;

3. delineating roles and responsibilities of the nurse in the school setting;

4. exploring the influence of interpersonal relationships on the role of the school nurse;

5. examining the involvement and influence of official agencies and professional organizations on the development of school nursing;

6. enumerating the accomplishments and contributions of pioneers and leaders in school nursing.

Each data chapter is composed of the following sections:

Introduction

The Early Years (1902 - 1920)

The Twenties and Thirties (1921 - 1940)

The Midcentury Years (1941 - 1960)

Recent Years (1961 - 1982)

Summary

The concluding chapter, Chapter IX, presents the summary of findings, conclusions drawn, and recommendations made as a result of this study. Inferences drawn about the future of school nursing are addressed in the epilogue. The
prologue, prefacing the study, describes the significance of investigating, from an historical perspective, the role of the nurse in the school.

Summary

This chapter outlined the five steps comprising the design of the study. Guided by the historical research models of Gay and Van Dalen, the problem to be examined was selected; research questions were formulated; data were gathered from written materials, sources were examined using eight criteria to ascertain authenticity and accuracy; and findings were interpreted and recorded using a topical and chronological approach.
CHAPTER III
ANALYSIS OF THE DATA SOURCES

Information about new ideas and developments often appears in periodicals long before it appears in books. Periodicals also publish articles of temporary, local, or limited interest that never appear in book form. Current periodicals are the best source for reports on recent research studies, and the older volumes provide a priceless record of past proposals, accomplishments, conflicts, attitudes, propaganda, ideas, and events.¹

The two sections comprising this chapter describe the literature reviewed and analyzed for the study. Data sources are classified and defined in section one. Section two shows results of a quantitative analysis performed on the major source of data: articles in periodical literature.

Classification of Study Data

Data deemed relevant to the study were gleaned from the following sources: articles in professional education, health education, nursing, and public health journals; reports of school nursing committees of the American School Health Association and the National Organization for Public Health Nursing; reports of national conferences,

commissions, and committees, namely, the Brown Report, the 
Goldmark Report, the National Commission for the Study of 
Nursing and Nursing Education, the Committee on the Grading 
of Nursing Schools, the International Congress of Charities, 
Correction and Philanthropy, and the National Conference on 
School Nursing Services; published addresses and speeches of 
school nurses and public health nurses; published memoirs 
and addresses of leaders and pioneers in nursing and school 
nursing; books written by school nurses and public health 
nurses; National Organization for Public Health Nursing and 
National League of Nursing Education curriculum guides; 
public health nursing manuals; school nursing monographs; 
biographies; and general histories of nursing.

For clarity and convenience, sources were coded and 
grouped into three general categories: articles in 
periodical literature, documentary materials, and monographs 
and books. The types of sources included in each category 
are defined as follows:

Articles in periodical literature: articles, 
speeches, addresses, committee reports, and position 
statements published in professional education, health 
education, nursing, and public health journals.

Documentary materials: reports of national 
committees and commissions, proceedings of national 
conferences, National Organization for Public Health
Nursing and National League of Nursing Education curriculum guides, and public health nursing manuals.

Monographs and books: histories of nursing, books written by school nurses, books written by public health nurses, published memoirs and addresses of leaders and pioneers in nursing and school nursing, biographies, and school nursing monographs.

Sources were accorded either a high or low priority. The sources yielding data relevant to the four issues associated with the role of the nurse in the school were classified as high priority. These sources were photocopied, coded according to topic, critically examined for authenticity and accuracy, and used for the final data analysis.

A low priority was assigned to sources containing data with little or no relevancy to the four issues; for example, "Should School Nurses Wear Uniforms?" Bibliographic information was recorded and retained for low priority sources, but eventually these sources were rejected for use in the study.

A total of 560 sources was reviewed and analyzed for the study. The number of sources in each category was:

Articles in periodical literature 488
Documentary materials 21
Monographs and books 51
Quantitative Analysis of Articles in Periodical Literature

Articles collected for the study were searched first for statements pertaining to professional preparation, service functions and responsibilities, health instruction, and interpersonal relationships; then sorted topically by content; and subsequently divided into four time periods: 1902-1920, 1921-1940, 1941-1960, 1961-1982. If an article alluded to more than one topic, it was classified according to the central focus. Any article containing data relevant to the study, but not specifically addressing the four topical areas, was grouped into a fifth category termed "miscellaneous."

Of the 488 articles used in the study, 474 specifically dealt with school nursing. The remaining 14 served as collateral material. Sorted by topic, the number of articles in each was:

- Professional preparation: 57
- Service functions and responsibilities: 244
- Health instruction: 31
- Interpersonal relationships: 90
- Miscellaneous: 52

Analyzing the articles by time periods yielded the following results:

- 1901 - 1920: 27
- 1921 - 1940: 102
An examination of the articles, in relation to authorship, showed that a registered nurse was the sole author, a co-author, or one of multiple authors in 75.52 percent of the articles. (In the bibliography these articles are marked by an asterisk.) Other authors included physicians, 4.00 percent; educators, 5.27 percent; and allied professionals, namely, social workers, psychologists, sociologists, dentists, and the like, 3.79 percent. The position of the author was not specified in 2.32 percent of the articles, and no author was identified for 3.57 percent. Committee reports and position statements comprised 5.69 percent of the articles.

The 488 articles, used as data sources, were found in a variety of periodicals. The periodicals, plus the number of articles appearing in each, are listed below:

- The Journal of School Health: 235
- Public Health Nurse/Public Health Nursing: 113
- American Journal of Nursing: 49
- American Journal of Public Health: 13
- Nursing Outlook: 13
- Visiting Nurse Quarterly/Public Health Nurse Quarterly: 7
- School and Community: 5
- Journal of Health, Physical Education and Recreation: 4
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<tr>
<th>Journal Title</th>
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<tr>
<td>Teachers College Record</td>
<td>4</td>
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<tr>
<td>The American School Board Journal</td>
<td>3</td>
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<tr>
<td>New York State Education</td>
<td>3</td>
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<tr>
<td>Ohio's Health</td>
<td>3</td>
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<td>The American City</td>
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<td>Health Values: Achieving High Level Wellness</td>
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<td>The National Elementary School Principal</td>
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<td>Nation's Schools</td>
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<td>School Life</td>
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<td>Today's Education</td>
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<tr>
<td>American Journal of Maternal-Child Nursing</td>
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<tr>
<td>Bulletin of National Association of Elementary School Principals</td>
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<tr>
<td>Childhood Education</td>
<td>1</td>
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<tr>
<td>Educational Horizons</td>
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<tr>
<td>Elementary School Journal</td>
<td>1</td>
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<tr>
<td>Journal of American Medical Association</td>
<td>1</td>
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<tr>
<td>Journal of Psychiatric Nursing and Mental Health Services</td>
<td>1</td>
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<tr>
<td>Mental Hygiene</td>
<td>1</td>
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<tr>
<td>Michigan Education Journal</td>
<td>1</td>
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<td>Minnesota Journal of Education</td>
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<td>NEA Research Bulletin</td>
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<td>Nursing '75</td>
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<tr>
<td>The Nurse</td>
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<td>Nursing Clinics of North America</td>
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<td>Nursing Forum</td>
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Excepting for several personal holdings, all data sources were procured at the following Ohio State University libraries: Education Library, Health Science Library, Main Library, Newark Campus Library, and Social Work Library. Sources used in the study stretched from 1860 through 1982.

Summary

To glean data for an historical investigation of the professional preparation, the service functions and responsibilities, the teaching role, and the interpersonal relationships of the nurse in the school, a total of 560 sources was reviewed and analyzed. Articles in periodical literature, numbering 488 and extending back to the early 1900s, served as the major source of data. Supplementary data were derived from a host of documentary materials, monographs, and books.
Religious teachings, humanitarian endeavors, social reforms, public health movements, and self-determined, altruistic individuals provide an historical foundation for school nursing. These five forces were instrumental in fostering events that "set the scene" for school nursing. The purpose of this chapter is to trace briefly the heritages from which school nursing evolved.

Visiting Nurse Heritage

School nursing was an outgrowth of the public health nursing movement. Public health nursing is the extension of an old service variously known as sick nursing and visiting nursing.

The first organized visiting of the sick in their homes can be traced to early Christian deaconesses. Acting on the principle that service to mankind is the equivalent of service to God, churches established orders of deaconesses and delegated to them the Christian duty of visiting and caring for those who were sick and in need. Duties of the deaconesses varied: presiding over church services, teaching, spreading the Gospel, and performing charitable
services. As their work progressed, so much of it became nursing among the sick poor that they are now considered the first visiting nurses. Attending the sick in their homes was a special duty of the deaconesses.¹

Visiting nursing arose then, if never before, as distinguished from the mere visiting of the sick, for the care of sick rapidly became the special work of women, and the spirit of community service was intensified by every condition under which the Christian brotherhood lived.²

The care of the sick poor provided by early Christian deaconesses may seem to have little bearing on the practice of modern public health nurses. Care was purely palliative; it was to relieve suffering, not to prevent or cure disease. Yet, a similar spirit of service to mankind inspired these early pioneers.

The deaconesses, in the role of district visitors and social workers, investigated the conditions of the poor, reported cases of distress to the bishop, and made it possible to render to the sick or needy the kind of assistance required.³

The work of the deaconesses began to decline after the fourth century. As the monastic movement gained momentum, monks and nuns gradually assumed the activities of the deaconesses. The care of the sick was an important aspect of monastic life. Monastic orders founded hospitals,


²Ibid., p. 45.

offered hospitality and shelter to the homeless, and served the poorest of the sick poor.4

The Middle Ages witnessed the formation of many military, chivalric, and secular nursing orders. These groups established hospitals and provided multiple services: care of the poor, the pilgrim, the traveler, and the orphan, as well as the sick. One order, the Sisterhood of the Common Life, founded in Flanders in the fourteenth century, specialized in visiting nursing.5

The rise of Protestantism during the sixteenth century profoundly affected nursing. The sudden closing of monastic hospitals and the dissolution of nursing orders threw nursing into a state of disorganization. As governments brought hospitals under municipal control, standards deteriorated. "Graft and mismanagement were rampant, patients were exploited and neglected, living and working conditions were generally deplorable and moral conditions were at a low ebb."6 Uneducated, overworked, and ill-treated, nurses were often indifferent to the sufferings of those entrusted to their care.

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The secular nurse was illiterate, heavy-handed, venal, and overworked. She divided her time between housework, laundry, scrubbing, and a pretense at nursing of the most rough and ready kind. She seldom refused a fee, and often demanded it. Strong drink was her refuge from the drudgery of her life.7

The first efforts to upgrade nursing came in the seventeenth century from Vincent de Paul and the Sisters of Charity. Vincent de Paul laid the foundation for modern concepts of philanthropy and visiting nursing. In 1633, with the help of Mlle de Grass, he founded the Sisters of Charity, a secular order comprised of intelligent noblewomen sincerely interested in philanthropic service. Practicing within the framework of principles and fundamentals acquired in a systematized training program, the Sisters devoted their time to ministering to the poor in their midst. Their work consisted primarily of visiting nursing among the sick poor. As decreed by Vincent de Paul, their convents were the homes of the sick; their cloister, the streets of the city.8

By the middle of the nineteenth century, social reform and welfare work were flourishing in England and Germany. Simultaneously, organizations evolved to alleviate the suffering and miseries of the poor. In 1840 Elizabeth Fry, a prominent social reformer, established a visiting nurse

7Dock and Stewart, op. cit., p. 95.

service, the Nursing Sisters of Devonshire Square, to provide skilled care for the sick poor in her neighborhood. Other Anglican Sisterhoods included visiting nursing among their activities.

In Germany, Pastor Theodor Fliedner and his wife, Frederika, revived the deaconess movement. Inspired by the philanthropic endeavors of Elizabeth Fry and prompted by a lack of facilities for the care of sick poor, Pastor Fliedner opened a small hospital with a training school for deaconesses at Kaiserwerth in 1836. Like the sisters of Charity the deaconesses not only nursed the sick in hospitals, but also did parish or district nursing, their training being systematic, though simple.9

The efforts of the Fliedners eventually spread far beyond the small German village and gave rise to modern secular nursing. Nursing became a respectable vocation for women. Movements to train young middle-class women to nurse the sick, especially the sick poor, started in other towns and countries. Policies and practices developed by Theodor and Frederika Fliedner, and later by his second wife, Caroline Bertheau, influenced nursing education into the twentieth century: careful selection of students, a probationary period of study, formal instruction, and assignments to clinical services. Florence Nightingale

received her only formal training in nursing at Kaiserwerth.  

The Legacy of Florence Nightingale

It was left to Florence Nightingale to show the way, and to demonstrate that nursing, and especially that most important branch of nursing, the care of the sick poor in their homes, was no amateur work, but required knowledge, patience, self-denial, tact, kindness, and an abounding love of one's fellow creatures.

From the standpoint of nursing history, the doctrines of Florence Nightingale mark the turning point for visiting nursing to public health nursing. Modern public health nursing descended directly from the philosophy and work of Florence Nightingale. Miss Nightingale believed disease and suffering resulted from one's own carelessness in not following principles of health and sanitation. Forceful ideas on prevention, hygiene, and education for healthful living formed the theoretical base of her life's work.

Florence Nightingale established nursing as a profession with two missions: sick nursing and health nursing.

It [nursing] has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light,


11Brainard, *op. cit.*, p. 84.

warmth, cleanliness, quiet, and the proper selection and administration of diet.13

In a paper contributed to the International Congress of Charities, Correction and Philanthropy in 1893, Miss Nightingale defined nursing as care that puts a person in "the best possible conditions for nature to restore or to preserve health— to prevent or to cure disease or injury."14

Nursing proper is therefore to help the patient suffering from disease to live— just as health nursing is to keep or put the constitution of the healthy child or human being in such a state as to have no disease.15

Florence Nightingale recognized the importance of training women to educate communities in the essentials of hygiene. "On women we must depend, first and last for personal Hygiene."16 She visioned a corps of nurses, "missioners of health", going into homes, not only to nurse the sick but also to teach the essential principles of keeping the body healthy.17


15Ibid., p. 446.

16Nightingale, Notes on Nursing, p. 221.

17Nightingale, "Sick Nursing and Health Nursing", p. 452.
Through the joint effort of Florence Nightingale and William Rathbone, an English philanthropist, modern visiting or district nursing was founded. Coming from a family with strong philanthropic and liberalistic beliefs, Rathbone had long been sensitive to the needs of the poor. In 1859 he put into practice the idea of using the services of trained nurses in the homes of the sick poor. To test the idea, one nurse was employed for a three month period to visit the sick poor in Liverpool.\textsuperscript{18}

The utilization in the homes of the people of nurses, who at the same time became teachers and sought to remove the causes underlying much of the trouble, was astute and logical from the philanthropist's point of view.\textsuperscript{19}

Results of the experiment were so satisfactory, Rathbone decided to establish, at his own expense, a body of trained nurses to care for the sick poor at home. Consequently, he turned to Miss Nightingale for assistance and advice. She suggested that nurses be trained for the task. In 1862 Rathbone opened a Training School and Home for Nurses in conjunction with the Royal Liverpool Infirmary. A major goal of the school was to provide district nurses for the poor.\textsuperscript{20}


\textsuperscript{20}Woodham-Smith, \textit{op. cit.}, p. 295.
Although Miss Nightingale lamented that she could not give herself to district nursing, she "held the threads of the movement in her hands." In 1874 she wrote a pamphlet, "Suggestions for Improving the Nursing Service for the Sick Poor," and collaborated with Rathbone to found a district nursing program, the Metropolitan Nursing Association, in London. One of her ablest students, Miss Florence Lees (later Mrs. Dacre Craven), was chosen as the first director.

With their services encompassing preventive as well as therapeutic aspects, Miss Lees recognized the knowledge and training of district nurses should differ from that of hospital nurses. She recommended district nurses be recruited only from the class of educated gentlewomen.

There were several grounds for this decision suggested by me, and these were chiefly that, in nursing the poor in their own homes, nurses were placed in positions of greater responsibility in carrying out the doctor's orders than in hospitals; that women of education would be more capable of exercising such responsibility; and that a corps of nurses recruited altogether among ladies would have a greater influence over patients, and by their higher social position would tend to raise the whole body of professional nurses in the consideration of the public.

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21 Ibid., p. 350.
22 Ibid., p. 337.
After completing a year of hospital training, candidates for district work were admitted to a special six-months course in district nursing. This supplementary training was carried out in a district and under the constant supervision of a district superintendent.24

In 1887 Miss Nightingale gave her support to the newly founded Queen’s Institute of District Nursing, established in honor of Queen Victoria’s Jubilee.25 Funds, donated by the women of England to commemorate the fiftieth anniversary of her Majesty’s reign, were set aside to provide training for district nurses. Incorporated by royal charter, the Queen Victoria Jubilee Institute for Nurses consolidated existing groups of district nursing into one organization and standardized the training and service for district nurses. District associations affiliated with the Institute had to be non-sectarian and conform to the prescribed educational standards and working conditions. Inspectors systematically visited associations to assure compliance.26

The Queen’s Institute endeavored to upgrade standards of education and practice for district nurses. The Institute recruited primarily well-educated young women of

24Ibid., p. 549.


good social position, set educational requirements, and delineated conditions of service.\textsuperscript{27} The Queen's nurses were missioners of health as well as bedside nurses. Practicing in both cities and country villages, they provided skilled nursing care and taught basic principles of hygiene to patients and their families.\textsuperscript{28}

District nursing was in transition. The concept of district nursing as charity for the sick poor was changing into one of public service.

At last, we find the work of visiting and caring for the sick poor safely placed on a sure and solid foundation. . . . It is in the hands of brave, strong, competent trained nurses. Bedside care and health teaching go hand in hand; the service is offered to all without restriction to creed or church; the work is not only a charity, based on the old, old precept "love thy neighbor as thyself," but it is also a public service based on scientific principles for the protection of the health of the people.\textsuperscript{29}

The First School Nurses

In the beginning school nurses were predominately district nurses. During the early 1890s a district nursing association in London founded the first school nursing program and provided staff for work in the schools.\textsuperscript{30} Yet the original idea for school nursing is attributed to

\begin{itemize}
  \item \textsuperscript{27}Ibid., p. 537.
  \item \textsuperscript{28}Ibid., p. 238.
  \item \textsuperscript{29}Brainard, \textit{op. cit.}, p. 131.
  \item \textsuperscript{30}Gardner, \textit{op. cit.}, p. 264.
\end{itemize}
Dr. Malcolm Morris. In 1891 at the International Congress of Hygiene and Demography, Dr. Morris suggested that a staff of specially educated nurses visit elementary schools to inspect the children.31

A year later Dr. Morris' idea became a reality. The unhealthy condition of poor children in London's Drury Lane district so distressed Mrs. Leon, a school manager, that she requested a nurse from the Metropolitan Nursing Association visit the school. Amy Hughes, Superintendent of the Nursing Association, made the first visit and returned daily to treat minor ailments of the children: sore eyes, discharging ears, festering sores, and broken chilblains. Home visits were made to teach parents proper care of the children.32

Miss Hughes' work was successful for the most part. Teachers welcomed the new idea and sent children to the nurse. A nearby physician showed support by organizing a school clinic. Even though the Queen's nurses undertook similar work in other districts of the city, some nursing associations objected to the work because of insufficient funds and staff.33

The first effort to organize school nurses occurred in 1897. At that time Honnor Morten, a trained nurse and


33Ibid. p. 29.
member of the London School Board, founded the London School Nurses' Society. Supported by private donations, the Society provided nurses for elementary schools in the poorest districts of the city. Three nurses were appointed, each responsible for four schools.  

Quoting from a report of the Society, Miss Morten described the nurses' work.

There is no more sure way of securing the health of the people than to arrest small ills at the beginning; a nurse can see at a glance whether a child should be sent to a doctor; she can impress cleanliness; she can follow up bad cases to their homes; she can recognize the early symptoms of fevers and do much to stop the spread of those infectious diseases which so often devastate our schools.

The school nurse achieved excellent results. Within six months cases of "bad eyes and dirty heads" declined significantly.

In 1900 the London School Board employed one nurse, at a salary of seventy pounds a year, to inspect children's heads. Four years later, a municipal organization, the London County Council, assumed the work of the School Nurses Society.

The sympathetic attitude of the Board of Education toward the school nurse has had the result of creating a growing army for the care of the children, the usual mode of recruitment being by agreement with district nursing associations,

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34 Morten, op. cit., p. 274.
36 Struthers, op. cit., p. 30.
the education authorities paying sums proportioned to the work they required.  

The Rise of School Nursing in America

Turn of the century events: influx of immigrants, congested tenement and slum living, sweatshops, high infant mortality, and a growing emphasis on preventive medicine and communicable disease control, fostered the development of visiting nurse associations in America. Initially visiting nursing was confined primarily to general care of the sick poor. As public health and social reform movements gained momentum, activities of the visiting nurse broadened. She became "a part of a community plan for communal health." Recognizing the preventive and educative, as well as curative, value of the visiting nurse, many social agencies and anti-disease crusades sought her help.

But with expansion came specialization; organized branches of service, focusing on specific populations and illnesses, emerged from daily tasks of the visiting nurse. In time, a prefix denoting her specialty, was added to the title of the visiting nurse, namely, tuberculosis nurse, maternity nurse, baby nurse, and the like. Public school nursing was an outgrowth of this movement.

38Ibid., p. 214.
39Brainard, op. cit., p. 263.
Nurses expanded their role in the community and became more responsive to societal health needs largely through the humanitarian efforts of Lillian Wald. Distressed by the sight of a sick woman in a New York tenement, Miss Wald envisioned a nursing service for the sick poor in New York’s lower east side.

That morning’s experience was a baptism of fire... to my inexperience it seemed certain that conditions such as these were allowed because people did not know, and for me there was a challenge to know and to tell. When early morning found me still awake, my naive conviction remained that, if people knew things—and "things" meant everything implied in the condition of this family—such horrors would cease to exist, and I rejoiced that I had a training in the care of the sick that in itself would give me an organic relationship to the neighborhood in which this awakening had come.40

In 1893 she and a training-school friend, Mary Brewster, opened the first visiting nurse service for New York City on the top floor of a Jefferson Street tenement. "We were to live in the neighborhood as nurses, identify with it socially, and, in brief, contribute it to our citizenship."41 Two years later they moved to the house at 265 Henry Street.

The work begun from the top floor of the tenement comprised, in simple forms, those varied lines of activity which have since been developed


41Ibid.
into the many highly specialized branches of public health nursing.\textsuperscript{42}

Throughout her career Lillian Wald endeavored to enhance the health and quality of life for the less fortunate. She founded the Henry Street Settlement, directed the Henry Street Visiting Nurse Service, and conceived the idea for school nursing, the Children's Bureau, and the Town and Country Nursing Service. She was a leader in civic, educational, and social reforms. She fought for child labor laws, parks and playgrounds, better housing in tenement districts, classes for the handicapped, milk stations, and licensure for midwives. The work of Miss Wald and the Henry Street nurses exemplified all that nursing could and should be.

She [the nurse] is enlisted in the crusade against disease and for the promotion of right living, beginning even before life itself is brought forth, through infancy into school life, on through adolescence, with its appeal to repair the omissions of the past. . . . The nurse is being socialized, made part of a community plan for the communal health. Her contribution to human welfare, unified and harmonized with those powers which aim at care and prevention, rather than at police power and punishment, forms part of the great policy of bringing human beings to a higher level.\textsuperscript{43}

Miss Wald's idea for school nursing originated with a twelve year old boy excluded from school because of

\textsuperscript{42}Ibid., p. 44.

\textsuperscript{43}Ibid., p. 60.
eczema.44

I had been downtown only a short time when I met Louis. An open door in a rear tenement revealed a woman standing over a washtub, a fretting baby on her left arm, while with her right hand she rubbed at the butcher's aprons which she washed for a living.

Louis, she explained was "bad." He did not "cure his head," and what would become of him, for they would not take him into the school because of it? Louis, hanging the offending head, said he had been to the dispensary a good many times. . . . But "every time I go to school Teacher tells me to go home."

It needed only intelligent application of the dispensary ointments to cure the affected area, and in September I had the joy of securing the boy's admittance to school for the first time in his life.45

This experience triggered a series of events that ultimately gave rise to the practice of school nursing.

Louis set me thinking and opened my mind to many things. Miss Brewster and I decided to keep memoranda of the children we encountered who had been excluded from school for medical reasons, and later our enlarged staff of nurses became equally interested in obtaining data regarding them.46

Data supplied by the Henry Street Nurses Settlement helped the city procure funds for medical inspection in the schools. In 1897 New York City appointed its first medical inspectors. Physicians daily visited the schools for the purpose of examining children and excluding those with contagious diseases. But medical inspection proved to be a perfunctory service and only superficially met the health

44Ibid., p. 53.
45Ibid., 46.
46Ibid., p. 48.
needs of students. The Henry Street nurses recognized that medical inspections were deficient from the standpoint of the child: exclusion without treatment, counseling, or follow-up care.

The total results of the visits of the medical inspectors to the schools was the exclusion of children of communicable disease. No effort was made to obtain treatment for the sick, remedial measures for those with physical defect, or care for the anaemic and undernourished. It was quite common to have schools report that ten to twenty percent were absent because of disease, devility, or defect.

Children were sent home until proof of cure was shown or they were free from contagion. Oftentimes neither excluded children nor their parents understood the instructions on the exclusion card. With few children receiving treatment truancy was encouraged.

In many cases the excluded children, not fully understanding the instructions, played on the street with their companions as they came out of school and lost or destroyed the cards. In other instances the cards were taken home, but the parents, often ignorant of the English language, did not understand what the child tried to explain and the Latin names were uncomprehended. . . . In many instances the cards were never looked at, but remained in their sealed envelopes while the child played on the street.

In 1902 thousands of children were excluded because of trachoma. Where medical inspection was most thorough, classrooms were depleted, "In a single school three hundred

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47Struthers, op. cit., p. 16.

children were out at one time." To resolve the dilemma, Miss Wald presented an idea to the Boards of Education and Health: send a nurse into the schools. She offered the services of a Settlement nurse as a demonstration of what a nurse could do to alleviate absenteeism among ill and neglected children.

The time has 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.50

On October 1, 1902 Lina Rogers inaugurated school nursing. As a one-month experiment, she daily visited four schools, spending an hour in each.

Here she dresses or cleanses all such cases as the physician directs, mild cases of conjunctivitis, minor skin infections, such as ring-worm, etc., and the children need not then miss their class-work, as otherwise they would have to do as a matter of protection to the rest. She then visits those who have been sent home, and keeps records of them.51

Her primary objective was to keep the children in school.

But Lina Roger's task was not an easy one. Her only supplies were those donated by the Settlement. Dispensaries


50Wald, op. cit., p. 51.

were improvised in the schools. Describing the early years of school nursing, Miss Rogers recounted her experiences.

In old school No. 12, an unused stair closet was the only available space for a dispensary, and although the nurse could not stand erect here, there was sufficient room to store supplies. In front of an adjacent window a radiator did duty as a dressing table. An old high chair such as was then used in the New York public schools, was rescued from an ash heap, and the janitor repaired the seat by nailing on a rough board. This was the only accommodation for the children while being treated for eye and skin diseases. This constituted the full equipment of the dispensary for some time. . . . In the other schools the dispensary was in the basement playground where the nurse used the window sills as dressing tables.52

Home visits brought her face-to-face with "all the social problems of humanity."

It was found that many, many school children were out of school from other causes than illness. Many were absent for want of clothing or boots; many were undernourished for want of food; many girls from ten to twelve or thirteen were absent as nurses for the baby sisters and brothers, and cooks for the rest of the family while the mother went out working; many were working at home under wretched conditions at sewing or other work; others were found nursing a sick mother or father; too many others were truants and were already the victims of the temptations of the streets.53

And she struggled with parental fear and indifference.

Children excluded for trachoma were instructed to go to the dispensary for treatment. Parents at first refused to send their children because they were told the treatment consisted of burning the eyes out. It was difficult to make the ignorant parents understand the nature of the


53Ibid., p. 23.
treatment, and not easy to overcome this fear and prejudice. It was most difficult too, to have home care even fairly well carried out.54

Nevertheless, she persevered. She referred families to relief agencies, secured food and clothing for the needy, provided lessons in practical hygiene, and, most importantly, safely retained children in school. Results of the experiment were more than satisfactory. "Eight hundred and ninety-three treatments were given, one hundred and thirty-seven visits were made to the homes, and twenty-five children returned to school."55

Following the one-month experiment, the New York City Health Department appointed Lina Rogers as its first school nurse. In December 1902 the Department added twelve nurses to the staff and named Miss Rogers Superintendent of School Nurses. Early in 1903 funds were appropriated for a staff of twenty-seven nurses. With the advent of school nurses exclusions fell dramatically; statistics from the Health Department revealed that ninety-eight percent of the children previously excluded for medical reasons were retained in classrooms.56

Placing nurses in the schools revolutionized the process of medical inspection.

54Ibid., p. 22.


56Ibid., pp. 767-769.
Medical inspection was succeeded and almost transposed by the addition of the visiting nurses. The medical inspection got the child out of school, and the visiting nurse got the child back. It seems almost foolish to have medical inspection without the visiting nurse.57

From the standpoint of the child's health and education, one without the other was ineffective.

It requires the trained nurse to lend assurance that the advice given by the physician . . . is not thrown away. The medical inspector has accomplished much, but only with the trained school nurse, and her individual care, personal inquiry and knowledge of home life, is the highest degree of efficiency in education procured.58

Educators, boards of health, and the public, in general, supported the idea of school nursing. By 1909 municipalities throughout the country—Boston, Philadelphia, Baltimore, Cleveland, Chicago, Atlanta, Los Angeles, and Seattle—were employing school nurses.59 During these early years the majority of school nurses were functioning under the auspices of visiting nurse associations. Yet once their effectiveness was demonstrated, the Board of Education or Health often assumed administrative control.

Within a decade school nursing became a viable practice. Its philosophical base broadened to include preventive and educative aspects as well as humanitarian and

57Jane Addams, "The Visiting Nurse and the Public Schools," American Journal of Nursing 8 (August 1908): 919.


59Waters, op. cit., p. 367.
curative services. Responsibilities became more varied: 
daily, weekly, or monthly inspections in classrooms; 
emergency services; instruction of children in personal 
hygiene; sanitary inspections of homes; summer work in 
prevention of infant mortality; and reporting of truancy 
cases."\(^6\) As an outgrowth of home visits, school nurses 
performed many duties of the truant officer and social 
worker.

In 1912 school nursing became a specialized branch of 
the newly formed National Organization for Public Health 
Nursing. Founded for the purpose of standardizing visiting 
nurse activities, the N.O.P.H.N. assimilated all types of 
visiting nursing into one body.\(^6\)

The use of the word "nursing" instead of 
"nurses" made it possible to bind together, in one 
great national organization, the great and ever 
increasing body of layworkers with nurses in the 
common cause of public health education and 
service.\(^6\)

Thereafter, nurses engaged in school work and community 
health services were known collectively as public health 
nurses.

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\(^6\)Isabel M. Stewart, "The Educational Value of the 
Nurse in the Public School," in The Ninth Yearbook of the 
National Society for the Study of Education 

\(^6\)"Report of the Joint Committee Appointed for 
Consideration of the Standardization of Visiting Nursing," 

\(^6\)Mary S. Gardner, "The National Organization for 
Public Health Nursing," Visiting Nurse Quarterly 4 (July 
1912): 16.
Summary

Using a chronological format, this chapter reviewed the historical foundations of school nursing. Benchmark events and movements influencing the course of visiting nursing, and ultimately school nursing, were emphasized. Florence Nightingale and notable pioneers in school nursing, namely, Lillian Wald and Lina Rogers, were recognized for their contributions to humanitarianism and public health.
CHAPTER V

PROFESSIONAL PREPARATION OF THE SCHOOL NURSE

It is clear that the school nurse needs the soundest training that can be given for work so far reaching and so full of public service as is hers. But of what this training shall consist, just how and where it shall be given are not so evident. . . . For we have a form of service belonging not only to public health but to education as well and both are highly active social movements. As they broaden and develop so must school nursing broaden and develop, charged always with its double set of responsibilities. Clearly then the training of women for school nursing . . . presents many problems distinct and peculiar to itself.¹

Although written in 1916, Anne Hervey Strong’s words still have applicability. Clearly the effectiveness of the school nurse’s work and her professional preparation are interrelated. To function effectively, the school nurse must enter the practice field with essential knowledge and skills. Her professional preparation must reflect the roles and responsibilities she will assume.

Official agencies, professional organizations, public school educators, nurse educators, and school nurses themselves have addressed the professional preparation of the school nurse for years. Despite efforts to define

parameters of practice, to upgrade minimum standards, and to promote supplemental training, confusion and controversy persist. From past to present, there is diversity of opinion about the roles and responsibilities for which the school nurse should be prepared and the academic level necessary for entry into the practice.

Within the context of four time periods, this chapter examines forces and factors that affected the professional preparation of the school nurse. Special emphasis is given to the involvement and influence of professional organizations and official agencies. To place developments and issues of the early years in perspective, an overview of happenings in the education of nurses prior to the turn of the century is presented.

The Early Years

Originating in America during the 1870s, the movement to establish hospital schools of nursing spread rapidly. In 1880 there were fifteen hospital training schools; in 1890, there were thirty-five, and by 1900, over four hundred.2 The stability and low cost of student labor benefited hospitals. Many training schools were hastily improvised for economic reasons only. "It soon became an accepted

principle that a school of nursing was indispensable in running a hospital."³

Unfortunately service duties often usurped student learning. A lack of trained teachers, a meager and insufficient body of theory, and a paucity of classrooms, laboratories, and teaching materials further daunted the education of student nurses.⁴

The educational scheme in Training Schools for Nurses comprised little beyond such information and training as accrued from the various activities which went into the day's work. There was in addition a small amount of formal instruction, limited to the first year and consisting chiefly of lectures irregularly given by voluntary lecturers. The real function of the School of Nursing was not education but service.⁵

The idea prevailed that nursing the sick did not require educated women. Physicians, in particular, conceded that education for nurses was neither necessary nor desirable.⁶ Perceiving nursing as a subordinate branch of medicine, some physicians feared nurses would become overeducated and supplant them. That the private duty nurse


⁴Mary Adelaide Nutting, "How Can We Care for Our Patients and Educate the Nurse?" in Nutting, op. cit., p. 317.

⁵Mary Adelaide Nutting, "The Evolution of Nursing Education from Hospital to University," in Nutting, op. cit., p. 295.

would emerge as an independent practitioner was a major concern.7

By the 1890s proliferation of schools, lack of program uniformity, and exploitation of students beset the nursing profession. Standards for the education of nurses were non-existent. Programs differed widely in scope and length, ranging from three year schools to correspondence courses.

The object of schools for nurses is primarily to secure to the hospital a fairly reliable corps of nurses. . . . Each school is a law unto itself. Nothing in the way of unity of ideas or of general principles to govern all exists, and no effort towards establishing and maintaining a general standard for all has ever been attempted. . . . A "trained nurse" may mean then anything, everything or next to nothing.8

Endeavoring to effect change, newly founded nursing organizations called for uniform standards of training. The first national nursing organization, the American Society of Superintendents of Training Schools for Nurses, formed at the International Congress of Charities, Correction and Philanthropy in 1893 under the leadership of Isabel Hampton, sprang from the belief that banding together was necessary for educational reform and advancement.


Until we can get superintendents united regarding the fundamental principles of the work, we cannot expect the nurses to work and to unite and to be as successful as they must be later on when we hold ideas in common. The next thing we can take steps toward accomplishing is to organize a superintendents' society and also alumnae associations in connection with every good school in the country.8

Forerunner of the National League of Nursing Education, the Society resolved to "further the best interests of the nursing profession by establishing and maintaining a universal standard of training."10

By urging schools to organize alumnae associations, the Society fostered the creation of a national association of graduate nurses. In 1886 delegates from the Society and school associations founded the Nurses Associated Alumnae (renamed the American Nurses' Association in 1911). As stated in its constitution, the purpose of this group was to "strengthen the union of nursing organizations, to elevate nursing education, and to promote ethical standards in all the relations of the nursing profession."11

8 Isabel Hampton during a discussion following Isabel McIsaac's paper on "Alumnae Associations for Nurses" at the International Congress of Charities, Correction and Philanthropy, in Hospitals, Dispensaries, and Nursing, pp. 577-578.


To advance the practice of nursing, Isabel Hampton Robb, the Associated Alumnae's first president, urged the membership to form state associations and to institute licensure laws.

State registration is certainly the next and most important step towards achieving a fixed professional standard. ... Only by a complete system of registration will it be possible for trained nursing to attain to its full dignity as a recognized profession and obtain permanent reforms. ... The introduction of a legalized registration would naturally stimulate both schools and graduates to reach the required educational standard. Each school would be obliged to give the pupils such thorough instruction in the theory and practice of nursing as would enable them to pass the examination prescribed by law and obtain the certificate which would authorize them to practice as trained nurses.12

Simultaneously, the International Council of Nurses sought to raise standards of nursing education. Addressing the Council at its first meeting in September 1901, the president, Mrs. Bedford Fenwick, enumerated the organization's most pressing concerns.

We need post-graduate teaching to keep ourselves in the running; we need special instruction as teachers to fit us for the responsible positions of sisters and superintendents; we need a State-constituted board to examine and maintain discipline in our ranks, and we must have legal status to protect our professional rights and to insure to us ample professional autonomy.13

12 Isabel Hampton Robb, "Address of the President," American Journal of Nursing 1 (November 1900), pp. 101-103.

She expressed the need for "a more thorough and better organized educational curriculum for trained nurses, and the foundation and endowment of colleges in which such education can be centered." During the course of their meeting Council members passed a resolution endorsing the state registration of nurses.

It is the opinion of this International Congress of Nurses, in general meeting assembled, that it is the duty of the nursing profession of every country to work for suitable legislative enactment regulating the education of nurses and protecting the interests of the public, by securing State examinations and public registration, with the proper penalties for enforcing the same.

With nursing associations, both nationally and internationally, urging legislative action to regulate standards of practice and education, a move to form state associations commenced. Lobbying for nurse registration was the principal motive of state associations. In March 1903 North Carolina enacted the first nurse registration law. Later that year New York, New Jersey, and Virginia passed legislation governing the education and practice of nurses.

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14 Ibid., p. 7.


16 Dock, op. cit., pp. 142-156.
As a part of the Society of Superintendents' efforts to improve the quality of training schools, a course in teaching and administration, Hospital Economics, was created at Teachers College, Columbia University, in 1899. The course was the idea of Isabel Hampton Robb, chairman of the Society's education committee. A trained teacher as well as a nurse, Mrs. Robb had long advocated special preparation for graduate nurses teaching in schools of nursing. "A Normal School for preparing women for such posts is quite as necessary as those established for other kinds of teachers." Even though the course was developed for the purpose of training graduate nurses to teach, its ultimate aim was to attain uniformity in curricula and training methods.

In the midst of the struggle to enhance the education of nurses and institute licensure, school nursing emerged. Initially, visiting nurses were sent into the schools with limited preparation for their duties. They were simply graduate nurses. Some served an apprenticeship but most learned from experience, from their successes and failures.

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17 Hampton, Hospitals, Dispensaries, and Nursing, p. 40.
18 "Columbia University in the City of New York-Teachers College: Special Course in Hospital Economics," American Journal of Nursing 2 (May 1902): 596.
19 Strong, op. cit., p. 354.
At the turn of the century training in district work at the Henry Street Settlement was advised for students in "certain training schools having, or planning to have the three year course."  

There are many arguments for bringing this into the hospital curriculum. All the responsibility of the sick poor has not been assumed unless a share is taken in the problem of efficient treatment in their homes, and the numerous inquiries that come to the Settlement from educators and graduated nurses show that many of the best thinkers in the profession are interested in the subject. The frequent demand for nurses who have had any experience in it is another reason.

But few schools of nursing supported the idea that students should be prepared for practice in non-hospital settings. Most schools perceived visiting nursing as a specialty requiring post-graduate training and experience.

In 1902 a prominent visiting nurse, Harriet Fulmer, proposed special post-graduate courses be instituted for all nurses entering the field. "Too many nurses come into the work having little idea as to the requirements and demands."

Eight years later Teachers College endeavored to alleviate this deficiency by opening the first university program for nurses engaged in community health work. A

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21 Ibid.

$150,000 endowment from one of its trustees, Mrs. Helen Hartley Jenkins, enabled Teachers College to create a Department of Nursing and Health and to initiate post-graduate training for the preventive and social branches of nursing. The program aimed to prepare "teacher nurses" for visiting nursing, school nursing, boards of health, and the like.23

The case for special training was further aided by the American Red Cross. In 1912, acting on Lillian Wald's suggestion, the Red Cross created a rural nursing service. Embracing a number of public health specialties, including school nursing, the program aimed to improve health care and living conditions in rural areas.24 To function competently with limited facilities and minimal supervision, the Red Cross mandated that nurses in the Town and Country Nursing Service have special training.

Training centers for Red Cross rural nurses offer good opportunities for students to become familiar with social work of various kinds through lectures, study courses, and affiliation with philanthropic societies in the city. . . . It is important that the rural nurse be informed upon the various branches of public health nursing and social service as carried on in cities, in order that she may initiate work along these lines in


country places where it is often wholly unorganized.\textsuperscript{25}

The prerequisite for the service besides three years of hospital training, was a special four-months course in municipal sanitation, preventive medicine, dietetics, and public health.\textsuperscript{26}

The activities of rural nursing were centered in public schools. Rural nurses served in health centers and clinics but their greatest impact was in the schools, "where so much could be done both in caring for children and giving them health education."\textsuperscript{27} Hence, educational standards set for rural nursing carried implications for the preparation of school nurses.

The lack of preparation for practice was a persistent concern throughout the early decades of school nursing. Two or three years in a good hospital training school were generally recognized as a necessary foundation. But hospital programs were academically deficient from the standpoint of the practice's roles and responsibilities. Attempting to offset these deficiencies, a number of recommendations were issued to upgrade the training and competency of school nurses.

\textsuperscript{25}Fannie F. Clement, "Rural Nursing," \textit{American Journal of Nursing} 13 (April 1913): 521.

\textsuperscript{26}Dulles, \textit{op. cit.}, p. 100.

\textsuperscript{27}Ibid., p. 252.
In 1910, speaking before the National Society for Education, Isabel Stewart, a nurse educator at Teachers College, recommended the training of school nurses be "broad, sound, and thorough."²⁸

The school nurse should be a graduate of a recognized general training school, which includes special work with children, a good experience in eye, ear, nose, and throat work, and in infectious and skin diseases. She should also have a thorough training in everything that relates to nutrition and general hygiene.²⁹

She maintained that school nursing demanded educated women, who knew not only "how to do" but also "why". Consequently, she emphasized the necessity of post-graduate training.

Much of the training of the school nurse must inevitably come after graduation. If she is to be an expert in her field, she must specialize on the subject of children, on their physical and mental constitution, on child hygiene and child psychology, on children's diseases, the history of infant mortality, the social movements which involve child welfare, etc. She should also be in touch with the educational problem, so that she can co-operate sympathetically with the work and the ideals of the school.³⁰

Anne Bervey Strong, professor of public health nursing at Simmons College, echoed Miss Stewart's belief that broad, through training was a requisite for effective school nursing. To provide a sounder basis for specialization, she


²⁹Ibid.

³⁰Ibid., p. 59.
proposed training schools offer more thorough instruction in "hygiene, in nutrition, in pediatrics, in both major and minor contagion and throughout the course greater emphasis upon the social aspects and implication of disease." She urged post-graduate training in a university for the non-technical aspects of school nursing.

The school nurse should know at least the elements of psychology and the principles of teaching, of sociology and social work, of chemistry and biology, and their applications to preventive medicine and sanitation. She can profit greatly by other college studies, especially theme work in English, history, and economics.

Ella Phillips Crandall, Executive Secretary of the National Organization for Public Health Nursing, declared that school nurses should be not only graduate nurses but also registered. Since the term "graduate" or "trained" nurse was subject to many interpretations, this requirement was the only assurance that prospective school nurses had received even a minimum of suitable training. She further suggested the educational preparation of school nurse emulate that of the teaching staff.

... It should be insisted upon that her preliminary education shall be at least a high-school graduation or its equivalent. At

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31 Strong, op. cit., p. 358.

32 Ibid., p. 359.

present the statutory requirement in some States is one year of high school, and nurses are holding even that standard with difficulty. . . . Therefore it is obviously necessary to select carefully even among registered nurse to secure those who have had suitable general education. . . . There should not be placed upon the staff of the public schools in the capacity of school nurse women of much lower educational attainments than would be appointed to any other office in the schools. . . .

As a fair proportion of women graduating from our nurses' training schools have had full high-school work or normal training, while several have college degrees, or a partial college course, it will be possible ultimately to secure women of such education when once the requirement is made.\textsuperscript{4}

Like many of her colleagues, Miss Crandall felt school nurses required special training not attainable in hospital programs. To develop expertise in their field, she recommended school nurses pursue post-graduate studies:

(1) Special theory and practical experience in the care and study of infants and children, including general diseases of childhood, contagious and skin diseases, and those of eye, ear, nose, and throat.
(2) Special dietaries and food economics and nutrition.
(3) Physiology, hygiene, and psychology of child welfare.
(4) History of the movements in behalf of child welfare.
(5) Domestic and municipal sanitation, including house construction.
(6) Principles and methods of relief.
(7) Principles and methods of teaching.\textsuperscript{5}

\textsuperscript{4} Ibid.

\textsuperscript{5} Ibid., p. 533.
Although she acknowledged the necessity of university courses, Lina Rogers Struthers favored visiting nurse experience as a prerequisite for school nursing.

A complete and thorough technical training, preferably in a children's hospital, is the necessary foundation for the superstructure of the additional training required to fit a nurse for the school service. . . . But the nurse who has just graduated from the best of hospitals is not yet fitted for school nursing. She needs experience before she undertakes the greater responsibility of school nursing. She should have two years' experience in private practice and six months in district nursing. Her training in district nursing will be her final preparation for beginning her training in school nursing, when she should spend six months under another nurse before being placed in full charge of schools.38

She also noted the responsibilities of school nurses demanded more than "thorough training, ability, keen observation, good sense, and sound judgment."37 Personal qualities were essential, too.

Above all other things the school nurse must have a deep, human love for children, a charity and kindliness that embraces all children in its sympathy. . . . She must gain the confidence of all by gentleness, affability, wonderful patience and persistence, by a missionary love for the child, and a great vision of saving childhood from suffering and disease. Her disposition should be cheerful but earnest, bright but not frivolous, with a sincerity and good sense not easily disgusted by crudeness.38

37Ibid., p. 228.
38Ibid., p. 229.
That school nurses required additional training was a certainty, but the "what, how, and where" were enigmas. The diversity of the practice hindered attempts to define essential requisites. School nursing was a service belonging not only to public health but also education. Some nurses were employed by departments of health, others by boards of education, still others by rural health programs. Along with familiar duties--conducting classroom inspections, administering first aid, visiting parents, and teaching hygienic practices--a variety of activities, demanding unique qualifications, were being requested of school nurses.

One community sent to us for a school nurse who was trained in recreation work and who would be qualified to direct all the organized recreation and to supervise the school playground. Another school wanted a nurse who could teach also the regular classes in hygiene; and for this work, quite rightly, normal training and successful teaching were prerequisite. . . . A smaller institution wanted a school nurse who could act also as director of physical education. And a rural community wanted to find a school nurse who was qualified to act as truant officer. . . . A suburban community . . . wanted to find a nurse who could conduct a summer playground, teach handwork, organize clubs of various sorts, and in general keep the children healthy and busy. 38

As their role shifted from correction to prevention and education, the teaching responsibilities of school nurses expanded. They were teaching principles and practices of

hygiene to teachers and parents, as well as elementary students.

Efforts to prevent the spread of disease must be actively supplemented by teaching the laws of health. . . . The school nurse should, therefore, be able to present these laws in a simple but instructive way. 40

But the training of most school nurses was especially deficient in pedagogical principles and methods.

The Cleveland School of Education was one of the first normal schools to devise a course for school nurses. 41 Initiated during the summer of 1916, at the urging of a school nurse supervisor, Anna Louise Stanley, the course encompassed both theory and practice. Subjects focused on practical information about school nursing, the hygiene of school children, and the school's role in child and community health. The nurses spent two hours per week in elementary schools actively participating in classroom drills and teaching infant hygiene. 42 Several years later the School's Dean designed a course in teaching methods for school nurses.

They know the school problems confronting them, they know what the boys and girls ought to be taught in the matter of health control, but they frequently do not know the best scientific,

40 Struthers, op. cit., p. 245.


42 Ibid.
economic methods to employ in presenting their subject matter.44

From 1910 to 1920, as school nurses struggled to enhance their professional training, a series of noteworthy events unfolded in nursing education. In 1912, the chairman of the Education Committee of the N.L.N.E., Adelaide Nutting, assisted the United States Bureau of Education in a study of nursing schools. The findings, printed in Educational Status of Nursing, revealed a vast disparity in standards, curricula, and facilities.44

Two years later the Committee began work on a standard curriculum for schools of nursing. Published in 1917, the Standard Curriculum for Nursing Schools served as a guide for schools laboring to upgrade educational standards. Although limited in social and preventive aspects, the program of study was designed thoughtfully with objectives, content, instructional methods, and bibliographies for each course. The Committee emphasized the need for well-prepared faculty, better-qualified students, and shorter hours of student service.45


Two generic programs, leading to a baccalaureate degree in nursing, emerged in 1916, one at the University of Cincinnati and the other at Teachers College. Both schools offered a five-year curriculum comprised of liberal arts and clinical nursing courses. Most of the fifth year was devoted to special preparation in either public health or teaching.\(^4^6\)

In 1919 a committee, appointed by the Rockefeller Foundation, initiated a national survey of nursing and nursing education. Originally devised as a study of the "proper training of public health nurses," the survey was broadened to include "a study of general nursing education."\(^4^7\) The committee sought

\[\ldots\] to survey the entire field occupied by the nurse and other workers of related type; to form a conception of the tasks to be performed and the qualifications necessary for their execution; and on the basis of such a study of function to establish sound minimum educational standards for each type of nursing service.\(^4^8\)

The Twenties and Thirties

In 1923 the committee published their findings, and recommendations in a 585 page document, *Nursing and Nursing Education in the United States*. Written by Josephine Goldmark, a prominent social researcher and Secretary of the

\(^4^6\)Ibid., p. 226.


\(^4^8\)Ibid.
Committee, the survey, commonly called the Goldmark Report, revealed certain basic faults in nursing education: lack of good teachers, lack of correlation between theory and practice, waste of students' time in non-educational duties, inadequate supervision of practice, and long hours of ward service. The committee concluded

... that the instruction in such schools is frequently casual and uncorrelated; that the educational needs and the health and strength of students are frequently sacrificed to practical hospital exigencies; that such shortcomings are primarily due to the lack of independent endowments for nursing education, that existing educational faculties are on the whole, in the majority of schools, inadequate for the preparation of the high grade of nurses required for the care of serious illness, and for service in the fields of public health nursing and nursing education.49

Hence, they recommended public health nurses receive supplementary training beyond their basic education.

All agencies, public or private, employing public health nurses, should require as a prerequisite for employment the basic hospital training, followed by a postgraduate course, including both class work and field work, in public health nursing.50

The Committee further stressed the necessity of endowing collegiate schools of nursing.

The development of nursing service adequate for the care of the sick and for the conduct of the modern public health campaign demands as an absolute prerequisite the securing of funds for the endowment of nursing education of all types;

49Ibid., p. 21.
50Ibid., p. 11.
and that it is of primary importance, in this connection, university schools of nursing.51

Another study of significance closely followed the Goldmark Report. In 1926, an interdisciplinary group, the Committee on the Grading of Nursing Schools, embarked on an extensive investigation of nursing economics. Composed of representatives from the American Nurses Association, the American Medical Association, the American Public Health Association, the American College of Surgeons, the American Hospital Association, the National League of Nursing Education, and the National Organization for Public Health Nursing, the committee purported to study the "ways and means for insuring an ample supply of nursing service, of whatever type and quality is needed for adequate care of the patient, at a price within his reach.52

Study findings revealed a surplus of nurses in public health. On the average, 5.5 individuals applied for each staff position.53 Yet vacancies remained because many aspirants were inadequately prepared.

The most frequent reasons for refusing applicants were usually because they lacked theoretical courses and practical experience in

51 Ibid., p. 30.

52 May Ayres Burgess, Nurses, Patients and Pocketbooks (New York: Committee on the Grading of Nursing Schools, 1928), p. 17.

53 Ibid., p. 112.
public health, or because they did not have the academic background needed.54

The committee inferred the shortage was in quality, not quantity.

A revised edition of the N.L.N.E. Standard Curriculum, published in 1927, stipulated that training schools offer principles of public health nursing in their basic curricula.

Health nursing is just as fundamental as sick nursing and the prevention of disease at least as important a function of the nurse as the care and treatment of the sick. . . . With the recent rapid development of the public health movement, there seems to have been some tendency to identify these social and preventive elements with the work of the public health nurse and the social service nurse instead of with the basic practice of nursing itself. This was perhaps natural since there has been more opportunity to stress these elements in community health work, but it would be unfortunate if we should begin to consider them as "extras" in the nurse's training, to be obtained only through experience in public health nursing or social service.55

The revision was based on the premise that social, preventive, and teaching aspects of nursing should be taught in all good nursing schools. Urging community nursing as an elective, the League collaborated with the Education Committee of the N.O.P.H.N. to formulate objectives for student learning experiences.56

54 Ibid., p. 113.

55 Committee on Education of the National League of Nursing Education, A Curriculum for Schools of Nursing (New York: National League of Nursing Education, 1927), pp.11-12.

56 Ibid., pp. 56-57.
In the era following the Goldmark Report, a number of conferences and committees addressed the professional preparation of school nurses. Many recommendations and resolutions emanated from these meetings. Committees functioning under the auspices of the N.O.P.H.N. especially sought to elevate the educational status of school nurses.

In 1926, a committee chaired by Elmira Bears, Secretary for School Nursing in the N.O.P.H.N., suggested courses for school nurses as part of a statement on the objectives, scope of work, and methods in school nursing. To attain success in their practice, the committee urged school nurses to "see the school health program in its dual relationship to the educational program and the public welfare movement." Preparation for this duality was apparent in the broad topics recommended for study: Theory and Practice in Public Health Nursing, Theory and Practice in Sociology, Preventive Medicine, and Educational Methods in Public Health.

Two years later the Education Committee of the National Organization for Public Health Nursing approved an outline


58 Ibid., p. 77.

59 Ibid., p. 79.

At the 1932 biennial convention of the N.O.P.H.N. the School Nursing Section suggested "promoting higher qualifications for school nursing positions" as a program activity. Changes in committee structure, adopted during the assemblage, gave the School Nursing Section its own

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61 Ibid.

education committee. The Subcommittee on School Nursing of the N.O.P.H.N. Education Committee was dissolved and its functions transferred to a newly constituted Education Committee of the School Nursing Section.

In the late 1930s, continually endeavoring to raise educational standards, the N.O.P.H.N. prepared minimal qualifications for new appointees in school nursing:

Graduation from an accredited high school.

Graduation from a school of nursing accredited by the state board of nurse examiners and connected with a hospital having a daily average of 100 patients.

Instruction and experience in the care of men, women, and children, including patients with communicable diseases.

Registration for the current year under the nurse practice law of the state.

Personal qualifications: . . . an interest in and ability to work with children and adults; good physical health and emotional stability; initiative; good judgments; resourcefulness.

Although not requisites, instruction and experience in public health nursing, psychiatric nursing, and outpatient clinics were recommended.

During the twenties and thirties, regardless of their service field—urban, rural, generalized, specialized—

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63 Ibid.


65 Ibid.
school nurses were encouraged to prepare for dual responsibilities: education and nursing. Training on a par with teachers was advised.

In 1922, describing an educational program for school nurses, the Medical Director of the Trenton Public Schools wrote:

It is desirable that all public health nurses have an educational background of at least graduation from high school and hospital training school. It is further desirable that they have a public health course, of at least a year, as is now given at several colleges and universities. For work with children it is a great advantage if they have had training as a teacher in the schools.66

A health bulletin, published in 1924 by the Bureau of Education, urged rural school nurses to show evidence of a general education.

As a basis for school nursing, graduation from a good hospital training school is the first essential. This presupposes certain educational requirements for entrance to the hospital; and the more general education the school nurse has, the more fitted she will be to meet teachers and other educators on their own ground with a feeling of equality. In her own specialized field the nurse feels that she can speak with authority; it is essential that she should be, and feel, so qualified. It is very great help to the school nurse, however, to have and show evidences of an education. . . . The school nurse should use good English in speaking and writing and should know something besides her own work of school nursing.67


A four months' course in public health nursing also was suggested. In a school of public health nursing the student becomes familiar with public-health problems in general, any or all of which she is likely to meet in school-nursing work.\textsuperscript{68}


The nurse should be a graduate of an accredited school of nursing, which provides theoretical instruction and experience in medical, surgical, and obstetrical nursing. General education equivalent to a high school course is highly desirable and should be required where local conditions make this possible. The nurse should not undertake work alone without special preparation for the public health field obtained either by a postgraduate course or by experience in an organization offering educational supervision. Nurses should be registered in the state in which they work.\textsuperscript{69}

Delineating principles of school nursing, the manual addressed dual responsibilities.

School nursing requires that the nurse have an understanding of the school program as a whole and of her part in it, as well as of her part in the community welfare program. School nurses have a dual relationship to consider, one to public welfare workers and agencies, the other to the schools and school personnel.\textsuperscript{70}

\textsuperscript{68}Ibid., p. 38.


\textsuperscript{70}Ibid., pp. 110-111.
The N.O.P.H.N. reaffirmed its position a decade later.

Since the school nurse is working in an educational institution and is coordinating her activities with those of qualified educators, it is desirable that she be familiar with educational methods and school administration. The trend in school nursing today is toward individual and family health education instead of first-aid and clinic service. It believed, therefore, that in addition to her professional preparation, the educational qualifications of the school nurse should be comparable to those of other members of the school faculty.\footnote{National Organization for Public Health Nursing, Manual of Public Health Nursing, 3d ed. (New York: The Macmillan Co., 1939) pp. 260-261.}

By the mid-thirties dual preparation was deemed essential for the nurse in high school health services.

In addition to being a well prepared public health nurse she should have an understanding of the problems of this age-group; should be equipped to teach and to counsel students; and should be well informed in regard to the aims, administration, and activities of secondary schools.\footnote{Hazel Foeller, "The Nurse in the High School," Public Health Nursing 28 (September 1936): 619.}

A baccalaureate degree and special training in the principles and methods of teaching were desirable.

The basic principles of teaching are certainly as important to the nurse who teaches as to other teachers. The nurse needs to have some basis for selection of those experiences which will contribute to the aims of secondary education. . . .

Many schools are requiring college preparation of their teachers and the nurse who holds a degree and has had special preparation in
the theory and practice of teaching is being given preference over others.73

Supporting the philosophy that education for healthful living was the primary function of school nurses, Mary Ella Chayer, in 1936, recommended four major areas of preparation: "a strong background of science; knowledge of school administration and methods of teaching; knowledge of child development and health supervision, knowledge of community health and welfare."74 In the 1937 edition of her book, School Nursing, Chayer, a school nurse and professor of nursing education at Teachers College, enumerated minimum standards for practice.

Minimum qualifications should include graduation from an acceptable high school, of a school of nursing of collegiate rank, and at least one year of preparation in her special field; that is, in public health nursing. This graduate work should be supplemented as soon as possible by additional work in science as needed, further preparation in general education and more advanced work in public health nursing and in health education.

The general education background should include educational psychology, principles of teaching in elementary and secondary schools, an introduction to school administration and supervision, philosophy of education and an introduction to curriculum construction.75

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75Chayer, School Nursing, pp. 288-289.
She prophesied that, by 1940, many schools would require a college degree for school health work.\textsuperscript{76}  

The nurse should be one of the best educated members of the school staff. Her work is with teachers who are expected to broaden their professional and cultural background. Her work is with a cross-section of parents, many of whom are educated and cultured. The nurse is expected to contribute further to the education of these two groups, as well as to contribute to the education of elementary and secondary school children. Her cultural and professional preparation should be comparable to that of other professional members of the school staff.\textsuperscript{77}  

A nurse and associate in the New Jersey Department of Public Instruction, Lula Dilworth, iterated Chayer’s philosophical stance.

Since the work of the nurse and of the teacher are so closely interrelated, the general education of the nurse of necessity should be on a par with that of the teachers; and the nurse’s professional training should be adequate for the motivation and direction of a comprehensive program in school nursing.\textsuperscript{78}  

In a paper read at the 1938 Michigan School Health Education Institute, Grace Ross, Director of Nursing at the Detroit Department of Health, supported the belief.

The public health nurse who does meet the minimum standards of the National Organization for Public Health Nursing is a health teacher as well as a nurse. Being able to teach health is what makes a public health nurse different from the so-called private duty nurse. All public health nurses should meet at least the recognized minimum

\textsuperscript{76}Ibid., p. 289.  

\textsuperscript{77}Ibid., p. 301.  

standards of preparation, and any public health nurse who for whatever reason is not able to teach is not really doing public health nursing work.\textsuperscript{79}

But Ross noted that only a limited number of nurses met the minimum requirements.

The public health nursing work is being done by nurses whose preparation varies from a few months of limited experience following graduation to those who qualify academically and by experience in both the teaching and nursing fields.\textsuperscript{80}

She contributed a lack of preparation to several factors. States failed to provide state supported education for nurses as they did for teachers and physicians, and few hospitals were able financially to support a school of nursing on a college level.

Meanwhile, surveys and studies were confirming gaps between the ideal and real. Despite efforts to upgrade standards for competent practice, too few nurses were adequately prepared for their role in school health.

Completed by Lula Dilworth in 1930, the first study of school nurse certification revealed a diversity of standards. Of the forty-four states replying, twelve required certification; twenty-seven had no certification laws; and five provided for certification under certain conditions. Some states issued only permanent certificates;


\textsuperscript{80}Ibid., p. 238.
others granted only temporary certification; still others offered both the temporary and the permanent certificate. Standards for certification varied from administrative approval to definitive requirements. Registration within the state was the most frequently mentioned requirement.\(^{81}\)

In a 1933 investigation of nursing in high schools, Chayer analyzed the preparation of 100 nurses. Sixty-three percent of the group reported college credit for courses in public health nursing, educational psychology, school nursing, child hygiene, child development, and mental hygiene. Their post-graduate training ranged from one year or less (22%) to a college degree (16%).\(^{82}\)

A 1934 survey of public health nursing found deficiencies in both preparation and practice. An analysis of qualifications revealed that only one-third of 800 public health nurses had received some post-graduate training. Even fewer, seven percent, completed an accredited public health nursing course.\(^{83}\) Sampling the preparation of 156 school nurses, the N.O.P.B.N. found that 19 had not attended high school, 12 were graduated from non-accredited schools of nursing, 72 lacked post-graduate training, and 106


\(^{82}\)Mary Ella Chayer, "Nursing in High Schools-A Study," Public Health Nursing 26 (May 1934): 249-250.

entered their position without experience in public health nursing.\textsuperscript{84}

The quality of nursing practice was evaluated by using criteria based on the essential elements of a good home visit: approach, technique, teaching, and adequacy of care. Results indicated that teaching rated lowest in all aspects of public health nursing, including school nursing.\textsuperscript{85} In relation to instructive care, rankings of seven major services showed the health supervision of school children ranking lowest in quality of performance.

The fact that opportunities for instructing parents, such as the presence of parents at examinations and inspections, parent conferences in schools at other times, and visits to homes other than for follow-up of defects and absences, do not seem to be fully utilized, detracts from the educational value of the nursing supervision given to children of this age group.\textsuperscript{86}

That teaching should be consistently low in all types of service and for all types of agency reveals a serious weakness, since the very raison d'etre of public health nursing is health education.\textsuperscript{87}

In the mid-thirties, Esther Lucile Brown, a social anthropologist at the Russell Sage Foundation, utilized interviews, questionnaires, unpublished studies, books, and periodicals to examine nursing as a profession. Study

\textsuperscript{84}Ibid., pp. 65-72.

\textsuperscript{85}Ibid., p. 188.

\textsuperscript{86}Ibid.

\textsuperscript{87}Ibid., p. 191.
findings cited educational preparation of nursing personnel as the chief problem of public health nursing. Data verified that basic programs trained nurses primarily for private duty or institutional nursing and neglected to emphasize prevention of disease, public health nursing, or other forms of community nursing. Consequently, a number of nurses found themselves without the requisites for practice.

At the same time, but somewhat paradoxically, Brown commended public health nursing for its positive influence on the profession.

Through its insistence that its members must assume a large degree of responsibility for the prevention of disease and the education of the public, it has not only done much to develop initiative and resourcefulness in them, but it has added distinction and prestige and raised the professional tone of this phase of nursing.

As the 1930s drew to a close, the N.O.P.H.N. continued its appeal for better prepared school nurses.

What we can and do say—day in and day out—is that the school nurse in order to perform her special functions needs certain definite preparation for her job over and above her basic nursing education. We believe that she should meet the N.O.P.H.N. minimum qualifications for positions in school nursing no matter where she is working. . . . In local, state, federal, and national groups we must work toward the

**Esther Lucile Brown, Nursing As a Profession (New York: Russell Sage Foundation, 1936), p. 97.**

**Ibid., p. 105.**

**Ibid., p. 106.**
In principle, progress was evident. Yet much "toil and trouble" lay ahead before the ideal became a reality.

The Midcentury Years

The early forties were challenging, but trying, for school nurses. A raised health consciousness in the citizenry, a scarcity of physicians, and a critical review of school health programs, as well as wartime retrenchment, placed heavy demands on school nursing. In many communities the only accessible public health nurse was the school nurse.*2

To ensure optimal service with a minimum of personnel, the School Nursing Section of the N.O.P.H.N. moved to redefine activities and coordinate functions.

It is necessary to take direct action namely (1) define those health services which are essentially nursing and reallocate all others as rapidly as teachers, other paid personnel and volunteers can be given in-service training . . . to assume them (2) pool essential nursing services in schools with those of other community public health nursing agencies.*3

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With its scope of responsibility broadening, school nursing became more public health-oriented. Coordinating community services required school nurses who were skilled public health nurses.\textsuperscript{94}

By 1945 major changes were occurring in school health programs:

1. Greater emphasis on the importance of the classroom teacher in the teaching of health.
2. Increased interest in the special subject matter of health, in physical fitness programs and in home care of illness.
3. More abundant use of health councils. . . in the formulation and carrying out of health programs.
4. More universal acceptance of the need for correlating health instruction and health practice, and school and home health behavior.\textsuperscript{95}

No longer was the health of school children entrusted solely to school nurses and physicians. A shared responsibility emerged as classroom teachers, administrators, parents, and community agencies became involved actively with school health programs.

The trend toward coordination of services brought changes in the practice of school nursing. Shifts in roles and responsibilities called for reforms in professional preparation:

1. Greater emphasis on the technical expertness of the nurse.


4. Inclusion of inter-disciplinary course offering to better integrate theory with practice.

A Public Health Nursing Curriculum Guide, prepared by a Joint Committee of the National Organization for Public Health Nursing and the United States Public Health Service and published in the mid-forties, was the "first major step in attempting to define the objectives and content of public health nursing preparation." Intended as a resource for nursing educators, the Guide defined the knowledge and skills needed by the public health nurse practitioner to function competently. Objectives and learning experiences were outlined for sixteen service areas, including maternal and child health, mental health, and school health.

Efforts to set requisites for entry into the practice accelerated after the war. Between 1945 and 1956 recommendations were issued frequently.

In 1945 Chayer suggested a field experience, under the auspices of a university, as a requisite.

Both the teaching and the nursing profession are committed to the idea that actual work with students in a school situation is a necessary

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96 Ibid.


98 Ibid., p. 2.
complement to learning about children from books. School nursing can be learned only where school children are found. Therefore the school itself is the only available place where the nurse can learn to do school nursing.\footnote{Chayer, "Guided Field Experience in School Nursing," Public Health Nursing 37 (September 1945): 488.}

Since the school nurse attained her basic preparation in a setting unlike the public school, a guided field experience offered some degree of security for practice.

In a paper presented at the 1947 Joint Session of the School Health, Maternal and Child Health, Public Health Education, Public Health Nursing, and Food and Nutrition Sections of the American Public Health Association, a nurse educator, Ruth Freeman, delineated minimum requirements for school health work: rigorous preparation in the general aspects of preventive care, advanced study in child development and adolescent psychology, thorough familiarity with methods of health appraisal, basic knowledge of the philosophical and psychological bases of educational practice, and intensive training in counseling techniques.\footnote{Freeman, "Preservice and Inservice Preparation in Health of School Personnel," American Journal of Public Health 38 (January 1948): 43.} Even though a move was under way to include public health nursing in basic curricula, Freeman noted that advanced preparation was still necessary for school nurses. Few schools of nursing provided an academic base for specialization. "The experience and instruction given in
the undergraduate nursing curriculum even in the best we now know, does not equip the nurse to render the expert service needed in the school health program.  

That same year the School Nursing Policies and Practices Committee of the American School Health Association found, from a survey, "a decided lack of any national standards for the preparation of nurses serving in the school." Therefore, the committee recommended setting standards for the licensing of school nurses. "Preparation for this licensing should be offered in either colleges offering an approved course in public health nursing or colleges offering courses in education."  

Two years later, the N.O.P.H.N. School Nursing Section Committee on Qualifications of the Nurse in the School resolved "to promote the establishment of standards of professional preparation for nurses working with school-age children."  

Inasmuch as nursing services offered the school age child are an integral part of total

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101 Ibid., p. 41.


103 Ibid.

public health nursing services the nurse in the school should be prepared in public health nursing. The nurse entering the field of public health nursing should first be a well-prepared nurse; she should have state registration; and although the baccalaureate degree is not a requisite, it is desirable.

... The Committee [N.O.P.H.N. School Nursing Section Committee on Qualifications of the Nurse in the School] recommends either that the nurse in the school be a graduate from a university school of nursing preparing for public health nursing positions under qualified supervision ... or that she complete the program of study in public health nursing in a university accredited by the National Organization for Public Health Nursing.105

In the meantime, a 1948 report stirred the nursing community. Following a three year study, requested by the National Nursing Council and funded by the Carnegie Foundation, Esther Lucile Brown strongly concluded that baccalaureate education was essential for professional nursing.

Almost without a dissenting voice those who are conversant with the trend of professional education in the United States agree that preparation of the professional nurse belongs squarely within the institution of higher learning. So convinced are they that they consider this conclusion above argument.106

Brown perceived nursing as an evolving profession but conceded that only a few schools and their graduates were truly professional.

By no conceivable stretch of the imagination can the education provided in the vast majority of

105 Ibid., p. 441.
the some 1,250 schools be conceived of as professional education. In spite of improvements that have been made in most schools over the years, it remains apprenticeship training.\textsuperscript{107}

To attain a status commensurate with other professions required that all education for registered nurses take place in colleges and universities. Hence Brown urged the development of basic collegiate programs that were "sound in organizational and financial structure, adequate in facilities and faculty, and well-distributed to serve the needs of the entire country."\textsuperscript{108}

She further proposed that the term "professional" be limited to schools of nursing affiliated with degree-conferring institutions.

Such schools as can meet certain defined standards should be designated as "accredited professional schools" and a list of them should be published at frequent intervals for distribution to nurses, the public, and particularly to prospective students of nursing.\textsuperscript{109}

Likewise, she recommended

\ldots that the term "professional," when applied to nurses, be restricted to those who have been graduated from schools designated as professional, or whose right to be thus considered has been demonstrated through some system of examination.\textsuperscript{110}

\textsuperscript{107} Ibid., p. 48.
\textsuperscript{108} Ibid., p. 178.
\textsuperscript{109} Ibid., p. 77.
\textsuperscript{110} Ibid.
Four years later the A.S.H.A. Committee on School Nursing Policies and Practices included a baccalaureate degree in an outline of qualifications for minimum basic preparation:

1. Graduation from a school of nursing accredited by the State Board of Nurse Examiners or other legally authorized state body at the time when the nurse completed her education. This preparation should include or be supplemented by sufficient experience in pediatric nursing to insure the nurse's insight into health problems of children.

2. Licensure to practice professional nursing by a legally authorized state body usually the Board of Nurses Examiners.

3. Bachelors degree which includes 20 hours of course instruction in the fields of education sociology, public health or in combination.111

Courses specifically recommended, in addition to instruction and field work in school nursing, were organization and philosophy of public schools, human growth and development, health education, techniques of counseling, nutrition, epidemiology, social casework, psychology, and mental hygiene.112

That same year the Committee began work on guidelines for setting up standards of practice. Recommended policies and practices, compiled in a guide, were published as a special edition of The Journal of School Health in January


112 Ibid., p. 112.
1956. Qualifications defined for the school nurse included personal characteristics as well as academic preparation:

**Personal.**
1. Liking for, and understanding of children.
2. Ability to contact parents and work with them constructively.
3. Insights into the workings of the school and the purposes of public school education.
4. Ability to inspire confidence and respect of faculty members and to work with them effectively.
5. Pride in her dual profession and willingness to serve in both nursing and educational organizations.

**Educational preparation.**
1. Graduation from an accredited school of professional nursing.
2. Registration as a graduate professional nurse in the state in which she works.
3. Certification by State Board of Education in those states having such requirements.
4. Possession of a Bachelor's Degree is desirable.\(^{113}\)

Special preparation was to include prevention and control of disease; nutrition; principles and practices of public health nursing; the nurse in the school health program; psychology and child development; purpose, organization, and administration of schools; techniques of health counseling; materials and methods of instruction in health education; mental health; and supervised training in school nursing. The committee recommended that teacher education programs be responsible for some or all of this preparation.\(^{114}\)

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\(^{114}\)Ibid., pp. 17-18.
Despite recommendations, confusion and controversy surrounded the professional preparation of school nurses. That educational requirements assuring professional competency were needed for school nursing raised little doubt. But the differing points of view about the practice of school nursing posed a dilemma. Some insisted the school nurse should be prepared in colleges of education to be a teacher. Others maintained that she should be a public health nurse. Still others emphasized preparation for a dual role.

What the nurse is prepared to do is not always clear to her; she may major in health education for a number of reasons or if she specializes in public health nursing she does not always feel adequately prepared for school health. . . . Evidence is accumulating that many of the university programs of study in public health nursing are not preparing the three out of four nurses who now work in school programs sufficiently well so that they feel a degree of competency in school health.115

To add to the confusion, some school systems, due to inadequate public health nursing staffs, employed nurse aides to provide first aid care and maintain health records. Some nurse aides were, but did not necessarily have to be, registered nurses. Predictably, such appointments created confusion about the difference between

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nurse-aides (nurses) in a school health program and public health nurses.\textsuperscript{116}

Gratifyingly, though, certification studies at midcentury revealed steady progress in securing better qualified nurses for school health work.\textsuperscript{117} By 1956 twenty-one states required certification for certain school nurses. Eleven states demanded that all nurses working in public schools hold a school nurse certificate. The remaining ten states, with the exception of one, required only nurses employed by a board of education to be certificated.\textsuperscript{118}

Even though findings from both the 1949 and 1956 studies showed departments of health and education coordinating efforts to develop standards for school nurse certification, diversity prevailed nationally. Requirements varied from licensure as a registered nurse to the holding of a baccalaureate degree with a major in public health nursing, education, or health education. Graduation from high school or the equivalency, graduation from an approved


\textsuperscript{118}Dilworth, \textit{op. cit.}, p. 68.
school of nursing, and registration as a nurse were constants in certification requirements.\textsuperscript{119}

As Dilworth pointed out advances, other researchers noted deficiencies. In general, their findings indicated the school nurse lacked adequate preparation for her role.

Utilizing sixty-five public health nurses as his study sample, Jerome Grossman explored "the possibility that more knowledge of the practicing nurse's perception of problems and responsibilities could provide significant data in planning professional education."\textsuperscript{120} Evidence gleaned from the investigation supported two conclusions:

1. Professional education is largely planned and evaluated in reference to information and skills relating to specific technical aspects of the nurse's functions.
2. Professional education is not sufficiently concerned with efforts to prepare the nurse to deal effectively with the problems involved in relations with other individuals who must play a part in the total school health program.\textsuperscript{121}

Moreover, study findings pointed to a number of implications for preservice education, including the need for a broader concept of the role of the nurse and the objectives of the educational program; greater attention to the leadership skills involved in such areas as human relations, group processes, and inservice education procedures; greater

\textsuperscript{119}Ibid., p. 67.


\textsuperscript{121}Ibid., p. 24.
attention to the fact that the role of the nurse cannot be learned in a vacuum; and greater emphasis on school health in the public health training program.122

To clarify the role of the nurse in school health programs and to provide information for planning educational experiences, Ruth Klein analyzed the functions and professional preparation of nurses serving in New Jersey public schools.123 Several conclusions, relative to professional preparation, emerged from the data.

The hospital schools of nursing were the principal institutions preparing the public school nurses for their positions.

There seemed to have been a steady up-grading of the requirements for the school nurse certificate as the number of nurses employed in the public schools increased.

Nurses had a felt need for a list of accepted schools and courses which would be accepted toward certification requirements.

The technical competency obtained through the basic nursing diploma program does not adequately prepare the nurse for school nursing. Therefore it is necessary for the school nurse to continue her education in order to perform the school functions effectively.124

Findings illustrated a need for reciprocation between preparation and practice.

122 Ibid., p. 25.


124 Ibid., pp. 274-275
The responsibilities of the school nurse should be defined by the school administration in consideration of her professional preparation and nursing experiences.

The established nursing functions performed most frequently by the school nurse should be given major emphasis in professional preparatory programs.\textsuperscript{125}

Addressing the preparation-practice issue during the 1957 A.S.H.A. Convention, the School Nursing Policies and Practices Committee recommended that the Governing Council:

1. Authorize a survey of existing programs now set up in teacher training institutions that prepare nurses for public school nursing service, and
2. Finance or seek financial support for conducting this survey.\textsuperscript{126}

The Committee also requested that standards, functions, and qualifications, comparable to those defined by the A.S.H.A., be developed by the A.N.A. Public Health Nurses' Section.\textsuperscript{127}

Before long, the Committee's proposal triggered a joint venture. In June 1958 representatives from the American School Health Association, The Children's Bureau, The New York State Department of Health, The National League for Nursing, and the Division of Nursing Education, Teachers College, Columbia University met in New York City to explore problems associated with educational preparation. As a

\textsuperscript{125} Ibid., p. 275.


\textsuperscript{127} Ibid.
means of determining qualifications for competent practice, the conferees recommended four projects:

Suggest to the ANA that a separate statement of functions be developed by combining elements of current statements; that this statement be reviewed by school nurses, school administrators, and others in school health; that one statement of functions be prepared; and that endorsement of the statement be sought from the ASHA, AMA, APHA, and NKA

Evaluate the preparation of nurses in states having certification.

Summarize results of studies in school nursing as to points of view and issues involving professional preparation.

Refer the problem of school nurse preparation to the NLN's Department of Baccalaureate and Higher Degree Programs for discussion.128

The following year the League decided to undertake a study of the academic preparation of school nurses. With funding from the Children's Bureau and a nurse educator, Elizabeth Stobo, acting as director, the study was readied for inception during the early months of 1960. The study aimed to survey programs preparing nurses for school health work and to develop guidelines for preparation based on the findings.129

128Ibid., pp. 116-117.

Recent Years

The years between 1952 and 1962 saw the number of nurses in school health work rise dramatically. In 1952 boards of education employed 6,456 nurses. By 1962 the number was 12,119, an increase of 87.7 percent.\(^{120}\)

As the number of school nurses increased so, too, did their roles and responsibilities. Educational and societal changes, paralleling this expansion, broadened the scope of school nurses' activities.\(^{121}\) With an increasing number of nurses responsible for a multitude of services, concerns about professional preparation mounted.

A statement of "Functions and Qualifications", adopted by the School Nurses Branch of the Public Health Nurses Section during the 1960 A.N.A. convention, recommended that all school nurses have at least a baccalaureate degree in nursing and field experience in school nursing at either the undergraduate or graduate level.

The unique contribution of the school nurse is contingent upon her background in nursing. Her future as a school nurse depends on a sound educational background in a baccalaureate program in a collegiate school of nursing. Specialization in school nursing at the graduate level is


essential for the nurse entering the school nursing field.\textsuperscript{132}

A year later, findings from Elizabeth Stobo's study supported the belief that a baccalaureate degree was necessary for school nursing.

Findings indicate that much of what the nurse needs to know to carry out the functions outlined by the A.N.A. can be gained through a baccalaureate program in nursing, however, some work beyond this first degree is necessary in order to give the nurse an orientation to the school system. The study participants indicated that in their opinion this added work belongs in the master's degree program.\textsuperscript{133}

About this same time a nurse educator, Rozella Schlotfeldt, argued that only baccalaureate education in nursing was appropriate preparation for nurses engaged in school health work.

\ldots The essence of the work role in nursing and the competencies needed by incumbents can best and most efficiently be developed through education in the field of nursing.

How, for example, can schools of arts and science, or education, or business prepare practitioners to identify signs and symptoms (sometimes overt, often covert) portending illness? How can they prepare practitioners to carry out a plan of nursing action and to assess its effectiveness in reducing the stress experienced by school children suffering from physical and emotional ills? Where, except in schools of nursing, can aspiring practitioners of professional nursing learn to develop leadership

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\textsuperscript{132}Ibid., p. 95.
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and colleagueship with other professionals engaging in safeguarding the public health?134

She contended baccalaureate programs prepared practitioners for first level positions, regardless of the work situation. But others disagreed. A school nurse-educator advocated educational preparation in addition to nursing.

Nurses who are graduates of either a diploma or collegiate program function better in a school situation when they have had further preparation in methods, curriculum construction, sociology, and other educational courses to enable them to understand the organization and administration of the school.135

An associate in school nursing at the New York State Department of Education believed that a baccalaureate degree with additional preparation in the area of specialization was essential for beginning practice.

The "B.S. +" program is reasonable when we look at the philosophy of baccalaureate programs in nursing education as preparation in general nursing and education, with the preparation for specialist practice falling within master's or doctoral degree programs. Moreover, the "B.S. +" program is desirable when we think of the comparable preparation required for teachers.136

Two professors of school nurse-teacher education supported preparation at the master's level. A


baccalaureate degree offered no assurance of competency in school nursing. The multifaceted role of school nurses demanded preparation beyond that required for general professional nursing.

The traditional diploma program with its emphasis on the care of the sick and injured and the remedial aspects of health has never been adequate preparation for school nursing.

... The nursing profession has agreed in substance that basic education in professional nursing should occur at the baccalaureate level. It follows that preparation for a nursing specialty of either a functional or clinical nature should occur at the graduate level and school nursing is generally accepted to be a nursing specialty.137

But the gap between beliefs and practices persisted. Some school nurses were associate degree or diploma graduates with no additional training. Others had college credit for a conglomeration of courses. Still others, especially diploma graduates, were pursuing degrees in education.138

It is an existing fact that many school nurses have had to obtain a degree in education in order to get the necessary background for their field. ... Full-time school nursing is a specialized field and the school nurse needs courses that are not now available in our nursing schools.139


138 Ibid., p. 84.

The requisites set by certification boards added to the problem. Certification requirements often stressed courses in education to the exclusion of liberal arts and nursing components.

To meet these requirements some school nurses shop around for courses and credits with little or no thought of carrying out the course work in such a way that it represents a unified program of study. Since courses required for certification are either closely allied to the nurse's previous professional preparation, or to the field of teaching, the three year hospital graduates, already deprived of liberal education offerings, are directed still further away from studies in general education which might enhance the academic work in their specialized field.\textsuperscript{140}

Despite statements designating the baccalaureate degree as basic for entry into the practice, a 1964 survey of school nurse certification requirements revealed that only eleven states required school or public health nursing experience and/or college credits beyond the R.N. diploma, with considerable differences in the requirements. Thirty-four of the fifty states did not have state certification requirements for school nurses. Of the remaining sixteen states, five required no more than a diploma from an accredited school of nursing plus state licensure.\textsuperscript{141}

To complicate the situation, preservice education for nurses in general was undergoing change. Economic pressures

\textsuperscript{140}Stobo, \textit{op. cit.}, p. 307.

were forcing diploma schools to close. Nursing programs were moving into colleges and universities. Associate degree and baccalaureate programs were on the rise.

In a position paper issued late in 1965, the A.N.A. proclaimed that "education for all those who are licensed to practice nursing should take place in institutions of higher education."142 A need for improved practice, in light of scientific discoveries, technological innovations, and changing patterns of education, led the Association to classify nursing into two distinct levels of practice: professional and technical. The paper stated that minimum preparation for beginning professional nursing should be a baccalaureate degree education in nursing.142

A short while later, supported by the position of the A.N.A., the School Nursing Committee of the American School Health Association adopted the baccalaureate degree as the accepted minimum preparation for school nursing. "The first step in the professional preparation of the school nurse is the completion of a baccalaureate degree program in


142 Ibid.
Preparation at the master's level was recommended for specialist practice.

The nurse preparing for school health work should be admitted to a master's degree program designed to:

1. Enrich background in liberal education.
2. Develop increased understanding and a higher level of competency in meeting health and educational needs of children.
3. Develop a comprehensive understanding of the school health program and its relationship to education.
4. Encourage independent study or research.
5. Develop nursing and educational leadership.

In March of 1967 nurse representatives from boards of education, departments of health, colleges and universities, as well as national agencies concerned with school health services, convened in New York City for the purpose of reviewing the academic preparation of school nurses. Conference participants agreed that school nursing was a specialty requiring graduate preparation. "The ability of the school nurse to work with other highly qualified school health personnel in solving the social, emotional, and psychological problems of the school age child requires additional knowledge and skill."  

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145Ibid., p. 20.

universities offering master's programs in nursing were urged to include content necessary for school nurse practice.

That same year the National Commission for the Study of Nursing and Nursing Education, an independent self-directing group established on the recommendation of the A.N.A. and N.L.N., embarked on a three year study of nursing. Under the direction of Jerome Lysaught, the Commission set out to investigate nursing roles and functions, nursing education, and nursing careers. Its major objective was to improve the delivery of health care to the American people, particularly through the analysis and improvement of nursing and nursing education.  

The Commission's report, An Abstract for Action, published in 1970, iterated, for the most part, the recommendations of Esther Lucile Brown and the A.N.A.: all nursing education should be moved into institutions of higher learning.

Nursing education should be structured to offer the most incentive and the most reward for the student. The one clear way to accomplish this is to center the educational system within the overall pattern of higher education, that is, within the collegiate institutions.


148 Ibid., p. 157.
By the 1970s changes in practice were necessitating a reassessment of competencies and responsibilities. With the emergence of the school nurse practitioner in 1970, professional groups directed their efforts toward delineating standards of preparation and practice for an expanded role.

In 1972 the National Council of School Nurses depicted school nursing as a specialty requiring graduate level education.

Schools need nurses who can contribute a maximum impact as a social-health force because they can work within a complex school system as skilled clinicians and knowledgeable educators on an equal professional level with administrators, educators, and specialized personnel.\textsuperscript{149}

For competent practice in a broadening, multifaceted role, the Council recommended a course of study encompassing commonalities of clinical content and skills from various nursing specialties, a common core of content required for interdisciplinary collaboration, and special content from the behavioral sciences, the public health sciences, medicine, and education.

Three years later in a position paper, the School Nursing Committee of the American School Health Association expressed a similar view: school nursing was a highly

specialized field pursued through health and education avenues.

The educational preparation of a school nurse far transcends specific nursing skills and/or classroom management techniques. Since the school nurse acts as an active health-oriented liaison between child and parent, pupil and teacher, and school and community, professional preparation and experience in the areas of human relations, counseling, and communications are warranted. Skill in the practice of community health nursing and in the care of children and adolescents is desirable.150

At the same time the A.N.A. and A.S.H.A. were endorsing the collaborative efforts of medicine, nursing, and education to expand the traditional role of school nurses. In a joint statement these associations defined the educational preparation, expanded role, and functions of the school nurse practitioner.151

A second statement, issued a few years later by the A.N.A., the A.S.H.A., and the Department of School Nurses/National Education Association, presented guidelines for educational preparation and practice competencies.

Education programs for the preparation of school nurse practitioners, whenever possible, should be carried out in health centers and under the aegis of accredited baccalaureate nursing programs.


Programs should be developed jointly by schools of nursing, pediatric departments and/or pediatricians, and community school systems. School nurse practitioner programs should conform to the existing policies and regulations governing the conduct of comparable educational programs.

School nurse practitioner programs should provide adequate clinical facilities for demonstration, student observation, and guided practice in ambulatory and inpatient settings. The program should include a combination of theory, clinical practice, and work experience in a school setting.

The course of study of the school nurse practitioner program should add to the nurse's existing base of nursing knowledge and skills and should provide an opportunity to increase the nurse's ability to make discriminative assessments of the health status of the school child.\(^{152}\)

It was recommended that school nurse practitioner programs emphasize ten general areas in their curricula: growth and development, interviewing and counseling, family dynamics, positive health maintenance and health education, childhood illnesses, learning disabilities, mental health, community resources and delivery of child health care services, family-nurse-physician-school relationships, and field experiences. Four months of intense academic preparation followed by a preceptorship period of six to eight months were needed to achieve program goals.

Certification was setting minimum standards for practice but qualifications varied from state to state. A 1973 survey found that twenty-eight states had some type of school nurse certification. Nineteen of the states had a mandatory requirement; nine, a permissive requirement. Twenty-two states issued a provisional or limited certificate. The educational preparation needed for renewal of a provisional certificate ranged from four credit hours per year to a master's degree. A permanent certificate was valid from three years to life. Twenty-six states identified the B.A., B.S., or B.S.N. degree as basic requirements for the permanent or life certificate.153

A repeat of the survey in 1981 disclosed few changes. The number of states certifying school nurses increased by four to thirty-two. A school nurse practicum was required for certification in thirteen of the states. Two states certified school nurse practitioners. Twenty-six states required a baccalaureate degree for the school nurse certificate, but in five states RN licensure was the only requirement.154


Summary

For the past eighty years a number of individuals, committees, and organizations have endeavored to set requisites for entry into the practice of school nursing. Despite numerous recommendations, guidelines, and joint statements, the professional preparation of school nurses remains an enigma. A poorly defined role and dual professional commitment, as well as diverse educational modalities and varying certification requirements, hinder the development of uniform standards.
CHAPTER VI

SERVICE FUNCTIONS AND RESPONSIBILITIES OF THE SCHOOL NURSE

SCHOOL NURSING is a varying combination of what an administrator wants, teachers expect, students need, parents demand, the community is accustomed to, the situation requires and what the nurse, herself, believes.

... It is helping a teacher understand and handle the disturbing behavior of a frustrated student. It's exploring with worried parents the needs and resources for caring for their crippled son. It's aiding the school adjust its curriculum to the physician's recommendation for a child with rheumatic fever. ... It is exchanging information with the social worker or Health Center about a family with social or health problems. ... It is teaching health in informal groups and concurrently with health services.

... It is reinforcing a teacher's lesson on cleanliness. ... It is giving information to further nursing careers. It is visiting a home to learn why Johnny is absent so much.1

What is school nursing? Is there a school nurse role? What do school nurses do? What should they not do? What are their major responsibilities? What effect does their professional preparation have on service? What activities constitute an effective practice? What tasks do they share with others? What unique contributions do they make?

School nursing is an enigmatic practice. It is a socially commendable service pursued through the avenues of

education and health. It is a generalized service. It is a specialized service. It is a jumble of activities. It is inspecting, screening, advising, counseling, interpreting, consulting, collaborating, and educating. It is multiplicity and diversity. It is keeping records, controlling contagion, visiting homes, applying bandages, correcting defects, teaching health, and linking the home, school, and community. It is a series of shifting emphases. It is curative measures and education for healthful living.

Against a background of political, social, economic, and educational events, this chapter delineates the ever-changing and multifarious duties of the nurse in the school setting. It describes the evolution of school nursing from a relatively simple practice to a complexity of services. No attempt is made to present a complete, or exhaustive, analysis of all tasks and responsibilities, but rather to offer insights on current practices through a review of past activities.

The Early Years

The first school nurse directed her efforts toward fighting disease and poverty among children of the urban poor and foreign populations. She treated minor cases of contagion at school and visited the homes of excluded children.
I began by taking a group of four schools . . . in the crowded part of the city, spending an hour in each daily. . . .

At the appointed time each child was attended to as his needs required. Sore eyes were washed with boracic acid solution; ringworm scrubbed thoroughly with tincture of green soap and water, then with bichloride of mercury, and finally painted over with collodion to prevent contagion. Other skin diseases were treated according to their condition. As soon as the children received treatment, they were returned to their classrooms.

When all the children had been attended to and the dressing-room put in order, a list of the children sent home was obtained from the clerk. . . . These were visited after school hours on the same day, and necessary instructions were given in ample detail. 2

The saving of school time for the children was a primary concern.

The chief object the nurse has in view is to help to keep the children in school, and as the great majority are taken from school at fourteen years of age and sent to work, it will readily be seen how essential it is that not a day be lost. 3

Within six years while the functions of school nursing expanded. By 1908 the nurse was conducting classroom inspections and securing parental cooperation in the correction of defects.

. . . A nurse assigned to two schools of 2,000 children each makes the following routine:

She reports at the first school at 9 o'clock, and from that time until 11 o'clock makes as many classroom inspections as possible. Then she proceeds to the dressing room and from 11 to 12 o'clock treats all cases found during the


inspection, and any others who come for daily dressings. Instructions are given to those whose condition does not demand treating. In the afternoon the same program is carried out. When school closes, at 3 P.M., the nurse makes the home visits, five being considered the average for each day.4

Home visiting was her most efficacious task. "This part of the work of the school nurse is by far the most important in its direct results, and most far reaching in its direct influence."5 In the home nurses detected unsanitary and social conditions propagating the troubles of excluded children:

... The whole family using the same towel and other linen, where the child was excluded from school with contagious eye trouble; children not at school equally suffering with pediculosis capitis, the mothers not realizing that it was useless to keep the school child clean if all the others in the family were neglected. Cases were found where the child sent home from school with severe forms of scabies was helping to finish and carry the bundles of sweat shop clothing; bad conditions of drains and sewers, filthy conditions of yards, where delicate children played. Moreover, the nurses discovered many cases of contagious illness. One such illness was that where a nurse, on entering a room without a window, found what seemed to be a bundle of rags on a cot. Upon investigation, she found a man in the last stages of tuberculosis.6

Opportunities for demonstrating hygienic practices and reporting needy families to relief agencies were manifold.

5Ibid., p. 970.
6Ibid.
Between 1910 and 1920 the parameters of school nursing services broadened. The school nurse's "field of labor" was "a wide one." In city, county, and rural schools, the nurse performed a myriad of activities: making routine class inspections, diagnosing and treating skin diseases, rounding up the unvaccinated, assisting in the process of vaccination, examining posture for evidence of spinal deformity, supervising the sanitation of schools, providing first aid to the injured, conferring with parents about the correction of defects, conducting lessons in hygiene, organizing little mothers' leagues, counseling girls in matters of personal hygiene, carrying out toothbrush and noseblowing drills, taking children to dispensaries, reporting truancy cases, and keeping records.

Duties depended on the circumstances of the position, but there were always "enough to satisfy the most work hungry". More and more, the work of the nurse was being perceived in terms of preventive measures.

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The aim of the school nurse to-day is prevention rather than cure. Cures must be effected to bring about normal conditions, but the aim is "to keep the body in such a condition that disease cannot assail it." When the school nurse has taught the children that a healthy body and a sound mind are his greatest assets, her work will have given our educational system an inestimable force.\(^{10}\)

The Twenties and Thirties

By 1920 the primary activities of school nurses were shifting from correction to prevention and education. From Maine to Arizona, in the city and in the country, school nurses were concentrating their efforts on securing optimal health for the school-age child.\(^{11}\) Weaving principles of hygiene into service responsibilities, they sought to establish habits of healthy living.

Classes were talked with and the children impressed with the idea that the nurse came to the schools to promote health. . . .

. . . Particular stress was made on habits, as brushing of teeth, correct sitting and standing posture, drinking fresh cow's milk daily where available. These habits and their relation to health and the prevention of disease were discussed in short health talks before the classes at intervals. . . . Individual effort and responsibility were encouraged in establishing and

\(^{10}\)Struthers, op. cit., p. 235.

maintaining a health standard in each class room.¹²

About the same time "everyone" was becoming interested in promoting and protecting the health of school children.¹³

Out of 2,510,708 men who were examined on the first draft, a vast army of 730,756 men were rejected on physical grounds. A large proportion of these defects might have been corrected or prevented if the schools had been doing their part to train children to conserve and improve their health.¹⁴

Challenged by the health status of World War I draftees, school health programs were evolving into cooperative ventures. With more professionals assuming responsibility for the school child's health, the role of the nurse was less clear.

Recognizing the need to define the nurse's responsibilities in relation to other professional groups, the N.O.P.H.N., in 1926, published its first statement on the objectives, scope of work, and methods in school nursing.

The primary goal of every school nurse should be to secure maximum health and intelligent cooperation of the school child. In working toward this end, her work is closely related to the activities of parents, of teachers, and of

¹²Fuess, op. cit., p. 397.


other health and social workers in the home, the school and the community. Activities that the N.O.P.H.N. suggested the nurse use to attain her goal included diverse tasks: inspections for control of communicable diseases and detection of defects; group and individual teaching in habits of healthy living; nursing care of emergencies; hygienic management of school grounds, plants, and supplies; conduction of classes in Home Nursing, Infant Care, and First Aid; instruction of parents to establish health habits and correction of defects; cooperation with local, state, and federal agencies to promote the health and welfare of the family; promotion of public welfare legislation; and study of problems in school health.

A few years later school nurses were advised to prevent rather than cure; teach rather than correct.

... Teach the cause and prevention at the same time you apply the remedy. Teach cleanliness and honor correction of defects. Don't be satisfied with discovery of dirt and noting number of defects. Recording defects without correction of the same as the goal will accomplish little or nothing.

Remedial work was discouraged. "Much valuable time is lost performing routine measures that should have been

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16 Ibid., pp. 77-79.

discontinued or minimized long before the present nurse's occupancy of the school nursing position."18

But the days of curative and "routine" services were not gone. An analysis of the daily-weekly reports of eight school nurses in Lincoln, Nebraska during October 1927 showed that, on the average, each nurse weekly inspected five classrooms, took 17.4 temperatures, performed 50 miscellaneous treatments, consulted with 8.9 pupils and 10.8 teachers, held 4.6 conferences with principals, visited five homes, tested vision and hearing in three classrooms, and spent five hours on clerical tasks. The nurses did no regular classroom teaching.19

On the basis of daily-diary reports, kept during April 1928 for another phase of the study, the average percentage of time nurses spent on "first aid, examinations, exclusions, temperatures, etc." was 19.7. Pupil conferences averaged 16.1, clerical work 11.3, home calls 11.2, cleaning and arranging equipment 6.3, vaccination clinics 5.2, classroom inspections 4.1, teacher conferences 4.8, and principal conferences 4.1. Individual averages revealed that a nurse's preferences largely determined the activities she emphasized in her work.20

18Ibid., p. 547.


20Ibid., p. 299.
By the early 1930s the school nurse's program was "filled to the brim." Multi-varied duties, both in the school and outside the school, had been relegated to her: assisting the school physician and dentist with examinations and inspections, conducting weekly and monthly inspections, caring for emergencies and minor ailments, testing vision and hearing, advising teachers and students, inspecting buildings and equipment, helping with immunization programs, teaching accident prevention and safety, counseling the "sex problem child", administering intelligence tests, disseminating mental health principles, following up on correction of defects, giving health talks and demonstrations, participating in clinical services for school children, and tracking down tuberculosis contacts.

The school nurse was, for the most part, a "jack-of-all-trades." Seemingly, everything that no one

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else wanted to do was thrust upon her. And this was especially true of social hygiene problems.

Children who scribbled obscene words in school toilets or on circulated notes, children who masturbated, children whose parents reported absence from home at night, usually were sent with all dispatch to the school nurse, while the baffled teacher washed her hands of the whole affair and thanked heaven that somebody was "going to do something about it."23

The school nurse supposedly had an objective attitude toward her charges and the ability to analyze their difficulties.

In contrast to the teacher, whose training and experience have shown her the child en masse, and who must deal with the regulations of the school system, the curriculum and examination schedules, you are able to view the child as an individual to whom others must adjust. You have learned to view a child's behavior as a symptom to be interpreted in the light of his past experiences, habit patterns, physical condition, emotional and temperamental as well as intellectual development.24

Despite her overextended practice, the school nurse was facing curtailment and elimination. The country was in the throes of a great depression. With financial insecurity and economic deprivation permeating the land, schools were cutting programs and personnel.

The dismal economic situation called for a re-evaluation of school nursing. Was it essential? Was it a "fad and frill"? Could the teacher take the nurse's place? Should the school nurse change her emphasis? Just


24Patry, op. cit., p. 439.
what was the school nurse's unique contribution. To offset a potential hazard, namely, the elimination of school nursing, the nurse was encouraged to examine her contributions to the school health program and accept new challenges: interpreting health needs of the home to the school, integrating health into the total educational program, and teaching sex education in high schools.

By 1936 school nursing was a complex practice offering a wide variety of health and educational services.

School nursing is the most complicated field of public health nursing, combining as it does those functions for which departments of health are held legally responsible with those for which educational institutions are legally and morally charged.

The nurse in the school was, at once, a public health nurse and a school health educator. She was a provider of health services, a teacher of hygiene and home nursing, an integrator of health education and health services, an interviewer, a mental hygiene counselor, a sex educator, an interpreter of health problems to teachers and parents, a consultant to teachers and guidance personnel, a promoter of


a healthful school environment, a physician's assistance, and an attendance officer. But multi-varied responsibilities beget role confusion. With curative and corrective measures de-emphasized, the school nurse was struggling to find her place in the educational setting.

Her greatest problem is to know what to select, from among all of these possibilities, in order to make that unique contribution which requires the services of a well-prepared nurse; and having determined how and where she may function the most effectively, to convince the administration of the importance of her program. Very few of her activities were clearly and categorically a nursing function.

The things she does are done or could be done by someone else were she not there—by classroom teacher, principal, physician, dean, attendance officer, visiting teacher, or perhaps by the teacher of physical education or home economics.

Meanwhile, endeavoring to keep pace with changes of emphasis, the N.O.P.H.N. prepared and promulgated revisions on the functions of nurses in school health programs.


Swanson, op. cit., p. 363.

Objectives and functions published in 1931 replaced those issued in 1926. The ten functions, disseminated in 1936, served as the basis for school nurse functions set forth in the 1939 edition of the Manual of Public Health Nursing:

- Assisting the teacher in encouraging the pupils, through classroom activities, to acquire the knowledge necessary to the establishment of healthful practices and attitudes.
- Acquainting parents, teachers, and pupils with the indications of good health.
- Promoting the maintenance of a safe and healthful environment in the school, home, and community.
- Teaching the value of adequate health supervision, including the selection and consultation of a family physician and dentist.
- Acquainting parents, teachers, and pupils with community facilities for medical care and aiding in the development of such facilities.
- Assisting in securing physical examinations of pupils.
- Assisting parents in arranging for the correction of defects.
- Participating in a program for the prevention, care, and education of handicapped children.
- Assisting in the control of communicable diseases.
- Assisting physicians and administrators to set up procedures for teaching parents, teachers, and pupils the reasons for such care and for accident prevention.
- Participating in curriculum making and, if qualified, to teach, conducting classes in the
principles of healthful living, care of the sick, and child care.\textsuperscript{32} 

But despite efforts to update tasks and responsibilities, diversity reigned. Some believed the school nurse should function as a nurse-teacher.

With the emphasis in education changing from subject matter to growth and development of the whole child, every activity becomes an integral part of the entire curriculum. Therefore the school nurse's work must be educational in scope if it is to survive. Her work must be in harmony with the philosophy of education that her particular school system has accepted as the basis of its curriculum.\textsuperscript{33}

Others contended she should be a public health nurse working in the school setting.\textsuperscript{34}

Ideally, the school nurse of the late thirties was a "health counselor" who coordinated her work with that of the teacher, the parent, and others interested in the health of the child.\textsuperscript{35} She collaborated with school and community groups to develop health education programs based on student needs. She taught principles of healthful living, served on health curriculum committees, and made each procedure, physical examination, or control of contagion an educational


experience. Yet, in reality, many emphasized the services of earlier years: assisting physicians with medical inspections, controlling communicable diseases, following up on correction of defects, and caring for the sick and injured.36

The Midcentury Years

During the late 1930s, while nurses were examining their duties and responsibilities in the school, German troops stormed across Poland. By the summer of 1940 Hitler controlled most of western Europe. A year later, on December 7, the Japanese bombed Pearl Harbor. Within days a world-wide conflagration was under way.

The war effort created "trials and tribulations" for school nursing. As thousands of nurses were joining the armed forces, severely depleting civilian services, the health needs of school-age children were mounting.

Life for most girls and boys returning to school this fall is very different from what it was a year ago.

. . . Homes have been disrupted by men being called away for service in the armed forces, industry, or agriculture, and by mothers entering war work. Many conditions have developed which have resulted in increased hazards to health. Trailer camps, crowded housing conditions with

accompanying exposure to disease are no longer exceptions in many war areas.\textsuperscript{37}

War-induced family disorganization especially threatened the child's well-being.

Many children show symptoms of undue mental strain, for home life and the security formerly found in the home have too frequently disappeared. Both parents in many instances are at work and children are left to their own resources, and with no home supervision roam the streets and seek amusement in devious ways. Former routine habits are no longer regarded as important factors of the child's daily life. He may eat what, when and if he pleases, and his bedtime hour may be disregarded. When he comes to school he is an overstimulated, undernourished, fatigued child, who soon loses interest in school and then becomes a problem.\textsuperscript{38}

With services critically curtailed and the maintenance of child health a grave concern, the Joint Committee on Lay Participation in School Nursing, a special committee of the N.O.P.H.N. School Nursing Section, set out, in 1942, to define essentialities in school nursing.\textsuperscript{39} A statement disseminated the following year by Bosse Randle, Secretary of the School Nursing Section, outlined essential wartime services:

1. Giving advisory service to school administrators with reference to the school health program. This should include guidance with regard


\textsuperscript{38}Eunice Lamona, "Essential Public Health Activities of the School Nurse," The Journal of School Health 36 (June 1944): 153.

\textsuperscript{39}"Joint Committee of Lay Participation in School Nursing," Public Health Nursing 35 (September 1943): 525-526.
to fuller use of all community health and welfare facilities.

2. Instructing teachers, individually and in groups, concerning health services they are to perform.

3. Interpretation of health examinations to teachers, parents and children as indicated, including advisory service in utilizing all community resources to make these examinations productive.

4. Visiting homes for the purpose of interpreting the needs of the child to parents, to learn family health problems for interpretation to the school, and to assist both the family and the school in the solution of these problems.40

To conserve time for these services, nurses were encouraged to delegate tasks not requiring nursing skill to teachers, volunteers, and clerical staffs.

About this same time, a sample of 45,585 examinations of 18 and 19 year old draftees revealed that 25 percent were unfit for military duty because of physical defects.41 Schools viewed the data with dismay. Despite an emphasis on education and prevention, school health programs were not achieving optimal health in the nation's young. Inasmuch as attainment of sound physical and mental health loomed atop most educational goals, the findings connoted failure.42


42 Palmer, op. cit., p. 221.
As a consequence, interest in the school child’s health escalated. School nurses found a “new health consciousness on the part of parents, teachers, and students.” There was a “new desire” to face health problems and to correct physical defects. The nation was appreciating, as never before, the importance of optimal health for millions of school children. “The vitality of our democracy will depend to a great extent upon the physical and emotional ability of these children to solve the difficult problems which face our nation in the years ahead.”

Meantime, military demands were creating critical nursing shortages on the homefront. In the face of depletion, with school health programs under close scrutiny, and not with regard to essentiality as some thought, school nurses were told to “redirect activities to produce the most constructive results as to time, economy, and local community needs”. Coordinating efforts and avoiding duplication of services were musts.

To help children realize health requires coordinated effort, for health needs extend into all phases of human living. . . . School administrators; classroom teachers; special teachers as those in physical education, household arts, social studies and science; school custodians; parents; members of community social

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43 Lamona, op. cit., p. 154.


and health agencies; and children themselves within their limits—all of these must work together.

. . . Duplication must be eliminated, and ways in which each is best fitted to share on the basis of the child's health needs must be determined objectively.46

With the emphasis on effective and economical utilization of services, school nursing became more public health-minded. Serving as a liaison between the child and the school, the child and the parents, the parents and the school, and the child, parents and community health agencies, the school nurse was accessible to most segments of the population. In this unique and strategic position, her first objective was the health of school children; her second, health of the community.47

By the mid-forties, perhaps as an outgrowth of war-related changes, school nursing was giving way to school health programs. Responsibility for the school child's health was shifting, conceptually, to everyone.

. . . All who come in contact with the child have a responsibility for preparing him to live as a well adjusted person. Each one—parent, school administrator, school physician, teacher, health educator, and nurse—has a part to play, a contribution to make to the health and welfare of the school child.48

46Axelson, op. cit. p. 441.


Endeavoring to assure competency in light of changing emphases, the N.O.P.H.N. again moved to update practice statements. When a revision of qualifications for public health nursing personnel was undertaken in 1945, the N.O.P.H.N. Education Committee asked the School Nursing Section to study responsibilities of the nurse in school health. Two years later, in its statement on qualifications, the Section's Committee on the Qualifications of the Nurse in the School set forth five functions:

1. To participate with others in planning and developing a school health program which will take into consideration the personal and environmental needs of the child and which will promote the health of the school personnel.

2. To participate in interpreting the principles and plans which underlie healthful school living and to work with school personnel in establishing and maintaining a safe and healthful school environment.

3. To work with appropriate administrative officials in developing and conducting school health services, and in interpreting their purposes and scope.

4. To serve as a health adviser in curriculum planning, interpreting to the school staff home backgrounds and community conditions which affect the health of children.

5. To help interpret the school health program to the home and community and the health needs of the home and community to the school, aiding them to coordinate their efforts effectively.  

Their list of functions reflected the Committee's belief that school nursing encompassed health instruction, health services, and control of the emotional and physical environment.

Shortly thereafter, the Committee on School Nurse Policies and Practices of the A.S.H.A., in response to requests for standards of practice, commenced work on a school nursing guide. As part of a comprehensive statement, "Recommended Policies and Practices for School Nursing" published in 1956, specific functions the nurse performed in health appraisal, emergency care, communicable disease control, nutritional advisement, guidance and counseling, mental health, exclusions and readmissions, exceptional children programs, home visitations, health instruction, community relations, record-keeping, and environmental health were delineated along with the following general responsibilities:

1. Gives leadership and guidance in the development of a total school health program.
2. Participates in the formulation of policies, standards, and objectives of a school health program.
3. Serves as a consultant to the administrator, parents, children and teachers in regard to health needs of children.
4. Assists in planning the budget for health services.
5. Serves as a member of the school health council.
6. Acquaints the administration and other school personnel with health problems in the school, home, and community.
7. Participates in the coordination of the school program with the total health program of the school and community.
8. Assists in planning and conducting in-service health education for school personnel.
9. Is an active participating member in faculty and parents' meetings.
10. Is an active participating member in school building meetings. 50

At midcentury greater visibility, collaborative relationships, and active involvement characterized the practice. The school nurse made home visits with teachers; provided child guidance; followed up absentees; planned programs for children with physical and social handicaps; secured resources for health educators; arranged clinic appointments; administered emergency care and first aid; counseled parents, teachers, and students; served on curriculum committees and health councils; demonstrated screening techniques to teachers and volunteers; advised parents and children about nutrition, disease prevention, and dental care; and interpreted the health problems of students to teachers. Achieving optimum health for every school child was her goal. 51


At the same time, concerns about school nursing functions were sparking scientific study. Early in 1955, for three months, the activities of public health nurses assigned to New York City public schools were recorded to determine "how seriously the burden of clerical and other routine details" affected nursing service. Time studies revealed that, for all the schools in the study, nurses spent about 73 percent of their time in nursing activities and almost 25 percent in non-nursing ones. Clerical tasks consumed most of the non-nursing time.\textsuperscript{52}

Conversely, findings from a survey of public school nurses in New Jersey indicated that, as a group, nurses were performing "most frequently" those functions described for the school nurse by authorities in the field. At least once a week, or more often, nurses inspected pupils with symptoms of illness; aided ill, injured, or isolated pupils in school; advised teachers about health conditions of pupils; referred children to school or family physician in case of sudden illness or injury; interviewed pupils returning from absences because of illness; advised parents and pupils on health conditions revealed by school health appraisals;

\textsuperscript{52}Grace M. McFadden, et. al., "How do Nurses Spend Their Time in Schools?" \textit{American Journal of Public Health} 47 (August 1957): 937-943.
recorded information pertaining to accidents, and referred pupils with symptoms of poor health to school physicians.\footnote{Klein, \textit{op.cit.}, p. 274.}

That school nurses performed a wide variety of functions was confirmed by a study of 610 nurses in four midwestern states.\footnote{Nancy M. Poe and Leslie W. Irwin, "Functions of a School Nurse," \textit{Research Quarterly} 30 (December 1959): 452-464.} Analyzing a multiplicity of functions according to frequency, importance, and complexity, two researchers found that one or more of the nurses performed each of the 132 items in the rating scale and no item was performed by 100 percent of the nurses. But there was a similarity in the functions performed: "two-thirds or more of the nurses performed 59 (44\%) of the items and one-half or more of the nurses performed 76 (57\%) of the items".\footnote{Ibid., p. 462.}

In performance, the follow-up category ranked highest; healthful school living last. The frequency of performance varied according to time spent in the school.

Philosophically, the fifties were "good times" for school nursing. School nurses were redefining the scope of their practice. They were extending their services. They were participating in research projects. They were educating, counseling, coordinating, and promoting health.

But at the "grassroots" level, all was not "sweetness and light". Some were carrying out their activities in a 2
by 4 space under the stairs with no water closer than the second floor. Others were persevering to get soap, paper towels, and sweeping compound. Still others were struggling to delegate non-nursing duties. Overburdened teachers in crowded classrooms had no time for screening procedures and first-aid care.\textsuperscript{56}

And, as always, the practice grappled with vestiges of school nursing past. Obstacles were still encountered in translating theory into action. To the exclusion of health guidance and counseling, nurses were too often occupied with routine duties: assisting the physician, weighing and measuring, vision screening, and audiometric testing.

\ldots Such duties are measurable and tangible so the nurse who does not understand the unusual opportunities she has for health education, or whose superior officer is overly anxious to show measurable results is apt to let herself become buried in the security of the tangible. Thus the schools often think of the nurse's work as an office job, first aid rendered, and judge of whether a child is sick enough to go home or well enough to return to school.\textsuperscript{57}

Supposedly, "no man can serve two masters" yet school nurses continued to do so. The dual role of professional responsibility remained.

The position of school nurses is quite unlike that of any others of the nursing profession--whether she has realized the distinction or not.

\textsuperscript{56}See Dierkes, \textit{op. cit.}, pp. 132-133; Hilliard, \textit{op. cit.}, pp. 137-138; and Schwarzler, \textit{op. cit.}, p. 130.

She was born professionally, we shall say, into Nursing and she has married into Education. This at once gives her added prestige but requires additional qualifications and thrusts her into a dual role.58

Likewise, diversity of opinion about the nurse's role in the school persisted.

Prominent among the problems in school nursing today is the uncertainty within the profession as to the appropriate functional role of the nurses serving in the public schools. The functions of the school nurse are sometimes confused with those of other pupil-personnel specialists.59

Recent Years

In many ways the 1960s closely resembled previous seasons. Obstacles remained:

Insufficient time to conduct a good program;
. . . lack of adequate school health personnel;
lack of participation by the nurse in health curriculum planning; inadequate over-all school health planning; . . . lack of medical supervision in the program; teachers poorly prepared in school health; . . . an inadequate budget; insufficient space and facilities; lack of participation by the nurse in formulating school health policies; and lack of an adequate job description.
. . . Not enough written school health policies; lack of community resources; poor coordination of school health services and health instruction; . . . lack of parent interest and support; lack of teacher interest and cooperation; non-acceptance of the nurse as a member of the


school staff; and poor utilization of community resources.60

Confusion continued:

The school-nurse has evolved from nurse to nurse-teacher. So too bad, however, is the fact that in thinking of the school nurse there seems to be a tendency for people to have a fixation concerning her duties at some previous level of her development. True, she still inspects students; she still does first-aid; she still follows up defects; but in everything that she does her goal is one of helping students toward positive attitudes of health.61

Diversity prevailed:

... A particular constellation of community needs, resources, and philosophy may dictate that in one district the nurse does initial vision screening of all elementary children, or in another that the nurse is directly responsible for classroom teaching, or in a third that she drives to their homes, those children too ill to remain in school. We have then, the possibility of conflict between school nurse functions as defined by the nurses' professional community, and those defined by the political-geographical communities in which they work.62

Continuing to seek better clarification of the school nurse role, professional groups updated and refined practice statements. In a statement, adopted in 1960 by the School Nurses Branch of the A.N.A.'s Public Health Nurses Section,

60 Joseph G. Dzenowagis, "Some Major Obstacles to Better School Health Programs As Seen by School Nurses," The Journal of School Health 32 (June 1962): 149.


functions, similar to those promulgated by the A.S.H.A. in 1959 were outlined for eight areas of responsibility: faculty membership, community relations, evaluation and research, health appraisal, counseling and guidance, health education, and health protection and safety. A 1966 statement presented major functions and related activities under five broad groupings: assessing, planning, implementing, evaluating, and study and research.

In 1967 the School Nursing Committee of the A.S.H.A. disseminated revised guidelines for practice in a comprehensive statement, "The Nurse in the School Health Program." The guidelines were intended to be neither definitive nor restrictive but rather suggestive of broad areas of responsibilities. It was hoped they would serve as "mileposts"—significant points by which the school nurse could establish a course of action. Section III of the report described nursing responsibilities related to program

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organization and implementation, pupil health, coordination of program activities, evaluation, health of school personnel, and professional relationships. Sections IV and V specifically addressed teaching and counseling functions.67

But gaps between the real and the ideal persisted. Findings from research studies, comparing and analyzing the functions of school nursing, indicated that other professional still perceived the role of the nurse within the context of health services: health appraisal, follow-up, correction of defects, and first aid.68 Only ten to twenty percent of the superintendents and principals, in one study, ranked participation in curriculum planning as important.69 In another study teachers ranked first aid as a high priority; nurses ranked it low. Teachers rarely acknowledged nursing responsibilities in counseling and

67 Ibid., pp.11-19.


69 Fricke, op. cit., 26.
Some nurses perceived health counseling and education as priority functions. Others did not.

It was disappointing . . . to discover that many school nurses do not see their role as a consultant or advisor in matters pertaining to health, nor potentialities for using their professional knowledge in the processes of guidance, counseling, advising and consulting.

An appraisal of the amount of time school nurses spent on functions revealed that nurses did not always allocate their time according to the priority of functions. Study findings justified a number of conclusions, including:

School nurses were performing functions in accordance with established criteria; however, the criteria suggest merely the significance of the functions, not the degree to which they are significant.

School nurses maintained cumulative health records, and recorded and reported statistical information regarding health service activities, according to established criteria; however, spending one-third of their total time for these activities is unwarranted.

In light of present knowledge concerning prevention and control of communicable disease, this function is considered of less importance than formerly; therefore, the time nurses spent for communicable disease control was more than was warranted.

Conference as an important function should receive a greater allotment of the nurse’s time than that which was actually spent.

Time allocated to lectures or health talks

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71 Eidens, *op. cit.*, p. 188.
72 Fricke, *op. cit.*, p. 28.
indicated that this is a function which needs strengthening.\textsuperscript{73}

In a way, the nurse's own ineptness was perpetuating her practice dilemma.

Formerly the nurse's primary function in the school seemed to be to check on truancy. She might have wondered if it took years of professional training to acquire the qualifications of truant officer or first aid expert. Yet, for years, the nurse never bothered to find out why she was confined to just such functions, nor did she try to set those in the educational field straight as to just what a nurse's capabilities were. . . .

Even today many administrators and teachers are unaware of the position of the nurse as nurse-educator, consultant, and resource person.\textsuperscript{74}

There was speculation that an age-old idea—nurses should take orders but not think, question, or make decisions—hindered the school nurse's ability to project her "real role."\textsuperscript{75}

The move to employ paraprofessionals for school health services was further muddling the role and creating controversy. Some pleaded for non-professional help in school health programs. "Aides could benefit school nurses who cannot develop the professional aspects of their programs because they have so many nonprofessional


responsibilities." Others viewed the use of aides as a wasteful and dangerous practice. "Functions of the school nurse fall into units of related activities, all of which encompass education. It is impossible to separate any of these activities to assign to an assistant without weakening the entire program."  

But the years between 1960 and 1970 were more than a series of perplexities. A decade of economic prosperity, political liberalism, and social upheaval, the 1960s ushered in events that added new dimensions to school nursing. To enhance the well-being of the culturally deprived and handicapped, government monies of considerable magnitude were flowing into Project Headstart and other "Great Society" programs. At the same time pressures of the decade--student revolts, minority protests, Viet Nam War, and anti-establishment demonstrations--were impinging on youth and giving rise to a host of social ills: excessive use of alcohol and mind-altering drugs, venereal disease of epidemic proportion, sexual promiscuity, communal living, teenage pregnancies, alienation, and suicide.  

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There was little doubt that America's young were a population at risk. "The silent and spoken 'pleas for help' from troubled children in the days of Lillian Wald could not have been greater than those from our children in schools today." Committed to optimum health and learning for all, the school nurse was in an especially unique position to help.

She not only knows the medical needs but also the environmental needs because she has visited the home and observed adult and child behavior in the home. She develops a rapport with the family because of the mutual concern with the parent regarding the child's health and medical problems. She becomes familiar with the environment and the attitudes of the parents toward school and society. . . . She is able to recommend to the family a realistic program with an ultimate solution for the health and/or social deviations.

Not surprisingly then, critical social, health, and educational problems found their way to the nurse's office.

But coping with complex health needs of the disadvantaged and handicapped, as well as burgeoning psychosocial issues, called for an expansion of the school nurse's role far beyond the band-aid and record-keeping stage.

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Schools are asking for nurses who can work shoulder to shoulder with the numerous specialized personnel now employed. Formerly, the classroom teacher, the parent, the school physician, and the principal were the primary individuals with whom the nurse worked. Today, she is expected to make judgments and professional decisions which she shares with guidance counselors, psychologists, school social workers, speech and reading consultants, and specialized teaching personnel who instruct emotionally disturbed or retarded children as well as those who are visually, auditorially, or neurologically handicapped.¹¹

A redirection of services was in order:

1. Better identification of the needs and problems of the students and their families (with emphasis on the culturally diverse or deprived) which can be resolved or improved through the school nursing service.

2. Clarification of the concept of school nursing with the identification of the goals of nursing service which can be realistically achieved, rather than an emphasis on activities to be performed or procedures to be carried out which may be unrelated to any goals of service.

3. Identification of knowledge needed and skills to be strengthened or developed, and to be used creatively by the nurse in seeking solutions, or some degree of resolution, to identified nursing problems.²²

By the late sixties, the school nurse was "giving priority to activities to assist the development of all boys and girls—socially, emotionally, mentally, and physically".³³ She was ceasing to be a provider of isolated services. Responding to societal needs, she was functioning

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¹¹Stobo, op. cit., p. 670.


³³Tipple, "Overview of School Nursing Today," p. 11.
as a mental health specialist, family life educator, child health consultant, community services coordinator, and school health counselor.\textsuperscript{84}

She also was carrying out familiar, oft-repeated routines. She was controlling communicable diseases, screening vision and hearing, weighing and measuring, keeping records, caring for the sick and injured, and visiting homes. She was explaining, interpreting, referring, and following up.\textsuperscript{85} In general, she was concentrating her efforts on the global tasks of maintaining, protecting, and promoting the health of school-age children.

Entering the 1970s school nursing encountered, almost immediately, an "old" and recurring obstacle--money. On the one hand, the school nurse was emerging as a specialist with multifaceted roles: health consultant; teacher; counselor; active participant in curriculum design, faculty affairs,


and professional activities; interpreter and liaison between education and medicine, and between the school and the home; family-centered worker; a participant in community health planning; and a user of epidemiological techniques for assessment of problems.86

Her knowledge of clinical deviations and their ramifications and her skill and ability to interpret these as she consults with children, parents, school personnel and others are highly significant in the furtherance of child health in an institution whose primary purpose is not health.87

On the other hand, economic conditions were threatening her practice. The squeeze was on the educational dollar. All school personnel and services not directly and demonstratively beneficial to the basic educational program were suspect to elimination. School nursing was no exception. Financial deficits were already forcing some cities to cutback nursing personnel.88

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87 Fricke, op. cit., p. 204.

Once more the school nurse must convince the public of her worth or face elimination. "Unless it can be demonstrated that application of nursing skills in the educational setting enhances or promotes learning in the educational process, justification for retaining the traditional school nurse is certainly questionable."89

Predictably, alternatives--some new variations of old themes--were proposed to offset the potential hazard.

The school nurse must expand her interest and abilities. She must become involved in the early identification and remediation of developmental lags and health problems in children. She must utilize her records as a basis for epidemiological studies. She must increase her effectiveness in mental health. She must continue to integrate health services with health education. She must work with community agencies to promote and protect the school child's health. She must assume greater responsibility for communication to keep her public informed.90

She must become accountable through behavioral objectives.

... Nurses must use some of the same techniques employed by the classroom teacher if


they are to demonstrate accountability to their educational institution. The writing of behavioral objectives, just as the classroom teacher does, is a necessary first step in showing how the school nurse makes a contribution to educational goals.¹¹

Achievement of specific goals must be emphasized rather than the nurse's role. "Developing a program with behavioral objectives for students tells nurses and administrators exactly what the nursing program is accomplishing instead of what nurses are doing".¹²

Moreover, she must reassess her practice.

... Like many other nurses, school nurses have been nursing things, not pupils and their families, but records, desks, etc., in health programs which are episodic in nature, rather than comprehensive in scope and isolated in practice rather than integrated into educational and health care systems.¹³

The nurse in the school had a "prime opportunity to be a first rate wellness clinician with expertise in nursing children of specific age groups within family and community patterns of living."¹⁴

But despite well-meaning alternatives, financial woes continued to plague school nursing.

As has been stated frequently by school health leaders, school boards and administrators

¹¹Dickinson, op. cit., p. 533.
⁹²Ibid., p. 537.
⁹⁴Ibid., p. 22.
can no longer financially justify the employment of school nurses for the limited purposes of serving as "first aiders," maintaining pupil health records, and giving a few health screening tests to pupils. With a little training, even interested parent volunteers with sufficient time to offer could adequately perform these functions.\footnote{5}

By the late 1970s the picture looked dismal. School districts were reducing nursing staffs through attrition and layoffs; pupil-to-nurse ratios were increasing.\footnote{6} One system voted, but later rescinded the decision, to eliminate all school nurses. Strong community support and action saved school nursing.\footnote{7}

To cope with the crisis, some urged school nurses to become unified, visible, accessible, and politically active.\footnote{8} Others encouraged accountability and justification of services.\footnote{9}


\footnote{7}Merdine T. Morris, "Holding Your Own When the Budget Cuts Strike," The Journal of School Health 48 (October 1978): 508-509.


It is essential that the school nurse become involved in those activities that can not be provided by any other school personnel. The school nurse has the expertise to see that student’s health needs are identified and met, to be the agent for linkages of service with other school personnel and with outside community resources. But most important is the task of interpreting the student’s health needs to the educator by identifying what these needs mean to the student as a learner and identifying any school modifications which would make it easier for the student to learn. The school nurse should be the case manager of the student with health needs.\textsuperscript{100}

Still others proposed a conceptual framework as a basis for practice.

Basing her practice on this framework which emphasizes "prevention" and "health promotion," the school nurse is in a unique position to facilitate the attainment of high level wellness by the children, families and school personnel whom she serves.\textsuperscript{101}

By consistently applying concepts in the model, school nurses could articulate and document their activities and outcomes.

Ironically, as some were threatening school nurses with elimination, others were promoting a new practice role. Collaborating with Denver Public Schools Health Services, the Schools of Medicine and Nursing at the University of Colorado Medical Center launched the School Nurse Practitioner Program in 1970. The school nurse practitioner

\textsuperscript{100}Hertel, \textit{op. cit.}, p. 314.

performed an expanded role in terms of assessment, health care, and health education. She was prepared to assume more initiative and accept increased responsibility for her acts.\textsuperscript{102}

Before long proponents of the school nurse practitioner were extolling her functions,\textsuperscript{103} and research findings were demonstrating her effectiveness. A study comparing traditional school nurses with school nurse practitioners found that school nurse practitioners:

1. Tended to be more sharply focused and specific in their management of pupils' health problems.
2. Excluded only about half as many pupils from school.
3. Referred only about half as many pupils for consultation, care, or further evaluation.
4. Were more likely to provide clear, specific advice to parents of excluded pupils.
5. Were more likely to have parents of excluded pupils agree with and follow their advice.\textsuperscript{104}


\textsuperscript{104}Norman A. Bilmar and Patricia A. McAtee, "The School Nurse Practitioner and Her Practice: A Study of Traditional and Expanded Health Care Responsibilities for Nurses in Elementary Schools," \textit{The Journal of School Health} (September 1973): 440-441.
Findings from another comparative study revealed that school nurse practitioners emphasized disease detection, reduction of disability, and improvement in communication between teachers, families, and other health care providers more than regular school nurses. A third study noted changes in secondary school health services after the school nurse completed pediatric nurse practitioner training and a full-time health aide was added to perform clerical and triage functions: twice as many problems requiring referral were identified; evaluations of student complaints became more complete and descriptive; and phone contacts with physicians increased in frequency.

Yet other than accolades were greeting the school nurse practitioner. As a new identity evolved, so did challenges—fears about accuracy in physical diagnosis, school and public apathy, redefinition of the nurse–physician relationship, lack of resources, and reactions of nursing peers. The response of traditional school nurses


to the expanded role involved a "whole continuum of behavior from enthusiastic acceptance to hostile rejection."\textsuperscript{108}

Meanwhile the American Nurses Association, American School Health Association, and Department of School Nurses/National Education Association were issuing statements on the expanded role and functions of the school nurse practitioner.\textsuperscript{109}

In this expanded role, school nurse practitioners can identify and assess the factors that may operate to produce learning disorders, psychoeducational problems, perceptive-cognitive difficulties, and behavior problems, as well as those causing physical disease. School nurse practitioners, with appropriate consultation, can assume a major role in health education and counseling. They can work collaboratively with physicians and other health professionals, educators, and parents to provide comprehensive assessment and remedial action.\textsuperscript{110}

Specific activities set down for the nurse with expanded role skills included taking health histories, performing developmental evaluations and screening tests, doing

\textsuperscript{108}Ibid., p. 39.


physical examinations, counseling parents and children, providing appropriate emergency care, and making home visits.\textsuperscript{111}

In a like manner, three University of Colorado professors promulgated "a concise, comprehensive compilation and descriptive definition of the wide variety of functions school nurse practitioners can perform, activities they can carry out, and services they provide in meeting the health needs of school-age children."\textsuperscript{112} Functions and activities, delineating the full scope of the practice, were defined under four categories: assessing health status, providing health care, integrating care, and fostering health education.\textsuperscript{113}

Despite changes and challenges, the traditional school nurse was persevering. In the course of the decade she expanded her mental health function. She extended her role to meet the needs of migrant families and inner-city communities. She counseled students, teachers, and parents. She participated in the identification of learning disabilities. She screened for scoliosis. She planned and implemented care for the handicapped student. And, just as

\textsuperscript{111}Ibid., p. 266.


\textsuperscript{113}Ibid., p. 599.
her predecessors did years ago, she tracked down sources of pediculosis infestations and carried out control measures.\textsuperscript{114}

The enactment of Public Law 94-142, in 1975, provided a viable mode for increasing the practice of the school nurse. Integrating a medical problem into an educational setting, PL 94-142 gave the school nurse an opportunity to "nurse" again. Seeking an optimal level of wellness for the handicapped child, the bill had the potential to enhance the

school nurse’s role and offered a definite purpose for practice.115

In 1980 the American Nurses Association, the National Association of School Nurses, and the American School Health Association issued a position statement on "School Nurses Working with Handicapped Children."

Provisions must be made for the early identification and assessment of the abilities and disabilities of students eligible under this act. Certain "related" services may be necessary in order to evaluate, develop and implement the mandated individual educational plan for each identified student. . . . School nurses can assume the responsibility for the delivery of professional health care. They are in a unique position to identify and evaluate any health related difficulties associated with the implementation of PL 94-142; to participate in planning a relevant school health program; and to accurately inform school personnel, parents, children and adolescents about the health status and needs of handicapped students.116

The statement urged nurses to become more involved in activities related to coordination of care, health promotion, safety, and IEP development.117


117 Ibid.
Two years later the National Association of State School Nurse Consultants further defined the role of the school nurse in PL 42-142. Thirty-eight nursing activities were categorized into six general areas: child identification, assessment, staffing, development of individualized education programs, implementation of individualized education programs, and annual review or reevaluation.  

By 1982 school nursing was alive but not as well as it could be. Plaguing the practice, along with budgetary cutbacks, impossible student-nurse ratios, and insufficient time to perform quality services, were diversity and a host of image problems.

Expansion, innovation, and PL 94-142 were doing little to alleviate the ambiguity surrounding the nurse's position. Research projects confirmed role confusion.

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Furthermore, each nurse was still doing "her own thing"; that is, selecting and prioritizing activities she would perform. Hence, a "jumble" of activities exemplified school nursing, and differing philosophies were producing just as many interpretations of "what a school nurse is" and "what a school nurse does." A single scope of practice statement did not exist, nor were there any uniform standards whereby the practice of school nursing could be governed.

**Summary**

School nursing services were introduced at the turn of the century in a move to control communicable diseases. Since that time the practice has evolved into a complexity of services. But as multiple and diverse functions emerged, in response to changing health needs, so, too, did confusion and controversy about the role of the nurse in the school. Despite the numerous efforts of individuals and organizations to clarify functions and responsibilities, ambiguity surrounding the role of the nurse has persisted.

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"The School Nurse as a Member of the School Health Team: Fact or Fiction?" The Journal of School Health 46 (October 1976): 466-469.

121Igoe, *op. cit.*, p. 308.
CHAPTER VII

THE TEACHING ROLE OF THE SCHOOL NURSE

The school nurse is not a passing experiment. She is a vital part of one of the most important of our national institutions. Through her work American citizens are physically fitted to receive the education which in its turn is to fit them for the responsibilities of citizenship. It is her duty to so teach the value of health both to children and parents as to make them realize that its attainment is worth some real sacrifice on their part.\(^1\)

That health teaching is a function of school nursing is a popular belief. Practicing educative and preventive measures, the nurse in the school strives to attain optimal health for every child. Health education permeates every aspect of her service. In community settings, in homes, in classrooms, in small groups, and in one to one encounters, she teaches.

Still, the teaching role of the school nurse stirs up controversy and raises questions. Is the nurse a teacher? Should she teach health? Should she correlate health teaching with service activities? Is one to one teaching the best use of her time? Should she participate in curriculum planning? Is she a part of the teaching staff?

Looking back through the decades, this chapter examines, from an historical perspective, the role of the school nurse as a teacher of health. Activities and methods used for instruction, issues emanating from the position, and references alluding to educative practices are featured.

The Early Years

From the beginning the nurse in the school was a health teacher. Education was a part of her heritage.

The public health movement did not create the public health nurse, it found her at work in her district, nursing the sick, watching over their families and the neighborhood, and teaching in the homes those sanitary practices, those measures of personal and home hygiene which do much to prevent disease and promote health.2

Teaching hygienic practices was the aim of the first district nursing association in America. In 1886 the Instructive District Nursing Association of Boston commenced functioning on principles promulgated by Miss Nightingale, Miss Lees, and other organizers of the English work.3

From the very beginning, Mr. Rathbone had insisted that the nurse teach her patients the value of cleanliness, order and fresh air, and instruct them in matters of sanitation and hygiene, as well as how to care for their families in health and in sickness.4


4Ibid., p. 126.
Within a decade nursing leaders were espousing the educative efforts of district nursing. Speaking at the International Congress of Charities, Correction and Philanthropy, in 1893, Isabel Hampton declared:

In district nursing we are confronted with conditions which require the highest order of work, but the actual nursing of the patient is the least part of what her work and influence should be among the class which the nurse will meet with. To this branch of nursing no more appropriate name can be given than "instructive nursing," for educational in the best sense of the word it should be.\(^5\)

The following year Edith Brent voiced similar ideas:

These different societies, though perhaps varying somewhat in their method of work, have one and the same object in view, primarily to provide skilled attendance for the sick poor in their own homes, and also through their nurses to instruct the poor to care for their sick in the best possible way, to impress upon them the great necessity of cleanliness, and to teach them the simple laws of health, thus giving them power to avoid much future evil.\(^6\)

In 1902 "teaching" was named as a duty for the first visiting nurse sent into the schools. Miss Wald and her Settlement associates suggested that the nurse follow "to their homes the more serious cases of eye, head, or skin


trouble, seeing that they received medical attention" and "teaching the mother, when this should be necessary." 7

The laws of health and hygienic practices soon become oft-repeated lessons. "That an ounce of prevention is better than a pound of cure" was Lina Roger's comment after a year's work in New York City schools. 8 "Not the least part of the education is the instruction given to mothers in cleanliness and the smaller details of nursing." 9

Before the first decade passed, the educative aspects of school nursing were receiving national attention. Promoting the practice in a 1909 journal article, a medical inspector wrote:

To sum up the case for the school nurse, she is the teacher of the parents, the pupils, the teachers, and the family in applied hygiene. Her work prevents loss of time on the part of pupils and vastly reduces the number of exclusions for contagious diseases. She cures minor ailments in the school and furnishes efficient aid in emergencies. She gives practical demonstrations in the home of required treatment, often discovering there the source of the trouble, which if undiscovered, would render useless the work of the medical inspector in the school. . . . Her work is immensely important in its direct results and far-reaching in its indirect influences. 10

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9Ibid., p. 184.

The following year a nurse educator told the National Society for Education that the strength of the nurse's teaching "lies in the practical application of simple principles to everyday concrete situations." Addressing the values of school nursing, she proposed the nurse teach sex-hygiene, as well as first aid and home nursing.

The matter of sex-hygiene is difficult because there are so many factors to be considered in any proposal for the teaching of the subject in the schools. . . . Whether such knowledge can be given in the form of class instruction or not, it would seem that a wise and tactful nurse who is associating freely with the children could give much personal advice and assistance to the older girls in the school, at the same time supervising their health and watching over their development.

Experiences in girls' clubs in the settlements has shown that they do appreciate such instruction and often ask for it. They consult a nurse more readily because they know that this is such an everyday subject with her.

Yet at the same time she conceded:

In regard to the teaching of hygiene, there will always be a difference of opinion as to how the subject is to be taught, and who is to do the teaching. . . . Responsibility will be divided according to the number of special teachers and officials available and their relative qualifications, and according to local needs; sometimes it will be the regular grade teacher, sometimes a biology or physical-education or domestic-science teacher, sometimes a doctor or nurse.

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12 Ibid.

13 Ibid., p. 50.
Between 1910 and 1920 the teaching of health became a major activity of school nursing. Stressing self-responsibility and positive health behavior, the school nurse strived to translate learning into action. She devised health habit games, set up little mother leagues, formed health crusades, and organized toothbrush and handkerchief drills.¹⁴

At first the teaching of hygiene had been more or less didactic; and had failed to interest the children, therefore the nurse was often unable to get their co-operation. Little by little she realized that if she was to teach hygiene to children with any hope of lasting success she must teach it in a way that they would understand, and which would interest them. And so she began to tell them stories about the "Health Fairy" and the "Old Witch of Finger Nail Cave"; kindergarten methods were used, with handkerchief and tooth-brush drills; bright posters illustrated the use of the tooth-brush, the value of good food and fresh air, and the danger from flies and mosquitos, and the children were asked to make their own posters, prizes being offered for the best.¹⁵

Effectively conducting lessons of hygiene called for the nurse to "post herself thoroughly in such matters" and present them so they appealed to the pupils under instruction.¹⁶ She was advised to hold the children's attention for five minutes by a simple talk rather than


¹⁵Brainard, op. cit. 270-271.

... The dowdy nurse with bedraggled skirts, untidy hair, and holes in her gloves is no inspiration to personal neatness and cleanliness in others. ... The school nurse should be immaculate. ... Her hair should be tidy, her nails well trimmed and clean, and her teeth white and in perfect condition. The nurse who fails to observe these things wastes half of her energy, because she is trying to impress in words what she fails to carry out in practice. She should remember that her living example is more effective teaching than oft-repeated precepts discredited by her own practice.18

The Twenties and Thirties

With education for healthful living her mission, the school nurse of the twenties was functioning as a leader in school health. She was giving lessons in nutrition, home nursing, and first aid; conducting toothbrush and handkerchief drills; advising health leagues; instructing girls in the principles of personal hygiene; and presenting talks on health to mothers' clubs and parent-teacher associations.19

17Gardner, op. cit., p. 279.


At the same time she was striving to correlate health with school curricula by teaching every teacher to be a good teacher of hygiene.  

\[\ldots\] She can easily call the attention of the teacher to the correlating of penmanship with good posture, drawing with health posters, English with essays on health, and dramatization of health stories, making health stories and rhymes.  

Supplementing and supporting the teacher's work, not supplanting it, was her intention.

The nurse's responsibility should be to stimulate in the teachers a real interest in their own health and the health of the individuals in their classes—to the point where the teachers are convinced of the need for work in the classroom and will desire to do it themselves. The nurse can help to supply the material for the health lessons by holding regular monthly group meetings with the teachers . . . and by having frequent separate conferences with individual teachers.

But the move to make health teaching an integral part of school nursing was not without concerns. Should the nurse, pressured with other duties, take on the responsibility of teaching? What should be her preparation for health instruction in the school? With little or no pedagogical training, could she be successful as a classroom teacher?

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21 Chayer, *op. cit.*, p. 635.

22 Vera H. Brooks, "The Place of the School Nurse in the School Health Education Program," *Public Health Nurse* 17 (September 1925): 459.
teacher? What special contribution would she make to justify her appointment to this position?23

Despite questions and uncertainties, a new title was emerging for the nurse in the school. In some states nurses were allying themselves with educators and assuming the title of school nurse-teacher or teacher-nurse. Most school nurse-teachers were combining the activities of a nurse with those of a teacher.24

As the twenties ended, there were few definitive statements about the role of the nurse in health education. But general agreements were appearing. The nurse should teach rather than correct, prevent rather than cure. She should strive to correlate health teaching with other subjects. She should weave health instruction into the health service experiences. She should contribute to group instruction by invitation of the teacher or as a regular teacher of hygiene.25

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Furthermore, she should be a model of good physical and mental health. "The nurse should remember that she must always be the personification of what she teaches if her teaching is to be effective. She cannot teach one thing and live another."  

One very powerful aid which the nurse has in her educational work is her personal example and spirit. She should represent every day all the health principles which are taught in the classroom. . . . Information about the way she herself lives becomes common property, and either helps or hinders her program, according to the way she herself practices what she preaches.  

And lastly, cooperation and coordination should characterize her endeavors.  

As well as being a teacher of health in the school and in the home, the nurse must be a health educator in the community at large. . . . She must show interest in the activities of the community and make the most of her contact with the people. She should be willing to talk about her work whenever requested and should even seek opportunities to present health subjects to the various clubs or organizations existing in the town, such as the women's clubs, Parent-Teachers' Association, etc. In this way she has a chance to interest tax payers as well as the parents in her work, to acquaint them with what is being done for the health of the child, to enlist their support and sympathy.  


26Brooks, op. cit., p. 460.  

27Rood, op. cit., p. 9.  


29Brooks, op. cit., p. 460.
During the 1930s, educative functions were stressed even more. Whether or not she conducted formal classwork, the nurse in the school was essentially a teacher of health.\textsuperscript{30}

The nurse contributes to school health education by individual and group instruction and by way of several important relationships. These are through the school itself, through the teacher, through the parent and through the individual child.\textsuperscript{31}

Much nursing time was given to developing health curricula, conducting parent education programs, leading group discussions, addressing parent-teacher organizations, demonstrating screening techniques, teaching sex education, disseminating resource materials, and rendering instruction with service.\textsuperscript{32}

In principle, service responsibilities were regarded as a means to the end of health education. That the "nurse must teach everywhere she goes and in everything she does" was a common dictum.\textsuperscript{33}

\textsuperscript{30}Mary Ella Chayer, "School Nursing," \textit{American Journal of Nursing} 36 (March 1936): 261.


\textsuperscript{33}Ross, \textit{op.cit.}, p. 237.
The school nurse becomes a teacher and educator with every professional contact she makes, whether it be with student, teacher, or parent. Every physical examination should be done with the cooperation and interest of the student that it may become a teaching situation of value. Every inspection of an ill child and every case of first aid is a learning situation. . . . All the work in the control of infection; the investigation of absences, the correction of defects, the keeping of records, and immunization of children, presents some educational opportunities. 34

In practice, though, not every nurse was recognizing the educative aspects of her work. For school systems desiring to base their health programs on education, a chief problem was finding a nurse prepared not only in routine work but also measuring up to health educator standards:

1. The nurse shall be able to evaluate the educational assets and weaknesses of each of the routine procedures which she is required to do.
2. The nurse shall know what community resources are available which, if put to proper use, may make the life of those with whom she deals more worthwhile.
3. The nurse shall know how to compile her records in such a way that the community shall know the health needs and status of the school population. . . .
4. The nurse shall know when to shed responsibility on to the shoulders of its rightful owner. . . .
5. The nurse shall know how to make each contact with a child, a teacher, or a parent of real value, in that the individual feels better able to cope with the situation should it again occur.
6. The nurse shall evaluate all she does as to

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its real worth, eliminating all "busy work"
done to fill in time.35

Cognizant that the scope and quality of health teaching
among school nurses varied considerably, a state supervisor
of school nursing, in 1939, outlined factors affecting this
disparity:

1. The nurse herself—her philosophy as to what
her job is—whether it is to do just those
things demanded of her—or whether she sees
for herself possibilities for teaching beyond
those outlined for her by others:— . . .
2. The accuracy and extent of her scientific
information about health:— . . .
3. The adequacy of time allowed for her work:—
4. The philosophy of health service held by her
superintendent and by the other members of the
health staff:—
5. The physical set up—the space, privacy and
efficiency of health room:—
6. The recorded material available for her use:—
7. The proportion of pupils with whom she has
personal contact:—36

Meantime, with the classroom teacher assuming more
responsibility for health teaching in the school, the nurse
was striving to teach the teacher all she could.

. . . In school where the teacher is
responsible for the screening, for morning
inspection, and for the exclusion of pupils the
nurse has a great responsibility. She must feel
it her duty to demonstrate and instruct because
the usual preparation for these duties is apt to
be insufficient. It is the nurse's responsibility
to stimulate the teacher and thus keep the health
program a vital one. She should provide the
teacher with facts, preferably written, about the

35Gertrude E. Cromwell, "The School Nurse As a Health

36Marie Swanson, "Education Values of School Nursing,"
most prevalent health conditions which need attention in the school and in the community, about the individual health of each child, and the emotional, economic, and social factors affecting him in his home. . . . She should provide the teacher with authenticated health material and with scientific up-to-date facts as they become available.37

In the late 1930s teachers adequately prepared in health were as difficult to find as competent nurse-teachers.38

The Midcentury Years

As school nursing moved into the 1940s, the educative aspects of service responsibilities were stressed more and more. In 1940 Mary Chayer wrote:

The greatest contribution which the nurse can make to classroom instruction is through her day-by-day relationships with teachers, keeping them informed of the health status of the children, the home conditions, and the family health problems.39

The following year Jeanie Pinckney expressed a similar view.

In considering her teaching function, let the school nurse realize that all of her routine procedures provide opportunities for guidance and that her teaching can be and should be as educationally sound as that done by any classroom teacher. Learning experiences take place out of the classroom as well as in it.40

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38 Ibid.
40 Jeanie M. Pinckney, "Is the School Nurse a Teacher?" Public Health Nursing 33 (September 1941): 522.
She also advised the nurse to teach by guidance.

The nurse who during the health examination or a first-aid treatment or the isolation of a sick pupil from class makes that experience one that arouses in the child a desire for further information, better emotional control, or improved social relationships with others, is teaching by guiding that individual.41

Despite a shift of emphasis, the responsibility of classroom instruction remained. A few nurses were teaching units on the biology of reproduction and sex education. But mostly they taught special health classes: home nursing, child care, communicable disease control, community hygiene, accident prevention, and first aid.42

The advent of World War II further changed the role of the school nurse. To ensure essential services with a dearth of personnel, non-nursing responsibilities, as well as educative functions, were increasingly relegated to the classroom teacher.43

Teacher training institutions must better prepare teachers to take major responsibility for the health supervision and instruction of the school age child and to work cooperatively with community health agencies. When this is accomplished, public health nurses working in

41 Ibid., p. 519.


school should be relieved of many non-nursing services which can and should be performed by teachers.44

Because of their close contact with children, teachers conceivably could assume some of the nurse's duties.

Yet many teachers remained poorly prepared for these responsibilities. In 1944 a supervisor of school nursing alleged:

Our teachers must be given assistance in this teaching of health, for many have had little preparation for health instruction. One cannot take it for granted, unfortunately, that all teachers have automatically achieved knowledge of how to live healthfully and that they have the background and experience to pass on this information to their pupils.45

The following year a school nurse-teacher argued that the nurse was a qualified teacher of health.

... There has been opportunity through the office of the school nurse to teach healthful living through her office activities when the individuals are ready to learn. These situations have been and will continue to be an excellent time to instruct both the student and his family concerning scientific facts and their practical applications to healthful living. In addition to these office situations, through her home calls and parents' classes, she has brought health education to parents who are ready to learn or whom she endeavors to help develop the correct mental set for learning.46


Concerned that some school systems and teacher associations had a condescending attitude toward the nurse-teacher, she called on professionals to "accept the teacher of health whether his major be science, physical education, home economics or nursing, or whether it be accomplished in the classroom, nursing office, home or parent-teacher study groups."  

A year later she promulgated a list of contributions the school nurse-teacher should make to health education:

1. She should discharge her functions in such a way that student participation becomes in itself a learning experience.
2. She should conduct instruction through individual conferences with pupils, teachers, and parents weaving together this instruction with the experiences of the health service.
3. She should collect information from the home and make it a matter of record which can be utilized by the curriculum committee.
4. The nurse should keep the school in touch with the purposes and programs of other social and health organizations.
5. The nurse should contribute to group instruction as follows:
   a. She may, by invitation of the teacher lead class discussions on health subjects.
   b. She may put on a series of demonstrations of health procedures.
   c. She may address parent-teacher organizations and keep the needs of the school before teachers through regular teacher meetings.
   d. She may be a regular teacher of hygiene.
   e. She may provide the school with criteria

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47 Ibid.
for scientific health teaching and for the selection of materials.48

By the 1950s the nurse in the school was striving to achieve optimum health for the school-age population and playing an integral part in the total educational experience of the child. Her role had shifted, conceptually, from a "corrector of defects" to "educator for healthful living".49 Presumably, she was turning service routines into learning activities, assisting with classroom instruction, disseminating information to parent groups, providing inservice training for teachers, and participating in the development of sex education programs.50

Yet little teaching was seemingly done. In 1946 Gertrude Cromwell, the Supervisor of School Nursing at Des Moines, Iowa, declared:

The nurse in a school of course has certain routine duties which all too often occupy a greater percentage of her time than they should to the exclusion of an effective parent-teacher-child health guidance program. . . .

. . . The true implications of the nurse as a health educator are not as yet sufficiently


visualized to make her a really potent factor in many school health programs.\textsuperscript{51}

Her sentiments were echoed a few years later by two Denver staff nurses.

Teachers are not prepared in health subjects; the school program is full and subject to many interruptions; resource materials, textbooks, and audio-visual aids in this field are very few; the nurse is well-occupied with routine work and is not prepared in teaching.\textsuperscript{52}

In 1951 a third Denver nurse charged that too much professional time was taken with children who did not need it.

. . . The nurse should be responsible for emergency illnesses and accidents, but should have a decentralized first aid, with teachers responsible for minor injuries. There should be time for individual counselling with children presenting health problems, handicapped and referred students. She should help teachers with their health programs, getting health literature and materials that would help make the course interesting. Provision should be made for in-service training to interpret and help the teacher understand the health problems of children.\textsuperscript{53}

At the same time an Indiana public health nurse voiced similar feelings.

. . . The school nurses would like to be able to spend more time with the educational part of


\textsuperscript{52}Marion Grimm and Hazel Goetz, "As Denver Staff Nurses See Their Work," The Journal of School Health 19 (December 1949): 286.

the program. We spend most of our available time now accomplishing the services. The theory and actual classroom health program does not receive as much attention as it should.\textsuperscript{54}

Five years later the Committee on School Nurse Policies and Practices of the American School Health Association recommended the nurse use health services "as a means of direct and indirect health education."\textsuperscript{55} Relative to health instruction, eight functions were outlined:

1. May teach home nursing in the classroom, or routine health classes if she has a teacher's certificate, or, as a nurse, she may be responsible, with the help of the teacher, for single units of classroom instruction.
2. Serves as a resource person to all school personnel in matters of health education.
3. Suggests or procures suitable health materials for class instructions or bulletin board use.
4. Arranges with the principal to hold teacher-nurse conferences—
5. Assists teachers when special community programs are carried on.
6. Assists with the in-service education of teachers through workshops and institutes or through individual conferences, and works with school personnel on problems of children.
7. Gives health guidance in all her contacts with individuals and groups in the school and community.
8. In accordance with school policy develops a student aide program at the secondary level.\textsuperscript{56}

But as the 1950s ended, research data were showing that teaching was not a priority function. Rank ordering the categorized functions of 610 school nurses, according to

\textsuperscript{54}Patricia Hilliard, "Nurse in a Jointly Administered Program," \textit{The Journal of School Health} 21 (April 1951): 138-139.


\textsuperscript{56}Ibid., pp. 23-24.
frequency, importance, and complexity, Poe and Irwin found, on a scale of one to ten, health instruction ranking eighth.\(^57\)

In an analytical study of school health service practices, Neilson noted the school nurse had "the greatest responsibility for meeting the needs of the child in respect to the health services." Teaching was not identified as a part of service responsibilities.\(^58\)

Recent Years

Despite activities in the workplace, practice statements of the sixties repeatedly called for the nurse to be a teacher of health. In their statement of functions and qualifications, disseminated in 1961, the School Nurses Branch of the A.N.A. related six functions to health education:

1. Assists in planning curriculum for health instruction.
2. Uses health services as a means of direct and indirect teaching.
3. Plans with school personnel and parent teacher organizations for educational programs designed to inform pupils and others about community health projects being initiated.
4. Serves as a resource person to school personnel regarding the various aspects of health education and provides or suggests health education materials for classroom use.


5. Assumes responsibility for interpreting health needs of pupils for health instruction.
6. Plans with and assists teacher, upon request, in the instruction of certain health units.59

Guidelines, promulgated by the School Nursing Committee of the American School Health Association later in the decade, identified health education as one of the nurse’s major responsibilities. "It is reasonable that the functions of the nurse in an education setting should be almost exclusively teaching functions."60 The Committee concluded:

The teaching functions of the school nurse encompass the total school health program and are inextricably interwoven with every activity within the program. The educational setting is not limited to the four walls of a classroom and the pupils include, to some degree, every individual residing within that school district. No other member of the school’s teaching staff has an assignment which is comparable in its comprehensiveness and complexity. And no one has a greater opportunity to affect measurably the ability of so many individuals to live healthfully and well.61


61Ibid., p. 15.
Similarly, a number of school nurses endeavored to clarify and interpret their educative functions. Most believed the school nurse should coordinate health services with classroom instruction, provide individual teaching in the health room, offer inservice education to teachers, contribute to curriculum construction, educate parents about the health needs of children, and teach units on personal hygiene, first aid, and home nursing. A nurse-teacher speaking to a board of education in 1969 succinctly explained the role.

We bear a responsibility for Health Education in very direct way. Our role as an educator involves Health Counselling. This is individual health teaching with pupils, parents, teachers and other school personnel. We do some Direct Classroom Teaching. This is correlated for the most part with our health service activities. It might be relative to the pupil health appraisal procedures, relative to special health problems as they arise, or to supplement a teacher's program. We participate in the Development or Revision of Curriculum. We serve as a Consultant to the teacher in the implementation of that curriculum. We might teach a special unit in which we are specifically qualified. We help to Evaluate the curriculum and its effectiveness.


But many teachers were unaware of the nurse's role as consultant, nurse-educator, and resource person. At times the teaching staff was "not too cognizant of the potentials to be found in the school nurse for the enrichment of class health instruction." Even though practice standards were calling for the nurse to assist in the planning and development of health education, her role as an "expert" in the classroom often was ignored or overlooked.

Evidence, gleaned from research projects, of the late 1960s and early 1970s revealed disparity between the real and ideal. Theoretically, the nurse in the school was a teacher of health. In actual practice, however, roles and responsibilities were more service-oriented.

Studying the opinions of school nurses about their preparation and practice, Marriner found that more time than desired was spent maintaining records and providing first aid. Activities that nurses felt should have the highest priority were, in many instances, related to health instruction, health counseling, and curriculum development:


Serving as a consultant to the community, administrator, parents, teachers and pupils in regard to health needs.

Providing health counseling and guidance to pupils to promote optimum growth and development.

Contributing to the development of a sequential curriculum for the health instruction program.

Assuming leadership in planning and implementing health education specifically related to appraisal procedures, special health problems and community health projects.

Providing consultant service to classroom teachers in planning content, materials and activities related to health instruction.

Assuming responsibility for a program of in-service education for all school personnel.

Helping parents, school personnel and pupils to understand and adjust to physical, mental and social limitations.

Helping to establish channels of communication among school staff to assure referral of and follow-through on pupil health problems.

Counseling with parents, pupils and school staff regarding health aspects of attendance problems.67

In a survey of school nursing activities, Hawkins noted discrepancies between job descriptions and work practices.

Formal job specifications for school nursing imply considerable importance for the educational and preventive aspects of school health. Most of the nurses in my study, however, found themselves engaged in treatment, sometimes to the exclusion of their presumably more basic functions.68

67 Ibid., p. 419.

Many nurses wanted to function as health educators and resented being used as technical problem-solvers.69

By analyzing the amount of time school nurses spent on functions and activities, Lowis found nurses did not always allocate their time according to the priority of functions. Time allotted to health talks and lectures indicated this function needed strengthening.70

Fricke, in her study of school nursing practices in Illinois, voiced regret that nurses themselves attached more importance to record keeping and first aid than guidance, counseling, advising, and consulting. "The variation between current practice and known good practice is a discouraging revelation, and certainly one needing further study."71

Along with budgetary constraints and threats of elimination, the 1970s ushered in a revival of curative measures. The nurse in the school was encouraged to track

69Ibid.


down and correct defects and deviations. Maintenance of health for optimal learning was a priority concern.

The nurse can no longer be content to sit in the office and wait for children to come to her or be an occasional resource person in health education. Today the nurse must become involved in the early identification and remediation of developmental lags and health problems in children. The nurse was brought into the school over sixty years ago to help control health problems that interfere with learning. This is still the only justification for including her as a member of a school staff.

Still teaching remained a function of significance.

"The school nurse must relate to both the school and the health center--and interpret for both. She must be a professional nurse and professional educator." In a paper read at the 1974 A.N.A. convention, a supervisor of school nursing defined ways the nurse could demonstrate a leadership role in health education:

Stimulate the adoption of health courses at all levels in the school curriculum by serving on curriculum development committees.

Assist teachers to teach health more effective by serving as a consultant to individual classroom

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73Coleman and Hawkins, op. cit., p. 122.

and health education teachers; by team teaching, demonstrating, and serving as a resource speaker; conducting in-service education programs for teachers.

Assist students and teachers by compiling and maintaining a health education materials resource file.

Serve as a resource speaker and consultant for any type of parent group.

Utilize every student and parent contact to give health instruction and counseling appropriate to the occasion. ⁷⁵

The passage of PL 94-142 a year later strengthened both the curative and educative components of the nurse's role.

... Retraining and educating the child to maximum capability, as well as public education, are key activities for nursing. Assisting teachers with their knowledge of the disease and working with individual children in learning new skills and behavior to maximize health are only a small part of what the nurse can do. The school nurse's knowledge of the disease and understanding of the medical treatment plan can be central to developing a satisfactory individualized educational program. ⁷⁶

Rationale was offered in 1977 to support the argument that the nurse could teach regularly in the classroom and perform other duties as well.

1. ... Teachers do not feel comfortable or knowledgeable in health fields and want in-service training and a health coordinator.
2. Fewer models, equipment, and audio-visual


materials are needed around a school district because the nurse takes the materials to each class.

3. The nurse establishes many contacts with students on a positive health prevention program throughout the district.

4. Health aides can do many jobs necessary for health services and health education that do not require a registered nurse.

5. Using the nurse and other health professionals in the health classes is an excellent way to exemplify career education.

6. Nurses can give better examples of health problems than teachers, and students see the nurse as an "expert."  

A statement of functions and activities, promulgated that same year, indicated the school nurse practitioner had a responsibility to foster health education. Several statements described her educative functions:

---Participate in the education of teachers and other school personnel in the prevention of disease and the maintenance of health.

---Provide relevant health instruction, counseling, and guidance to students, parents, teachers, and others concerning a variety of acute and chronic health problems . . . and assume responsibility for appropriate intervention, management, and/or referral.

---Apply methods designed to increase children's motivation to participate in and assume responsibility for their own health care.

---Assist parents to learn about health problems and the need to assume greater responsibility for the health care maintenance of their children.  


Despite guidelines and recommendations, a myriad of problems followed the school nurse-educator into the 1980s:

1. Too much paperwork and not enough time for teaching health.
2. Difficulty in convincing people of the importance and/or accountability of the school nurse.
3. Positive efforts by school nurses are not reinforced or supported by administrators.
4. A lack of academic preparation in teaching approaches.
5. A problem in persuading elementary teachers to teach health education.
6. The concept of first aid care as opposed to preventive health teaching.
7. The low priority given to health education in schools.
8. Misinterpretations of the school nurse's role.
9. A lack of cooperation from other teachers to use or work with the nurse in teaching situations.\(^7\)

Few were viewing the nurse as a health educator. Her best defined and most clearly perceived role was caretaker of the sick and injured.\(^8\)

Students, parents, school personnel, school board members and health professionals outside the school feel the nurse's primary role is to administer first aid and care for the sick; and school nurses are frustrated by the general lack of awareness of their many roles.\(^9\)

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\(^9\) McNab and Canida, *op. cit.*, p. 89.
Nevertheless, the belief that the nurse was a teacher of health prevailed.  

The school nurse has a place in the school and community to teach self-care and preventive health. The teaching of health by nurses can be an exciting and rewarding experience for the nurse and, most importantly, for the student. Professional efforts and programs are needed which will utilize the expertise of the school nurse in providing preventive health education.  

Educating for health remained, in theory, a viable role for the nurse of the 1980s. Translating the idea into action was her challenge.  

Until school nurses are more comfortable with health promotion and public education, health will continue to have a minor emphasis, and a true integration of schools, health and nursing will not occur. The opportunity is currently available for greater involvement in an educational framework.  

Summary  

Over the years professional health and nursing organizations, leaders in school nursing, and nurse-health educators have sought to define the school nurse's role in educational terms. Yet discrepancies are evidenced between what is prescribed and that which is actually practiced. Many school personnel, including school nurses, continue to  

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83 McNab and Canida, op. cit., p. 90.

84 Dale, op. cit., p. 19.
view the school nurse in a traditional, rather than expanded, role. Theoretically, the nurse in the school has been perceived as a teacher of health, but, in reality, her expectations are more illness-oriented.
CHAPTER VIII

INTERPERSONAL RELATIONSHIPS OF THE SCHOOL NURSE

School nursing is only one unit in a large program of child health. The nurse has her closest relationships with the school and local department of health; yet every day she has potential relationships with local physicians and dentists, hospitals, clinics and outpatient departments, and with the public health nursing organizations and social workers of the community. She may herself be a member of a generalized nursing staff, spending part of her time with the school child and the rest with other age groups, or she may be spending all of her time with the school child. The important thing is to have well defined working relationships between the school and any other organizations participating in social and health service.¹

The nurse in the school has a large core of relationships. She consults with teachers, administrators, and parents. She collaborates with physicians, psychologists, and social workers. She confers with community representatives. In general, she links the home, the school, and the community. She interprets; she informs; she interacts. Rapport is the keynote of her practice.

Using four time periods as a frame of reference, this chapter explores the influence of interpersonal

relationships on the roles and responsibilities of the school nurse. Factors and events contributing to sound relationships are chronicled along with those hindering cooperation and collaboration. Especially highlighted are relationships with the classroom teacher.

The Early Years

In the early 1900s the nurse was the most effective link between the home and the school. She was the "intermediary between physicians, teachers, parents, and children." Bringing parents into a close relationship with school nursing services was a major feature of her work.

The nurse’s first duty is to explain why the child has been sent home and what is to be done. She instructs the mother and, where necessary, gives practical demonstration. She impresses on the parents the importance of having medical advice, and suggest calling the family physician. If too poor to pay a physician the proper dispensary is indicated. When the mother is overburdened with work, or where there are smaller children who cannot be left alone, the nurses make arrangements to have the children taken to the dispensary to ensure the treatment being given.

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4Rogers, op. cit., pp. 970-971.
She brought comfort and relief to many a stricken home where there were sick children and an overtired mother. She was a friend, an advisor, and, among the foreign-born, a potent force for Americanization. Hers was a service that they could understand; she made them comfortable; she eased their pain; she saw that their urgent needs were supplied.

But encouraging families to seek medical attention was, oftentimes, a trying task. Some parents were suspicious and defiant.

... One mother, for instance, was indignant when she learned from her son that "his eyes had to be taken out and scraped." The nurse on entering this home was greeted with a tirade of abuse but, after holding her ground, succeeded in making the explanation with the result the mother not only consented to have the boy operated on but invited the nurse to take tea.

... The Stock Yard district of Chicago is make up almost entirely of Polish, Lithovian, Bohemian, and some Swedish immigrants hardly any of whom speak or understand English. These people are all of the poorest peasant classes and, with the exception of the Swedes, have been for ages subject to the cruel despotism of Russian rule and are ignorant and suspicious to an astonishing degree. They are absolutely unable to grasp the idea of any person doing anything for them merely from a desire to help them...

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6See Ayres, op. cit., p. 84 and Struthers, op. cit., p. 27.


8Rogers, op. cit., p. 971.
Adenoids and enlarged tonsils, not being external defects, are calmly ignored, and no amount of argument will convince the majority of the parents that our desire to have them removed is not a scheme whereby we are in some unexplained way the gainers. 8

Others were indifferent and not easily persuaded.

"Ninety-nine visits" were made to one family before a nurse got results. 10

Much of the school nurse’s time has always been wasted in repeated visits to households where she has struggled in vain to induce the parents to secure proper treatment, to buy glasses, or to follow some desired line of action. Again and again she has been baffled not only by opposition, but by the utter indifference of the whole family. 11

Still others, to get rid of the nurse, sought treatment and remediation.

A school nurse tells of an incident in which repeated visits were made to a home where a child was suffering from defective vision. The father finally procured the proper glasses for his child, so that, as he said, "the nurse would stop coming." 12

At the same time the nurse was encountering resistance in the classroom. Not all teachers favored the new


In 1909 a nurse classified school personnel with negative feelings into three groups:

. . . Those who did not understand just what school nursing meant and feared that it would result in interfering with the school routine, or lower the attendance, when convinced that such was not the case became ardent advocates of it. Next came those who feared that part of the funds necessary to maintain the work were to be deducted from the already slender appropriation of the Board of Education.

The third group consisted of those who were old-fashioned and firmly believed that measles, scarlet fever, and diphtheria were dispensations of Providence which every one had to bear sooner or later, and the sooner we had them and got over it the better. . . . The members of this group . . . dismissed the whole subject of medical inspection as one more "fad" which had been thrust upon them. They neither assisted nor hindered, they simply ignored.14

A few years later a leader in public health nursing noted the teacher was a "new element" in the nurse's experience, and the "relation of the two positions" in the classroom was "occasionally misunderstood."15

To improve teacher-nurse relationships the nurse was advised to visit each classroom at the beginning of the term.16

. . . There are few teachers, who are not inclined to give a warm welcome to the school nurse as a co-worker who will simplify and render more valuable their own work. . . . Let the new nurse, therefore, establish for herself the

13 Stewart, op. cit., p. 33.
14 Kefauver, op. cit., p. 816.
15 Gardner, op. cit., p. 270.
16 Stanley, op. cit., p. 883.
reputation of being a welcome visitor in every school-room, and let her preserve it by an unfailing attention to those small details of courtesy and simple politeness which count for so much in the daily routine of life.17

Time spent interacting with teachers was viewed as time well spent. "We must never lose sight of the personal touch."18

Meanwhile nurses were realizing that cooperation was a requisite for effective service. In a paper presented at the 1916 N.O.P.H.N. convention, four Chicago nurses asserted:

Cooperation then must be the keynote of the school nurse's work if she hopes to reach the highest possible plane of achievement, cooperation which has for its object only the physical and moral betterment of the child.19

The following year Lina Rogers Struthers set forth similar ideas:

The school nurse must be able to cooperate in the heartiest way with school teachers, the family physician, and the Board of Health. It is hardly necessary to say that to obtain efficient work there must also be the heartiest cooperation between the school nurse and the school medical inspector. . . . The school nurse should rank as the principal's consultant in the physical welfare of the children, and everything pertaining to the child's health and well-being should be discussed with her, if we are to have the ideal organization and the best results.20


18Stanley, op. cit., p. 883.


Her sentiments were echoed in 1919 by the Superintendent of School Nurses in Cleveland.

In outlining a plan to serve as a foundation for the development of the work of the school nurse, one of the first topics to be considered is that of cooperation. Cooperation must be the keynote of all the school nurse's endeavors. . . . To be intelligent and effective it must be based upon a personal relationship with individuals and a knowledge of the scope and limitations of agencies or organizations.21

There was also a growing recognition that school nursing required skill in human relationships. For the nurse, patience and perseverance were essential characteristics.

The school nurse has also to remember that her work is not the most important work of the day to either the principal or teacher; . . . but they will soon learn to give the right kind of cooperation if they find they are not being forced into it and that the work is being earnestly undertaken.

The same may be said of parents; they are more ready to cooperate when a condition and its results on the future, as well as the present, of the child, has been made clear to them. . . . If they are advised, but not urged too strongly, at first, a second visit will often get results that would not have been gotten if a more pronounced attitude had been taken.22

So, too, were tact and diplomacy needed, especially with parents.23

21Stanley, op. cit., p. 882.


23See Gulick and Ayres, op. cit., p. 65; Stanley, op. cit., p. 884; and Struthers, op. cit., p. 230.
She must know how and when to be firm and insistent, in a kindly way, with some parents and to be sympathetic and affable with others. . . . It may not be easy to gain the confidence of parents, and the school nurse may have to patiently bear many indignities heaped upon her, but if she gains her point, and the child is cared for these things do not matter.\textsuperscript{24}

The Twenties and Thirties

By the 1920s the nurse was an integral part of the school setting. But no longer was she solely responsible for the health of the child. School health was evolving into a cooperative effort.\textsuperscript{25}

. . . The public health nurse has become a vital personality in the organization of the public school. . . . She has found her way into the hearts of children and parents and into the confidence of school officials. . . . Through the persistent follow-up of the nurse after examinations of school physicians, parents are cooperating in the correction of defects. Through the school nurse, dental clinics are caring for children's teeth. Through her, defective vision is being discovered at an early age and corrections are being made by specialists. Through her, under-nourished and anaemic children are finding place in open-air schools and are benefiting from a program which includes proper and sufficient nourishment, rest, regular elimination and the development of other health habits.\textsuperscript{26}

\textsuperscript{24}Struthers, \textit{op. cit.}, pp. 230, 232.


\textsuperscript{26}Mary O. Pottenger, "The Teacher Discovers the Nurse," \textit{Public Health Nurse} 21 (September 1929): 457.

... There must be no duplication; every home visit, every clinic visit, every contact must be as fruitful as careful planning can make it. And the nurse who has carried out her service in conjunction with the other health and welfare services in the community and has succeeded in making it a vital part of the whole health program has built a firm foundation that should withstand the attacks of a budget-cutting Board.\footnote{Carter, op. cit., p. 18.}

Carrying on a program of school health without the cooperation of teachers, pupils, parents, attendance officers, physicians, and community agencies was unthinkable.\footnote{McCaffrey, op. cit., p. 448.} An effective practice depended, largely, upon the activities of the nurse in the home and the community.\footnote{Anna L. Stanley, "The Responsibility of the School Nurse Outside of School," Public Health Nurse 22 (September 1930): 452.}
In the present condition of things, the school nurse should be more valuable than ever before. She works with families and with individuals, with children and adults who have been facing the strain of economic readjustment. Her preparation and experience should make her particularly fitted to serve them—to encourage and help them to establish a feeling of security in themselves and in the future. The school nurse has opportunities for service that are comparable to few vocations. She may well become in the future more than a nurse or an educator, a potent and indispensable factor in the development of a finer community life. Her vocation gives her entry into any home. . . . If she has vision as well as preparation, she is particularly fitted to serve—to weave together the strands of community life—the parent and teacher, the home and school.  

A "symbol of friendly help," the nurse was a "sturdy bridge" spanning the gap between the home and the school. Even though practice responsibilities shifted from time to time, she was still the most effective link between the home and the school, the teacher and the parent.

One of the most valued contributions of the school nurse, regardless of the administrative set-up under which she works, is the part she plays as an interpreter of the child's problems to the teacher and to the parents. On the one hand

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31 Scramlin, op. cit., p. 75.


she shares with the teacher her own understanding of the child’s school problems in the light of her knowledge of his personal health and his individual situation in the home. On the other hand she shares with the parents her understanding of the child’s home problems in the light of his personal health and his situation in school.  

Despite the emphasis on cooperation and coordination, there were gaps between the real and ideal. A study focusing on teacher-nurse relationships revealed "the teacher really does not know much about what the nurse is doing or why she is doing it."  

Theoretically, nurses were cogs in an extensive and complicated piece of machinery. They could not work alone. In practice, though, some did. For a variety of reasons, duties were carried out in almost complete isolation.

Some nurse feel strange or out of place in the school situation. They consider that a school is an institution made up of classroom teachers and educational administrators, and that because the nurse is not a teacher she is an ornament or an oddity. . . .

Working in an atmosphere that is saturated with teaching—with teaching techniques and procedures—some nurses come to feel that the activities of the nurse are on a lower plane than that of the classroom teachers. . . .

Partly as a result of the assumption that those who teach must know a lot and partly as a

34Marie Swanson, "The Nurses’ Work with School Children," Public Health Nursing 28 (June 1936): 364.


consequence of the emphasis that is placed in some educational circles upon the possession of higher academic degrees, many nurses feel intellectually and educationally inferior to the classroom teachers, supervisors, and administrative officers of their school system.\textsuperscript{37}

Moreover, some administrators left responsibility for the health program entirely to the nurse. One superintendent was quoted as saying: "My teachers do not do morning inspections, vision testing, weighing, and measuring. We have a school nurse who is supposed to do those things."\textsuperscript{38} And, in 1936, calling the nurse-teacher an asset, a principal wrote:

The presence of the nurse in the school makes it unnecessary for teachers to look down pupils' throats, nor will the classroom teacher have to take time out to search for pediculosis. . . .

A mother complains--"washed hair--no nits--my Doctor says so too." Here's a fine chance to escape a slander suit. Let the nurse carry the ball. It was she who sent the child home and she knows nits when she sees them.\textsuperscript{39}

A leader in school nursing was, in the meantime, proposing changes in emphases for more effective service. Citing findings from the School Health Studies of the American Child Health Association, Mary Chayer called for "a

\textsuperscript{37}Helen C. Manzer, "The Nurse in the School Community," \textit{Public Health Nursing} 30 (September 1938): 538-537.


\textsuperscript{39}Harold C. Rhode, "Nurse-Teacher an Asset," \textit{Nation's School} (March 1936): 32.
closer relationship between nurse and teacher; a sharing of information about the child."^40

. . . Studies of the American Child Health Association . . . showed that the one most important single factor making for success in the school health education program was the nurse-teacher relationship. Where nurse and teacher shared information about the child and made use of this in planning and executing a program, the results were apparent in every aspect of the health work which was measured—in improved physical status of the children, in their acquisition of more authentic knowledge, and in their practice of more desirable habits and attitudes toward health.^41

In 1937 school nurses became a section of the new Department of School Health and Physical Education of the National Education Association. Membership in the N.E.A. filled a long-felt need. Through the organization nurses would have "an opportunity to present their problems and their contributions in the development of the school health program."^43 No longer were nurses merely attached to the educational program; they were a part of it. School nurses now had two parents—the National Organization for Public Health Nursing and the National Education Association.


^41 Ibid.


^43 Cline, op. cit., p. 498.
Hopefully, the two parents would plan together for a fruitful union.44

But controversy was brewing over administrative control. Was school nursing a generalized or specialized service? Boards of education felt the nurse could best meet service and educational needs of the child by being a member of the school system. Health departments insisted school nursing belonged to them. And the National Organization for Public Health Nursing was, for the most part, non-committal.

With all the information gathered from the travels, correspondence, office interviews and committees, the N.O.P.H.N. staff is not in a position to say which type of school nursing administration is better. Our staff has seen good and bad school nursing under both auspices. . . . We must have more facts, more studies, more comparable data before we are in a position to make any recommendations. . . . There is much to be said for each method. . . . Perhaps there can never be a final decision on this point.45

Administrative alignment was not an emphasis of the Organization; of greater importance was the quality of service rendered.46

The Midcentury Years

As school nursing mushroomed into one of the largest and most complex fields in public health nursing, supervision of the practice became a matter of concern.

44Chayer, op. cit., p. 496.


46Ibid.
Most school nurses were working without supervision or serving non-nursing supervisors. Moreover, policies and standards to guide the nurse's conduct in the school health program were lacking. School administrators were often unaware of what they could expect of a nurse.

Desiring to upgrade the status of supervision, the School Nursing Section of the N.O.P.H.N., at the 1942 biennial meeting, authorized a committee to study the problems of supervision and work out a set of standards. Early in 1943 a country-wide investigation was launched.

The committee . . . decided that before standards of supervision could be set up which would serve all sections of the country, it would be necessary to know a great deal more about the present status of supervision, the ways in which various communities have analyzed their own situation with respect to supervision, and the specific problems which were encountered in providing supervision by various types of agencies in all parts of the country. Accordingly it was decided to appoint a committee in each state whose purpose would be to study the problems of supervision in their own state and then to share their experiences with nurses from other states.

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49 Chayer, op. cit., p. 523.

50 Ibid.

51 Ibid.
Findings of the committee, reported two years later in a series of articles, showed difficulties with school personnel dominating the problems of supervision:

Reluctance of school administrators to accept the concept of health as a vital part of the total program of education, and a tendency to think of the school nurse as a strictly medical advisor rather than a truly educational participant.

Lack of awareness of the services which should be expected of the school nurse and a confusion of her functions with those of the attendance officer and with those of the teacher in health education.

Reluctance on the part of school administrators to have teachers assume responsibility for simple first aid, and reluctance of teachers to assume this responsibility.

Lack of appreciation of the part of school administrators of the need for work with poor school children and of the contributions the school nurse should make to this program.

Lack of community understanding of the school health program especially among physicians.\textsuperscript{52}

Some supervisors felt their major difficulties lay in their own inability to interpret the work of the staff nurse and the supervisor to school administrators.\textsuperscript{53}

Yet, at the same time, study data cited interpretative functions and cooperative planning as major activities of the school nurse supervisor.


\textsuperscript{53}Ibid., p. 193.
the means for integrating the school health
program with all aspects of the educational
program of the school; she helps to establish
means or works through already existing channels
for school-community planning for health
education. She works with parent groups and with
local health and social agencies, and provides
opportunities for nurses and teachers to work
through these channels for coordination or
effort.54

Since the primary purpose of school nursing supervision was
the improvement of health service given to the pupil, and
not merely improvement of nursing service, extending
functions of the supervisor to school personnel, parents,
and community groups was imperative.55 Leaders of the study
believed that a qualified nurse supervisor would "aid the
school nurse to function more fully, to direct her energy
along economical lines, and to work smoothly and in harmony
with school personnel, parents, and community represe-
tatives."56

Meanwhile, the outbreak of World War II was bringing
cooperation and collaboration into sharp focus. With
military demands rapidly depleting civilian staffs, the
nurse in the school was endeavoring to carry out essential
services without duplication. She was delegating tasks, not
requiring nursing skills, to classroom teachers, other

54Mary Ella Chayer and Marie Swanson, "Analysis of
Supervision of School Nursing," Public Health Nursing 37
(May 1945): 266.

55Ibid., 267.

56Chayer, Dilworth, and Swanson, op. cit., p. 193.
professional workers, and trained volunteers. At the same time she was extending her work into the community.  

To bring about the greatest amount of service for the largest number of children, with existing personnel, the nurse was dovetailing school health services with the community health program. More and more she was extending her observations and practice to the "younger members of families" to forestall, as much as possible, the development of physical defects.  

The school health service is a part of the total community health program. It serves one group in the community--the school-age group. Unless it dovetails closely with other programs for the school child and his family, it realizes only a fraction of its possibilities.  

In ordinary times a program that is not integrated is wasteful and incomplete. In times of stress, when there is increased need for emphasis on the health of the nation's children coupled with a growing shortage of medical and nursing personnel, it may be catastrophic. The school nurse with vision is stepping more and more outside the circle of her own job and establishing a close working relationship with all the forces


in the community that affect the lives of the children she serves.59

Coordinating efforts to protect the health of the community, as well as the school-aged child, was her objective.

The nurse in the school whether she gives all or only part of her time to the school child is aware that his health and welfare depend on full development of community health resources. Unless his surroundings outside the school provide a safe environment, unless his parents have the opportunity and desire to send him to school with all possible defects corrected, unless community resources are available for use of the school health department so that he may be sent into military or civilian life well equipped in regard to health and health knowledge, the school health job itself is not done.60

By midcentury, with the emphasis on coordinated planning, a chief task of the nurse was interpreting the school health program to the home and community and the health needs of the home and the community to the school.

The school has to see the community needs and the family needs to best serve the child in his formative years, while the community on the other hand, must come to understand the gigantic task of the schools and provide the financial and moral support necessary. . . .

The school nurse may not be able to spread her influence too far, but she does have an enviable position in being the friendly link between home and school—home and community. Her interpretation of her work to either can give a vista of the extent to which schools go today in


At the same time the concept of teamwork was emerging. In following through on health needs of children, the nurse will find it necessary to have a positive relationship with community agencies, which may be resources for the families needing the help as well as have a positive relationship with the families themselves. To gain such relationships means the nurse must be prepared to do good home visiting, parent counseling, and adult health education. Above all, the nurse's own personality must be such that she enlists cooperation and inspires effort among parents, children, and co-workers.62

Theoretically, the nurse and the teacher formed a team that constituted the framework of the school health program. As partners they shared considerable responsibility for the health of the school child.63

... In the school situation the teacher can combine her skills in the field of education and her multiple opportunities for observing children with the specialized skills of the public health nurse. Together they teach the children the meaning of good health and how it is maintained.64

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64 Kearsley, op. cit., p. 199.
Moreover, the success of the school health program was dependent upon the teacher-nurse relationship. No other single factor affected the accomplishment of the nurse's work as directly as did the closeness, continuity, and harmony of her relationship with the teacher. Quality service called for health guidance and education to be "the interchangeable project" of the teacher and the nurse.

But securing harmony in relationships and continuity of purpose demanded considerable planning and a mutual understanding of roles and responsibilities. Both the teacher and the nurse needed a clear-cut picture of the services each carried out to help the child in school attain optimal health.

... There should be delineation of responsibilities so the teacher and nurse clearly visualize what each can do most effectively in line with their respective preparation and experience. Mutual understanding eliminates comments such as "that is the nurse's job" or "why shouldn't the nurse do the health teaching."

Meanwhile, seeing cooperation as the key to sound relationships, a N.O.P.H.N. board member was advising the

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67 See Kearsley, op. cit., p. 197; Mary B. Rappaport, "Cooperation of the Nurse and Teacher in the Health Program in Small Communities," The Journal of School Health 27 (February 1956): 48; and Swanson, op. cit., p. 369.

68 Rappaport, op. cit., p. 48.
nurse to plan, confer, and work with the school staff as much as possible:

1. Before school opens meet with physical education teachers, guidance experts or any other personnel to discuss respective programs. . . .
2. Through conferences and some type of referral system, share information and findings with other personnel who can make the best use of them. . . .
3. Plan undertakings with other school personnel --as, for example, posture tests in cooperation with the physical education department.
4. Encourage classroom teachers to consult with school nurses on general health matters, policies, and any health problems that may seem too involved for teachers.
5. Make a point of attending and participating in faculty and PTA meetings.
6. Work closely with a school health council if one is organized.
7. Be sure all publicity and undertakings are cleared through the school principal. . . .
8. Interest the administrator in appointing a committee to prepare a leaflet describing school health services.69

Despite recommendations and pronouncements, cooperation between teachers and nurses was not always a reality. In 1949 two Denver staff nurses suggested the use of referral slips because some teachers were not sufficiently discriminating in giving students permission to see the nurse.

... Many, many hangnails and invisible splinters serve as an excuse to get out of arithmetic, and to cause such congestions in the nurse's office that useful work is seriously impeded. Granted that many of these chronic

visitors do have problems with which they need help and that the nurse by her interest and a moderate amount of sympathy may be of help to them, there is still room for a little more selectivity on the teachers part. . . . Taking the trouble to make out a slip might serve to make the teachers a little more selective and to call their attention to the fact that certain children make very frequent trips to the nurse.70

At the same time they conceded that "communication with and complete reporting to the classroom teacher" was a weak point of the nurse.71

Seven years later, in a study identifying and analyzing on-the-job problems and responsibilities, the problem most persistently mentioned was the nurse's relationship with the school staff, especially the classroom teacher.

The basic themes were: that teachers are not effectively performing their role in the school health service program; that they lack a working concept of the role of the school nurse, referring cases which should not be referred and failing to refer those which should be; and that they have no interest in the health program and will not accept their responsibility for the health of the students and the functioning of the school health program.72

The second most persistent problem was relations with administrators. Dealing with parents, particularly in the follow-up of defects, ranked fourthly.


71Ibid., p. 286.

Much of the comment related to "parental attitudes"—lack of interest, failure to cooperate, failure to understand the significance of findings, and so on. About half of those who considered this a problem area saw the situation in terms of economic barriers—e.g., the inability of the parent, due to lack of financial resources, to follow through on the necessary preventive or corrective measures.\(^\text{73}\)

Results emanating from a questionnaire sent to 40 members of the School Nursing Policies and Practices Committee, in 1955, were not dissimilar. Needs for school nursing, as perceived by the survey sample, included:

- Creating an awareness of school administrators, teachers and the public of the need for the value of better school health and school nursing services.
- Provision for supervision of the school nursing program.
- Ways for improving the administration of school nursing programs using the generalized service nurse.
- The development and clarification of personnel policies.
- Acceptance of school nurses by teachers as health consultants rather than as "first aiders."
- Equalization of school nurse salaries with those of other credentialed personnel.
- Coordination of the school health program with health department services.\(^\text{74}\)

\(^\text{73}\)Ibid., p. 22.

In the mid 1950s "development of leadership ability" was proposed as a solution to the many problems confronting the nurse. To develop this ability, a supervisor of school nursing suggested mastery of four areas: (1) nurturing of one's own native intelligence; (2) skillful use of the talents of others; (3) adequate understanding of human relations; and (4) ability to inform others about the school nursing program and how to use it.75

... If my observations are correct when these four points are mastered, the isolations, discouragements, and frustrations which school nurses often have will be more easily handled. In addition, more nurses could move forward in various ways of helping others.76

At the same time the teacher-conference was being touted as a valuable means for strengthening and enriching relationships between the teacher and the nurse.

This close alliance of the nurse and the classroom teacher in their general approach to the maintenance of a good school health program welds their relationship and promotes a mutual respect for the contributions each is able to make toward the development of the whole child.77


76Ibid.

77Wilder, op. cit., p. 211.
An excellent medium for exchanging knowledge and information, the conference also fostered cooperative action.78

Equally beneficial was a team conference. After studying the role of the nurse in the school health program, the A.P.H.A Committee on School Nursing found that the team conference, when properly organized and conducted, led to a better understanding of the nurse's role and helped to clarify the responsibilities of others in the school health program.79 "The team approach raised the nurse's status, helped her to see total school problems, and permitted school, community, and health representatives to exchange ideas."80

Earlier in the decade, as plans for restructuring nursing organizations progressed and the N.O.P.H.N. was dissolved, membership in the American School Health Association was advised. School nurses were encouraged to lend strong support to the Association and "make their


80 Ibid.
contribution to its already highly professional character."

The school nurses must feel it to be to their professional advantage to belong to both nursing and teaching organizations, for their own prestige and recognition, as well as to establish a greater security for themselves, locally, by states, and nationally. . . .

The American School Health Association membership and its monthly magazine will gradually provide a vocal medium . . . for school nurses where they can express their views and communicate with each other on a National level.\(^2\)

Recent Years

In the early 1960s the question of who should administer school nursing services resurfaced. Despite a sharp increase in the number of nurses employed by boards of education, a public health nurse was challenging the desirability of maintaining separate services. That school nursing was a generalized service belonging within the framework of public health was her stand.

. . . The ancient and honored public health principle that the family should be dealt with as a unit still has validity. Nurses give better service when they deal with the family as a whole. The present arrangement produces a break in continuity of supervision as the child passes from the preschool phase and enters school. . . . When the child has a communicable disease or a crippling condition, responsibility for the child must be shared by the school nurse and the health department nurse. Supervision of the family is further fragmented if there are several children


\(^{82}\)Ibid.
in different schools with different school nurses. There is real reason to question whether the intensified health services now being provided school children are altogether justified when the extra expense of administering two programs and the fragmentation of family health services are considered.93

Not surprisingly, the School Nursing Committee of the American School Health Association took the opposite stance: school nursing was a specialized service administered by boards of education.

The school nurse works as a member of the school staff under the administrative direction of the school to which she is assigned. The school administrator has the responsibility for the development, interpretation and maintenance of the school health program as part of the total school program. The nurse has a leadership role in planning the essential elements of the school health program, in cooperation with administrative staff, school personnel and representatives of the medical profession and appropriate community agencies.84

Regardless of whether she was employed by the board of health, the board of education, or a voluntary nursing agency, the nurse was responsible for acting as a liaison between the school and community and interpreting the health needs of school-age children to the family, community and school. Consequently, by the late 1960s, her functions were


perceived in terms of complex relationships: child-family-
nurse relationships, school health team-nurse relationships,
teacher-nurse relationships, curriculum committee-nurse
relationships, and community-nurse relationships.  

But oftentimes, in practice, relations between the
nurse and other professionals were strained. Study findings
were showing little coordination between education and
service, poor utilization of community resources, lack of
participation by the nurse in curriculum planning and policy
formulation, poor understanding of the nurse's functions,
lack of teacher interest and cooperation, and non-acceptance
of the nurse as a staff member.  

According to one
researcher, the frustrations encountered by the nurse in her
work clearly indicated the need for closer teamwork among
school and community personnel.  

Even though the need for the nurse to project her "true
image" was "deep and immediate," she was putting forth
little effort to do so.  

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85 Delphie J. Fredlund, "The Route to Effective School

86 See Joseph G. Dzenowagis, "Some Major Obstacles to
Better School Health Programs as Seen by School Nurses," The
Journal of School Health 32 (June 1962): 148-149; Clyde O.
Eidens, "The Work of the Secondary School Nurse-Teacher as
Perceived by Selected Public School Staff Personnel," The
Journal of School Health 33 (April 1963): 187-188; and Irma
Fricke, "The Illinois Study of School Nurse Practice," The

87 Dzenowagis, op. cit., p. 149.

88 McAleer, op. cit., p. 50.
kept her from clarifying and communicating her real functions and capabilities.  

Noteworthily, a sub-committee of the A.S.H.A. School Nursing committee was, about this same time, preparing guidelines on the use of communications media. The committee took various recipients of the nurse’s communication and built guidelines on the media most suitable for each. Records, reports, forms, telephone conversations, and face-to-face conferences were the mediums specifically suggested for communications with parents, pupils, teachers, administrators, physicians, professional agencies, and the community at large.

Further confounding the roles and relationships of the nurse, in the 1960s, was the use of ancillary help in the school health program. Confronted with shortages of qualified professional personnel, schools were recruiting

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89Ibid. See also Sister M. Jane deChantal, "Nurse-Teacher Relationship on the Elementary Level," The Journal of School Health 32 (March 1962): 81-85


assistants to carry out service functions that did not require professional nursing judgment or skill.

Among paid employees, several types of nursing assistants may be found. First, there is the registered professional nurse, a graduate of a diploma or an associate degree program, who has had no additional academic preparation. Then, in a few instances, a practical nurse or a nurse's aide has been employed. . . . In addition to nurse assistants, technicians have been employed to carry out such special activities as vision and hearing testing. . . .

In some school districts, groups of volunteers may be enlisted and trained to carry out a variety of activities.92

Relieving the nurse of non-professional tasks was, seemingly, a sound undertaking. The presence of nurse aides "freed the nurse and made it possible for her to function in a professional capacity."93 Evidence emerging from a 1967 study suggested

... that a full-time non-nurse assistant can, through carrying out under specific supervision routine functions ordinarily performed by the school nurse, release the school nurse to devote more time for parent counseling, parent education, child supervision, and to work more intensively with parents of children with special health needs.94

But a state supervisor of school nursing observed that many non-professionals were not serving as assistants.

93 Dunphy, op. cit., p. 1341.
Rather they were serving in place of the nurse. She contended the auxiliary worker had no place in school nursing.

... The ineffective use of nursing personnel simply aggravates the problem of shortages. The employment of a nurse who is not a qualified school nurse is a wasteful and dangerous procedure. She is removed from the setting in which she is trained to function and where her potential contribution is at the highest level.

... In the hospital setting, it is possible to assign certain duties to a person with less training if direct and continuous supervision is provided. Such supervision is neither feasible nor desirable in the school. The nurse in the school works in relatively independent manner, so a high level of professional competency is essential.

Concerned that the overall responsibility for school health services remain with qualified professional personnel, the A.S.H.A. Nursing Committee, in 1968, issued a statement on the non-professional assistance. In a set of guidelines, the Committee called for the non-professional to work under the immediate supervision of the nurse.

It is the responsibility of the professional staff to develop a list of duties for the aide, to plan her schedule and supervise her activities. The schedule of the aide must be carefully assessed and her time effectively utilized. The assistant should not be placed in the vulnerable position of substituting for the school nurse, "covering" the health office in her absence, or making decisions regarding referral of pupils to

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95Tipple, op. cit., p. 100.
96Ibid.
the nurse. Assignments, ideally, should correlate with the school nurse's time so the aide works primarily with and under the nurse's direction.88

Yet, at the same time, a group of researchers were speculating that nurses needed to develop supervisory skills and learn more about the role of health aides. They found nurses were using neither their time nor non-professional help effectively.69

Meanwhile the National Council for School Nurses was getting under way. Instituted in 1967, by the A.A.H.P.E.R., to foster the professional activity and growth of school nurses, the council was not an isolated group or new organization, but a "fuller utilization of existing opportunities.100 It offered school nurses a chance to function alone on problems that were "purely school nursing and also to participate with other educators through the team approach."101

By 1970 some nurses were questioning whether or not school administrators, teachers, and paramedical personnel would ever recognize their role as being more than a "giver of first-aid," a "medicine distributor," or a "clinic

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88Ibid.


101Ibid.
Frustration was expressed over the volume of time spent on clerical duties which less experienced personnel might perform.

At the same time, a leader in school nursing was advising the nurse to "utilize to the fullest all opportunities for team participation." By sharing her expertise with others in the school and community the nurse could provide "a larger range of opportunity" for meeting child needs and promoting positive health.

But, as in past decades, theoretical pronouncements were often far removed from the realities of practice. Investigating the role of the school nurse, a sociologist, in the early 1970s found nurses wanted to consider themselves as part of a team, but only rarely had evidence they were thought of in that way.

The clearest evidence was in the frequency of health record notations and psychologic recommendations to which they should be party, but of which they were not notified. Lack of communication was a problem varying from mild to severe but always present. Rarely included in general planning and operations, they were yet routinely expected to contribute intelligently at


104 Ibid.
faculty meetings and as members of committees on student affairs or curriculum.\textsuperscript{105}

Nurses were seemingly vulnerable to exploitation by others, "losing in the process much of their potential for demonstrating the value of their services."\textsuperscript{106}

Later in the decade, similar results were gleaned from a study examining the nurse as a member of the school health team. Findings showed that relations with teachers, counselors, school administrators, and parents; staff communication—teamwork breakdown; and lack of acceptance by school staff were major problem areas of the school nurse position.\textsuperscript{107} Responses from the study sample contained such items as

\ldots "lack of acceptance as a professional person, no definition of school nurse role, not accepted for more than routine first aid and screening, failure to use nurses' training, communication, superintendents' lack of knowledge of school nursing, no interaction with public health nurse or other health professionals, lack of communication with agencies and lack of consensus regarding duties of a school nurse."\textsuperscript{108}

According to a school nurse practitioner, disparate perceptions of school health programs and the role of the

\textsuperscript{105}Norman G. Hawkins, "Is There a School Nurse Role?" \textit{American Journal of Nursing} 71 (April 1971): 748.

\textsuperscript{106}Ibid., p. 750.

\textsuperscript{107}Barbara Thomas, "The School Nurse as a Member of the School Health Team: Fact or Fiction?" \textit{The Journal of School Health} 46 (October 1976): 469.

\textsuperscript{108}Ibid., p. 488.
nurse were contributing to the communication disturbances between educators and health professionals. . . . For school administrators there is a general expectation that the nurses' first priority will be to care for the injured and ill, thereby safeguarding the school from potential legal encounters. The nurse, on the other hand, skilled and interested in health promotion activities (nutrition, exercise, health education), often is more inclined to assign a higher priority to health teaching and counseling than first aid.¹⁰⁹

To improve collaboration she proposed five approaches:

1. A formal ongoing communication network between schools and health agencies should be developed in which the parent and the child assume some responsibility.
2. Relationships between educators and health professionals must improve before communication problems will be resolved.
3. Health professionals within and outside schools must strengthen their support for one another.
4. School health must attain a position of greater importance if equitable relationships and collaborative communication are to develop between educators and health professionals.
5. Communication will improve when the child's welfare becomes the shared central goal for all our relationships with one another.¹¹⁰

In one district, nurses were using communication and public relations skills to counter the effects of retrenchment. Stunned in 1975 by budgetary and staff cutbacks, they were making a "unified department effort to educate the district and community to the health needs of


¹¹⁰Ibid., p. 409.
the students and the nurse's role in filling these needs." With few district personnel, from board members to teachers, aware of their role, the nurses committed themselves to publicizing the importance of the nursing role in the educative process.

All of this school year, the school nurses have talked to anyone who would listen about school health needs and the importance of the nurse in the educational system. Whether or not our attempts at public relation, will ever produce additional nursing staff, we don't know. We do know that these efforts have definitely been beneficial for school nursing in general by educating others to the importance of meeting health needs as an integral part of the education of children.

To illuminate school nursing and make it more effective, another nurse declared:

... We must (1) establish positive relationships, (2) interpret the philosophy of school nursing to interested persons, and (3) simplify community health and family-oriented relationships for school personnel, pupils, and parents.

She used words from the past to promulgate the idea that a multiplicity of relationships was the key to an effective practice.

The school nurse relationship is one of a good will ambassador who can help establish and maintain good rapport with home and school. . . .


112 Ibid., p. 614.

... The school nurse has to know, appreciate and positively respond to the roles of all members of the team.

The school nurse is a resource person, supplementing health instruction, providing private conferences regarding an individual pupil and having inservice programs for teachers. This important relationship requires careful planning, conferences, and mutual understanding, more so than the other relationships.

... She must interpret her role to the administrator and the faculty, and there must be respect and understanding in this relationship.

... In order to minimize conflict, the school nurse must learn to follow the policies and procedures of the employing agency. ... She must remember that she is a cog in the team's wheel.114

Meanwhile data from a study exploring role relationships in a school health team were revealing many "overlapping responsibilities" among school physicians, health coordinators, and school nurses.115 There was however, a consensus, at various levels, of role behaviors among members of each professional specialty.

School nurses had a high agreement on their own role behaviors and the role behaviors of the other two specialties. School physicians had a low agreement on their own role behaviors or the role behaviors of health coordinators. However, they did have a high agreement on the role behaviors of the school nurses. Health coordinators had a low agreement on their own role behaviors or the role behaviors of the school nurses.

114 Ibid., pp. 117-118.

physician, but they too did have a high agreement on the role behaviors of the school nurses.\textsuperscript{116}

At the same time, a director of pupil personnel services was proposing the administration and supervision of the school nursing program come from a division of health services.

"... This means first, that the preferred jurisdiction emanates from the board of health and secondly, that the actual management and supervision of school nursing practice falls to someone from the health community, i.e., a supervising school nurse or a school physician."\textsuperscript{117}

He believed such an arrangement would lessen the school principal's domination of the nursing role.

"... While it would be naive to assume that the school principal will ever cease to be a major factor in the determination of the school nurse role, the opportunities for intervention and direction would be considerably less in the proposed administrative arrangement."\textsuperscript{118}

Putting more "stress and strain" on roles and relationships in the 1970s was the advent of the school nurse practitioner. Reactions of traditional school nurses to the practitioner movement were, at best, ambiguous. On a

\textsuperscript{116} Ibid.

\textsuperscript{117} Charles W. Humes, "Who Should Administer School Nursing Services?" \textit{American Journal of Public Health} 65 (April 1975): 396.

\textsuperscript{118} Ibid.
continuum, their responses were ranging from enthusiastic acceptance to hostile rejection.119

... Some nurses viewed it as a heaven-sent solution to the need for a clearer role and as a means of receiving third party reimbursement for services not heretofore rendered by nurses in a school setting (e.g., physical examinations). ... Other nurses felt highly threatened that their less visible health education and counseling skills, emphasized by nonpractitioner school nurses, would become less valued and even obsolete in comparison with diagnostic skills and equipment.120

The movement was further challenged with the task of securing changes in the nurse-physician relationship. If the practitioner was to perform effectively in an expanded role, a redefinition of the physician’s role was imperative.121

... The physician-school nurse team emerges as a more effective provider of health care if the identity of both members is altered to meet the needs of school health. In optimal circumstances, the physician moves from care provider to preceptor to colleague. This altering of the physician’s role is a critical task which must be accomplished for effective team functioning.

... The challenge then becomes one of establishing an identity which allows respect for


the physician's contribution and yet in no way diminishes the valuable input of the SNP.122

Despite troublesome relationships, role ambiguities, and confusing expectations, a sense of optimism prevailed as school nursing approached 1982. There were beliefs that school nurses could and would succeed; that school nursing was alive and here to stay; that school nurses would continue to be the mainstay of school health personnel; that different roles could complement rather than compete with each other; and that school nurses, individually and collectively, could wield their political power to effect change.123

School nurses were advised to put aside professional jealousy and competition, to see themselves as powerful, and to take charge of their practice area.124 In 1980 a nurse declared:

... We can no longer afford to indulge in powerlessness, naivete, and political inexperience. ... 
... School nurses everywhere need to act now by whatever means are appropriate to their

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122 O'Donoghue and Hogan, op. cit., p. 39.


situation to acquire and wield political power to effect change in school health and school nursing. . . . School nurses have power; what we need to do is recognize it, mobilize it and wield it.\textsuperscript{125}

Shortly thereafter, a study examining school nurses' perceptions of powerlessness in the work setting found that nurses were in "strategic positions to interpret and promote their role to maximize both their expert and legitimate power."\textsuperscript{126} From a sociopsychological perspective, the nurses perceived themselves as having considerable control over situational events in their work settings that might impinge on their performance.\textsuperscript{127}

Summary

For decades the nurse in the school has networked with a myriad of pupils, parents, teachers, counselors, administrators, physicians, paraprofessionals, community representatives, and social workers. A cog in the health team's wheel, she has been the most effective link between the home and the school and the home and the community. Relationships have been the cornerstone of her practice; cooperation and collaboration, her mainstay. Historically, the success of her service has been dependent upon continuity of purpose and harmony in relationships.

\textsuperscript{125}Wold, \textit{op. cit.}, p. 596.

\textsuperscript{126}Dolores Santora and Heather Steiner, "School Nurses and Powerlessness," \textit{The Journal of School Health} 52 (September 1982): 431.

\textsuperscript{127}Ibid., p. 430.
CHAPTER IX
SUMMARY, CONCLUSIONS, RECOMMENDATIONS

Historical or documentary research has long been a respected method of inquiry and investigators of history have made immeasurable contributions to the understanding of man's behavior and his social progress. Historical research is not merely a collection of incidents, facts, dates or figures; it is a study of the relationships of facts and incidents, of themes or currents of social and professional issues that have influenced past events and continue to influence the present and the future. A major contribution of historical inquiry is in the development of a broader, more complete perspective to enhance our understanding of the present and our approach to the future.¹

The purpose of this study was to investigate, from an historical perspective, the role of the nurse in the school setting as reflected in the literature from 1902 through 1982. The study aimed to (1) trace the role of the nurse in the school setting; (2) to document and describe movements and benchmark events in both school health education and nursing which were influential in shaping the role of the nurse in the school; and (3) to draw inferences about the future of school nursing.

Research questions the study sought to answer were:

1. How did events and movements in both school health education and nursing affect the role of the school nurse? When did these events and movements occur? Why did they occur?

2. In what ways has the dual professional preparation of the school nurse enhanced or hindered her role?

3. What influences have official agencies and professional health, education, and nursing organizations exerted on the development of school nursing?

4. What part have nationally known leaders in school nursing played in the evolution of the role of the school nurse?

5. Historically, what relationship has school nursing had to the mission of the school? What special contribution has the school nurse made to justify her position in the school setting?

6. How can the role of the nurse in the school be effectively and creatively fulfilled in the future?

Five steps, derived from the methodologies of Gay and Van Dalen, comprised the design of the study: (1) the problem to be examined was selected; (2) research questions were formulated; (3) data were gathered from school nursing literature in the 1902-1982 time span; (4) the data sources were examined using eight criteria to ascertain authenticity.
and accuracy; and (5) findings were interpreted and recorded using a chronological-topical approach.

Hypotheses to confirm or disconfirm causality were not proposed. The primary thrust of the study was to seek answers to the research questions. Antecedent conditions behind movements and benchmark events were recorded but no attempt was made to confirm causation.

Data were organized around four issues associated with the role of the school nurse: professional preparation, service functions and responsibilities, health instruction, and interpersonal relationships. Each issue was examined in the context of four time periods: 1902-1920, 1921-1940, 1941-1960, 1961-1982.

In the data chapters special emphasis was placed on:

1. identifying and describing movements and benchmark events which affected the professional preparation, service functions and responsibilities, teaching role of the school nurse, and interpersonal relationships;

2. ascertaining to what extent the dual professional preparation of the school nurse enhanced or hindered her role;

3. delineating roles and responsibilities of the nurse in the school setting;

4. exploring the influence of interpersonal relationships on the role of the school nurse;
5. examining the involvement and influence of official agencies and professional organizations on the development of school nursing;

6. enumerating the accomplishments and contributions of pioneers and leaders in school nursing;

Several delimitations and limitations were inherent in the study. The study was restricted to:

1. school nursing in the United States;

2. school nursing literature in the 1902-1982 time span;

3. the role of the nurse in the school setting;

4. selected issues associated with the role: professional preparation, service functions and responsibilities, health instruction, and interpersonal relationships;

5. selected articles from professional education, health education, nursing, and public health journals; school nursing texts; nursing history texts; public health nursing texts and manuals; curriculum guides; school nursing monographs; and published addresses, speeches, memoirs, and committee reports.

It was limited by:

1. knowledge and competence of authors in school nursing literature from 1902 through 1982;
2. bias of authors in school nursing literature from 1902 through 1982;
3. missing or inaccessible source material in school nursing literature;
4. a researcher's effect: inability of the researcher to maintain complete objectivity in the process of selecting, sorting, and interpreting data.

Summary of Findings
The major findings of the study may be summarized according to the four major issues associated with the role of the school nurse: professional preparation, service functions and responsibilities, health instruction, and interpersonal relationships.

Professional Preparation
For eighty years a number of individuals, committees, and organizations have endeavored to set requisites for entry into the practice of school nursing. Despite numerous recommendations, guidelines, and joint statements, the professional preparation of school nurses remains an enigma. A poorly defined role and dual professional commitment, as well as diverse educational modalities and varying certification requirements, hinder the development of uniform standards.

Service Functions and Responsibilities
School nursing services were introduced at the turn of the century in a move to control communicable diseases.
Since that time the practice has evolved into a complexity of services. But as multiple and diverse functions emerged, in response to changing health needs, so, too, did confusion and controversy about the role of the nurse in the school. Despite the numerous efforts of individuals and organizations to clarify functions and responsibilities, ambiguity surrounding the role of the nurse has persisted.

**Health Instruction**

Over the years professional health and nursing organizations, leaders in school nursing, and nurse-health educators have sought to define the school nurse's role in educational terms. Yet discrepancies are evidenced between what is prescribed and that which is actually practiced. Many school personnel, including school nurses, continue to view the school nurse in a traditional, rather than expanded, role. Theoretically, the nurse in the school has been perceived as a teacher of health, but, in reality, her role expectations are more illness-oriented.

**Interpersonal Relationships**

For decades the nurse in the school has networked with a myriad of pupils, parents, teachers, counselors, administrators, physicians, paraprofessionals, community representatives, and social workers. A cog in the health team's wheel, she has been a most effective link between the home and the school and the home and the community. Relationships have been the cornerstone of her practice;
cooperation and collaboration, her mainstay. Historically, the success of her service has been dependent upon continuity of purpose and harmony in relationships.

Conclusions

Findings emanating from answers to the research questions tend to support the following conclusions:

1. There has been no common role expectation of the nurse in the school setting. Across the years, roles and responsibilities have been analyzed and categorized in considerable detail, and from numerous perspectives, but a uniform standard of practice does not exist. Some have believed the nurse should function as a nurse-teacher. Others have contended she should be a public health nurse working in the school setting.

2. The nurse in the school has been perceived as a health educator, but in actuality, the role expectations of the nurse are more illness-oriented. Even though preventive and educative functions have been emphasized theoretically, curative functions often dominate the actual practice of the nurse.

3. Historically, a variety of social, political, and economic events, namely, war, economic depression, and social upheaval, have brought changes in the roles and responsibilities of the school nurse. Ever-changing societal health needs are reflected in the shifting emphases of school nursing activities.
4. The activities of professional organizations have contributed greatly to the advancement of school nursing. The school nursing committees of The American School Health Association and the National Organization for Public Health Nursing have strived to clarify the role of the school nurse and to upgrade standards for professional preparation.

5. From past to present, the nurse has played a vital role in the school setting. She has endeavored to alleviate health problems interfering with learning and to achieve optimal health for the school-aged population.

6. Disparity between the real and the ideal has existed for years. Theoretical pronouncements regarding professional preparation, service functions and responsibilities, health instruction, and interpersonal relationships oftentimes have not been translated into practice.

Recommendations

Data findings suggest the following recommendations for future research:

Historical biographies on school nursing pioneers and leaders, namely, Lina Rogers, Mary Chayer, Marie Swanson, Gertrude Cromwell, and Dorothy Tipple.

Historical investigation of the contributions school nurses made to the National Organization of Public Health Nursing and the American School Health Association.
Comprehensive investigation of the scope of the public health nursing heritage of school nursing.

Historical investigation of the specific roles the American School Health Association played in the evolution of school nursing.

Examination of issues and trends in school health education and their influence on the development of school nursing.

Oral histories with contemporary leaders in school nursing, namely, Dorothy Oda, Judith Igoe, Georgia MacDonough, Victoria Bertel, and Susan Wold.

An update of school nursing information as reflected in the literature from 1982.

Summary

This chapter presented the summary of findings, conclusions drawn, and recommendations made as a result of the study. Also included was a review of the study procedures.
EPILOGUE

Sometimes the road to the future seems long and hard, looks as if it had been deliberately obstructed or even torn up, and we grow impatient and discouraged. Then we can turn in the pages of nursing history to the story of women whose energy and vision drove them "o'er moor and fen, o'er crag and torrent, till the night was gone." The dawn they looked for and labored toward is here. The coming day is ours.¹

The past can serve as an inspiration for the future. Despite a history marked with crises and uncertainty, school nursing has persevered and forged ahead. School nurses, across the years, have been unrelenting in their efforts to secure change and preserve the practice.

So what lies ahead for school nursing? Most likely it will remain an enigmatic practice continuously challenged by a myriad of social, political, economic, and educational forces. Until the many issues surrounding preparation and practice are resolved, diversity and controversy will persist.

Part of the answer as to what will happen to school nursing in the future rests with the nurse herself. To fulfill her role effectively and creatively, she needs to focus on her assets, rather than her liabilities. She needs


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to assume a leadership role in interpreting and defining the health needs of the school-aged child. She needs to translate theoretical precepts into reality. She needs to give high priority to the preventive aspects of her role. She needs to experiment with new ways of delivering health care services. She needs to take charge of her practice and destiny.

The nurse in the school needs to value historical research. She needs to study her "roots." She needs to build her future on the foundation of her past. History does tend to repeat itself.

History tends to make us humble. It often shows us that what we think original is only repetition of what has been done before. It shows us how our predecessors struggled with problems almost exactly like those which we meet. It lets us see that the conditions under which they worked are often like those of today; that their methods were not wholly unlike ours; and that even their results resembled ours, and were no less conspicuous than those which we laud as remarkable.2

2 Ibid., p. vii.
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